August 2016 Medicaid Bulletin

Attention: All Providers

NC Medicaid Electronic Health Record (EHR) Incentive Program Announcements

Program Year 2016 is the last year to begin participating

Program Year 2016 is the last year providers can begin participating in the NC Medicaid Electronic Health Record (EHR) Incentive Program. The first payment of $21,250 can only be received in the first year of participation. If a provider, or a practice, has considered participating, this is the final year to enroll and receive up to $63,750 over six years.

Providers are eligible if:

1. They have a CMS-certified EHR,
2. They are Medicaid-enrolled physicians, nurse practitioners, certified nurse midwives, or dentists, (some physician assistants also qualify), and,
3. At least 30 percent of their patients are Medicaid beneficiaries.

Assistance is available through step-by-step attestation guides, an extensive library of answers to Frequently Asked Questions (FAQs), webinars and a dedicated help desk. Providers who would like local support meeting Meaningful Use (MU) criteria, or guidance in registering and attesting successfully, can contact our technical assistance partners at the nine regional NC AHECs. Further, if providers send the EHR Incentive Program an email, we can help them get started and connected to the best resources.

The NC Medicaid EHR program has paid over $285 million in incentives to more than 10,000 N.C. providers. N.C. Medicaid Incentive Payment System (NCMIPS) is now accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and MU attestations.

For more information, visit the NC Medicaid EHR Incentive Program web page, or send an email to NCMedicaid.HIT@dhhs.nc.gov.

NC Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers

Rendering Dialysis Services to Undocumented Aliens

Under Federal law, undocumented aliens and certain legal aliens who have not resided in the United States of America for more than five years **do not qualify** for full Medicaid assistance, but **do qualify** for medical emergency services. Federal policy (P.L. 104.193 Title IV, 42 C.F.R. 435.406 and 435.350, and section 1903(v) (3) of the Social Security Act) limits Medicaid coverage for services considered to be medical emergencies. N.C. Medicaid covers dialysis to undocumented aliens as an emergency service in a facility where licensed professionals monitor the condition of the beneficiary during each episode of care. Once the beneficiary is stable enough to receive in-home hemodialysis without benefit of the immediate attention of the medical provider, the treatment is no longer an emergency service.

Effective for dates of service Feb. 1, 2016 and after, changes have been implemented in the NCTracks system to ensure that claims processed for undocumented aliens eligible for hemodialysis-related services are only allowed when the services billed are related to the emergency dialysis. At this time, there have been no changes to the existing editing related to codes included in the dialysis composite rate. Therefore, there may be codes in the list below that have been deemed as medically emergent as they relate to dialysis services, **but will continue to be denied separate reimbursement because they are included in the dialysis composite rate.**

Note: An undocumented alien may qualify (as determined by the local county Department of Social Services) for other emergency services (visits to the emergency department or treatment for an emergent or life-threatening condition). However, coverage for other emergency services is evaluated separately from coverage for emergency hemodialysis and must be applied for by the individual separately.

Providers may obtain beneficiary eligibility information/verification through NCTracks or by submitting a 270 transaction. The response the provider receives, both through NCTracks and through the 271 transaction, will indicate that the beneficiary is eligible for only service type 76 (dialysis).

Dialysis Related Procedure Codes Allowed for Undocumented Aliens

Dialysis Facility Billing:

- Billing taxonomy code 261QE0700X with Revenue Code 0300, 0301, 0302, or 0305 and one of the following lab CPT codes:

80047	84155	82232	85044	84165	82565	85060	84520
82043	84540	83625	80069	85004	84100	82040	85014
83021	85025	84157	82374	85046	84300	82575	85611
84134	80051	84550	84075	81001	85008	84132	
84525	82150	85041	84163	82436	85049	84460	
85018	83615	80061	85002	84080	81003	85013	
85730	84156	82310	85045	84295	82570	85610	
80048	84545	83735	81000	85007	84105	82042	
82044	85027	84160	82435	85048	84450	83020	
83026	80053	84560	84078	81002	85009	84133	

- Billing taxonomy code 261QE0700X with Revenue Code 0821

- Billing taxonomy code 261QE0700X with Revenue Code 0829 and CPT Code 90989 or 90993

- Billing taxonomy code 261QE0700X with Revenue Code 0250 and the following HCPCS drug codes:

J0171	J0210	J0360	J0380	J0400	J0401	J0882,	J1120
J1160	J1200	J1205	J1240	J1640	J1730	J1800	J1940
J2150	J2370	J2690	J2720	J2760	J3410	J7030	J7040
J7042	J7050	J7060	J7070	J7131			

- Billing taxonomy code 261QE0700X with Revenue Code 0634 or 0635, and HCPCS code Q4081

- Billing taxonomy code 261QE0700X with Revenue Code 0301 and CPT codes 82108 or 82728

- Billing taxonomy code 261QE0700X with Revenue Code 0302 and CPT codes 86706 or 86803

- Billing taxonomy code 261QE0700X with Revenue Code 0305 and CPT code 85048

- Billing taxonomy code 261QE0700X with Revenue Code 0739 and CPT Code 93040, 93041 or 93042

- Billing taxonomy code 261QE0700X with Revenue Code 0391 and CPT Code 36430

Note: The revenue codes listed above must be billed with the CPT or HCPCS code indicated.

Physician billing:

- CPT Codes:

90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90967	90968	90969	90970
90989	90993	36821	36825	36830	36831	36832	36833
36835	36860	93040	93041	93042	J0882	J0886	Q4081

Independent Laboratory Billing:

- Billing Taxonomy Code 291U00000X billed with the following lab CPT Codes:

80047	80048	80051	80053	80061	80069	81000	81001
81002	81003	82040	82042	82043	82044	82150	82232
82310	82374	82435	82436	82565	82570	82575	83020
83021	83026	83615	83625	83735	84075	84078	84080
84100	84105	84132	84133	84134	84155	84156	84157
84160	84163	84165	84295	84300	84450	84460	84520
84525	84540	84545	84550	84560	85002	85004	85007
85008	85009	85013	85014	85018	85025	85027	85041
85044	85045	85046	85048	85049	85060	85610	85611
85730							

Practitioner, Clinical Services Unit
DMA 919-855-4260

Attention: All Providers
Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the Division of Medical Assistance (DMA) website at https://dma.ncdhhs.gov/providers/clinical-coverage-policies:

- 1M-2, Childbirth Education (7/1/16)
- 3L, State Plan Personal Care Services (PCS) (7/1/16)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Urine Drug Screening Update

Note: This article updates a June 2016 Special Medicaid Bulletin and a July 2016 Special Medicaid Bulletin.

The N.C. Division of Medical Assistance (DMA) is in the process of updating NCTracks to add the new HCPCS urine drug screening codes. The rates for the new codes have already been implemented. Additional programming logic was implemented on Aug. 1, 2016.

The presumptive test limitation of 20 per fiscal year took effect July 1, 2016, and is based on the state fiscal year of July 1 through June 30. Once the 20 test limit has been reached, further presumptive testing reimbursement will be denied.

Per the definition of G0477-G0483, validity testing is included when a urine drug test is performed and is not separately reimbursable. Procedure codes currently used for validity testing will be denied or recouped if billed by the same provider on the same date of service as a urine drug test. Presumptive and definitive testing are each limited to one test per date of service, per beneficiary, regardless of testing method or number of tests performed. (One test = one unit.)

As of July 1, 2016, presumptive testing (G0477, G0478, or G0479) must be performed and a claim submitted to NCTracks by the same or different provider before any definitive test (G0480-G0483) is reimbursed. The only exception will be when a specific drug needs to be tested for based on clinical findings and cannot be detected with presumptive testing methods.

Documentation to support performing the definitive test, including the unavailability of a presumptive test, will need to be uploaded with the claim. For codes G0481, G0482, and G0483, the presumptive drug screen result and any other supporting documentation will need to be uploaded with the claim clearly demonstrating that the number of drug classes producing an unanticipated result match the definition of the service performed. If the documentation supplied and procedure code billed do not match, the claim will deny.

Providers may bill with CPT codes 80300-80377 for dates of service through June 30, 2016. Beginning with dates of service July 1, 2016, providers need to select the most appropriate HCPCS code for the service rendered as these CPT codes will be end-dated.

DMA will issue additional information regarding implementation and reimbursement of G0477-G0483 as it becomes available.

CSRA, 1-800-688-6696

Attention: All Providers

New NC Provider 2057 Insurance Referral Form Feature

On Aug. 1, 2016, HMS added options to the NC Provider 2057 Insurance Referral form, which is used by providers to update a beneficiary's insurance policy information. The online form is the most efficient and timely way to update a beneficiary's insurance information on NCTracks. Within three days of the form's submission, HMS will review it, verify policy information and update the beneficiary's policy information on NCTracks.

Criteria used to verify and update the policy information are:

- Medicaid identification number
- Social Security number
- Policy begin and end date
- Group number
- Insured first and last name
- Employers name and address

The new form also provides specific options for the reason of the referral, which are:

- The beneficiary's Medicaid eligibility file does not list the policy above
- Beneficiary has never been covered by the policy
- Beneficiary's coverage ended (date)
- Policy lapsed (date)
- Carrier has changed; new carrier is _____
- Other

Note: Providers who fail to add all of the required information with their submission will have their request denied. Required fields are marked with an asterisk.

To access the new form, click on the following link https://ncprovider.hms.com/.
Those with questions should contact HMS at 866-263-2227 option No. 4.

Third Party Liability
DMA 919-814-0228

Attention: All Providers

New Edits for Family Planning Modifier

As of Aug. 1, 2016, two new edits have been implemented in NCTracks for MAFDN-covered services, also known as Family Planning Medicaid.

The first edit denies outpatient clinic claims and lab claims for MAFDN-covered services when the service has been rendered to a beneficiary with MAFDN coverage and the code is not billed with the FP modifier. The Explanation of Benefits (EOB) associated with the edit is:

- EOB 01659 (Edit 02608) - CLAIM DENIED. PROCEDURE CODE MUST BILL WITH FP MODIFIER.

The second edit denies outpatient clinic claims when no procedure code is billed or the procedure code is not covered by Family Planning Medicaid (MAFDN). The EOB for the edit is:

- EOB 02609 (Edit 02609) - CLAIM DENIED. FAMILY PLANNING PROCEDURE CODE MUST BE PRESENT ON FAMILY PLANNING CLAIM OR PROCEDURE CODE NOT COVERED BY MAFDN.

When billing covered revenue codes for MAFDN beneficiaries, a procedure code will be required on the claim. If no procedure code is found on the claim or the procedure code is non-covered by MAFDN, the claim will deny. Providers can refer to Clinical Coverage Policy 1E-7 for Family Planning Services for a list of covered revenue and procedure codes.

The Division of Medical Assistance (DMA) payer is the only NCTracks payer affected by this implementation. These edits are applicable to the MAFDN Benefit Plan and MAFDN beneficiaries. There will be no claims reprocessing as a result of this new update.

For a complete list of benefit plans mapped to DMA eligibility coverage codes, providers can refer to the Provider Policies, Manuals, Guidelines and Forms page on the NCTracks Provider Portal.

CSRA, 1-800-688-6696

Attention: All Providers

Update to Place of Service Codes 19 and 22

As of Jan. 1, 2016, providers were given the capability to differentiate between on-campus and off-campus provider-based hospital departments. The Centers for Medicare and Medicaid Services (CMS) created a new description for place of service (POS) – Code 19 – and revised the description for POS code 22.

The descriptions for each POS are:

- POS 19 - Off-Campus Outpatient Hospital: A portion of an off-campus hospital provider- based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

- POS 22 - On-Campus Outpatient Hospital: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

These selections will determine if the provider-based hospital department is located on, or is separate from the hospital's main campus.

For more information regarding the updates, providers may refer to the CMS website.

CSRA, 1-800-688-6696

Attention: All Providers

Claim Edit for Rendering Provider Service Location

Note: This is a reposting of an article from the June 2016 Medicaid Bulletin **with a revised implementation date.**

On March 2, 2015, NCTracks claims processing began searching for any active location on the provider record for which the rendering taxonomy code on the claim is valid. The claim is then processed using that location.

An Informational (pay and report) Edit 04528 RENDERING PROVIDER LOCATION CODE SET BASED ON TAXONOMY has been posted with Explanation of Benefits (EOB) 04528 on the Remittance Advice (RA). This edit alerts providers to take action to update the rendering provider location on the provider record.

EOB 04528 states "UNABLE TO DETERMINE RENDERING PROVIDER LOCATION CODE BASED ON THE SUBMITTED ADDRESS. LOCATION CODE HAS BEEN SET BASED ON THE RENDERING PROVIDER TAXONOMY ONLY. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING THE SERVICE FACILITY ON THIS CLAIM AS AN ACTIVE SERVICE LOCATION."

This was intended to be a temporary change to allow providers time to update their provider records with the correct rendering provider location information. The User Guide, *How to Change the Primary Physical Address in NCTracks*, which explains how to update provider location information, can be found under the heading "Provider Record Maintenance" on the Provider User Guides and Training page of the NCTracks Provider Portal.

Effective Nov. 1, 2016, the claim edit disposition for invalid rendering provider location will change from "pay and report" to "pend." Rendering providers must have the addresses of all facilities where they perform services listed as provider service locations under their National Provider Identifiers (NPIs) in NCTracks. The system uses a combination of NPI, taxonomy code, and service location in processing claims. If the address where the service was rendered is not listed in the provider record as a service location for the rendering provider's NPI, the claim will suspend with Edit 04526 and EOB 04526 – RENDERING LOCATOR CODE CANNOT BE DERIVED. This will delay the completion of claim adjudication and payment.

For more information regarding how to correct these pended claims, see the May 27, 2014 announcement on the NCTracks Provider Portal.

Note: Claims with invalid billing or attending provider locations also will continue to pend.

Rendering providers can add service locations to their provider record by having their Office Administrator (OA) complete a Manage Change Request (MCR) in the *Enrollment Status and Management* section of the secure NCTracks provider portal.

Note: When adding a new service location, the application also will require that taxonomies and applicable accreditations be added to the new service location. The pended claims are recycled periodically and will recognize changes in the provider record that alleviate Edit 04526. The provider does not need to resubmit the claim.

When updating a provider record in NCTracks, the MCR will assign a default effective date of the current date to most changes. **This is important because the system will edit subsequent transactions against the effective dates in the provider record.** For example, claims are edited against the effective date of the taxonomy codes on the provider record. **The claim will deny if a provider bills for a service rendered prior to the effective date of the relevant taxonomy code on the provider record**.

Some effective dates can be changed from the default date. When providers add or reinstate a health plan, service location, or taxonomy code, the effective dates can be changed from the default date. However, the effective date must be changed **before** the MCR is submitted. (The effective date also cannot precede the enrollment date or the date associated with the relevant credential or license and cannot be older than 365 days.)

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone)**;** 1-855-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers

Manage Change Request and Reverification Application Process

Note: This article was *originally* published in the *July 2016 Medicaid Bulletin*.

Most providers are required to submit a full Managed Change Request (MCR) before submitting a re-verification application. The due date for the re-verification application is extended an additional 45 calendar days if a MCR is still in process. MCR's and reverification applications are processed in the order in which they are received.

Authorized users are able to check the status of MCRs/Reverification applications by viewing the Status and Management page within the secure NCTracks Provider Portal.

CSRA, 1-800-688-6696

Attention: All Providers

NCTracks Provider Training Available in August 2016

Registration is open for several instructor-led training courses for providers that will be held in August 2016. The duration varies depending on the course.

Note: All courses and the day/time they are offered are subject to change.

Following are details on the courses, their dates and times and instructions for how to enroll.

Prior Approval - Medical (Professional)

- Tuesday, Aug. 9 - 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA Request.

The course is being offered in-person at the CSRA facility:
2610 Wycliff Road
Raleigh, NC

It includes hands-on training and will be limited to 45 participants.

Submitting a Professional Claim

- Tuesday, Aug. 9 - 1:00 p.m. to 4:00 p.m.

This course will focus on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to enter a professional claim, save a draft claim, use the Claims Draft Search tool, submit a claim and view the results of a claim submission.

The course is being offered in-person at the CSRA facility:
2610 Wycliff Road
Raleigh, NC

It includes hands-on training and will be limited to 45 participants.

Submitting Dental and Orthodontic Claims

- Tuesday, Aug. 16 - 1:00 p.m. to 4:00 p.m. (WebEx)

This course will focus on how to submit dental and orthodontic claims via the NCTracks Provider Portal. At the end of training, providers will be able to enter dental and orthodontic claims, save a craft claim, use the Claims Draft Search tool, submit a claim and view the results of a claim submission. This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Prior Approval – Institutional

- Thursday, Aug. 18 - 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) Requests **with a focus on nursing facilities**, to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It will also cover PA inquiry to check on the status of a PA Request.

The course is being offered in-person at the CSRA facility:

2610 Wycliff Road
Raleigh, NC

It includes hands-on training and will be limited to 45 participants.

Submitting an Institutional Claim

- Thursday, Aug. 18 - 1:00 p.m. to 4:00 p.m.

This course will focus on how to submit an institutional claim via the NCTracks Provider Portal **with emphasis on long term care and secondary claims**. At the end of training, providers will be able to enter an institutional claim, save a draft claim, use the Claims Draft Search tool, submit a claim, and view the results of a claim submission.

The course is being offered in-person at the CSRA facility:
2610 Wycliff Road
Raleigh, NC

It includes hands-on training and will be limited to 45 participants.

New Office Administrator

- Friday, Aug. 19 - 9:00 a.m. to 11:00 a.m. (WebEx)

This course shows authorized users the process for changing the current Office Administrator (OA) to a new OA for an individual provider or organization with a National Provider Identification (NPI) number or Atypical Provider Number. At the end

of training, participants will be able to update the OA for an individual provider or organization, and upgrade existing users to managing relationships. This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

CSRA, 1-800-688-6696

Attention: All Providers

Re-credentialing Due Dates for Calendar Year 2016

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

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/re-verification. 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 statuses 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 (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers

Reprocessing of Crossover Claims for Services Rendered to Qualified Medicare Beneficiaries

Note: This is an update to a *[June 2016 Special Medicaid Bulletin.](#)*

The N.C. Division of Medical Assistance (DMA) began the reprocessing of QMB claims with the June 21, 2016, checkwrite. During the month of July, DMA did not reprocess any QMB claims. The reprocessing of QMB claims is scheduled to resume with the Aug. 16, 2016, checkwrite.

Additional details regarding QMB reprocessing can be found in the *[June 2016 Special Medicaid Bulletin.](#)*

Provider Reimbursement
DMA, 919-814-0060

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Re-Credentialing Reminders for Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers must complete the re-credentialing process in order to provide Medicaid services. Failure to re-credential jeopardizes the continuity of service for CCNC/CA enrolled beneficiaries.

Providers will receive a letter through their NCTracks Message Center Inbox on the Provider Portal when they are scheduled to begin the re-credentialing process. If the provider does not complete the process within the allotted 45 days, the provider record will be suspended until re-credentialing has been submitted. Suspension of the provider record will cause payment to suspend.

Once a provider record is suspended, the suspension will not be lifted until the re-credentialing application has been submitted. Providers who have been suspended should follow the instructions in the letter to complete the re-credentialing process.

Providers whose records are suspended have 30 days to submit the re-credentialing or the provider record will be terminated. There will be no extension of the due-date after the record has been suspended. Once providers are terminated, they must submit a re-enrollment application to be reinstated. Enrolled beneficiaries under their care may be assigned to other providers.

For additional information on the re-credentialing process, see the [Provider Re-credentialing/Re-verification web page](#) on the NCTracks Provider Portal.

[Regional consultants](#) are available to assist with questions regarding how the re-credentialing process affects CCNC/CA providers.

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

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Managed Care Referrals in NCTracks

Note: This article was *originally* published in the *July 2016 Medicaid Bulletin*.

Prior to rendering treatment, providers must obtain a managed care referral from the beneficiary's assigned Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP), **unless** the specific service is exempt from managed care referral requirements.

For a listing of exempt services, see Section 6.4.4.3.2 "Services Exempt from CCNC/CA Authorization" in the *Provider Claims and Billing Assistance Guide*, located on the NCTracks Provider Policies, Manuals, Guidelines and Forms web page.

Currently, providers may use the National Provider Identifier (NPI) of the beneficiaries' CCNC/CA provider on the claim. However, CCNC/CA providers have the option to enter managed care referrals directly into NCTracks, and are encouraged to become familiar with this process. **As announced in a June 2016 Medicaid Special Bulletin, effective Nov. 1, 2016 NCTracks will deny a claim when an NPI is not submitted for the ordering provider, referring provider, operating provider, or service facility.**

Editing must also be implemented to ensure that the ordering provider or the referring provider is an individual; claims should not be paid if the ordering provider or the referring provider is identified in the system as an organization. **Beginning with dates of service Nov. 1, 2016, CCNC/CA referrals must be entered directly into NCTracks. Providers will no longer submit the beneficiary's PCP organization NPI on the claim for CCNC/CA referrals.**

Providers should begin provisioning their staff that may use this function in NCTracks. For more information on entering managed care referrals in NCTracks, see Section 6.4.2.1 "Managed Care Referrals: Submission" in the *Provider Claims and Billing Assistance Guide* or Section 5.0 the *NCMMIS Prior Approvals: Medical (Providers) Participant User Guide* in SkillPort. **Training is scheduled for July and will be announced on NCTracks.**

Regional consultants also are available to answer questions regarding Carolina ACCESS.

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

Attention: Nurse Practitioners, Physician Assistants and Physicians

Defibrotide sodium injection, for intravenous use (Defitelio®) HCPCS code J3490: Billing Guidelines

Effective with date of service April 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover defibrotide sodium injection, for intravenous use (Defitelio®) for use under the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs.

Defitelio is currently commercially available as single patient use vials containing 200 mg/2.5 mL (80 mg/mL) of defibrotide sodium.

Defitelio is indicated for the treatment of adult and pediatric patients with hepatic veno-occlusive disease (VOD), also known as sinusoidal obstruction syndrome (SOS), with renal or pulmonary dysfunction following hematopoietic stem-cell transplantation (HSCT).

The recommended dosage of Defitelio for adult and pediatric patients is 6.25 mg/kg every six hours given as a two-hour intravenous infusion. The dose should be based on patient's baseline body weight, defined as the patient's weight prior to the preparative regimen for HSCT. Administer Defitelio for a minimum of 21 days. If after 21 days signs and symptoms of hepatic VOD have not resolved, continue Defitelio until resolution of VOD or up to a maximum of 60 days.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Defitelio are: K76.5 - Hepatic veno-occlusive disease, Z94.84 - Stem cells transplant status, and T86.09 - Other complications of bone marrow transplant

- Providers must bill Defitelio with HCPCS code J3490 - Unclassified drugs.

- One Medicaid unit of coverage for Defitelio is one mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $356.40.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Defitelio are: 68727-0800-01 and 68727-0800-02.

- The NDC units for defibrotide (Defitelio) 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-340B 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 web page.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Capitsol®-enabled melphalan for intravenous injection (Evomela™) HCPCS code J9245: Billing Guidelines

Effective with date of service April 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover Captisol-enabled melphalan injection for intravenous use (Evomela™) under the Physician's Drug Program (PDP) when billed with HCPCS code J9245 – Injection, Melphalan Hydrochloride, 50 mg.

Evomela is currently commercially available as 50 mg/10 mL (5mg/mL)* lyophilized powder in a single-dose vial for reconstitution.

   *Melphalan free base (equivalent to 56 mg melphalan hydrochloride).

Evomela is indicated for use as a high-dose conditioning treatment prior to hematopoietic progenitor (stem) cell transplantation in patients with multiple myeloma, and also indicated for the palliative treatment of patients with multiple myeloma for whom oral therapy is not appropriate.

For Conditioning Treatment: The recommended dose of Evomela is 100 mg/m^2/day administered over 30 minutes by intravenous infusion for two consecutive days (Day-3 and Day-2) prior to autologous stem cell transplantation (ASCT, Day 0).

For Palliative Treatment: The recommended dose of Evomela is 16 mg/m^2 administered as a single intravenous infusion over 15-20 minutes at two-week intervals for four doses, then, after adequate recovery from toxicity, at four-week intervals.

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Evomela are: C90.00 - Multiple myeloma not having achieved remission, or C90.02 - Multiple myeloma in relapse.

- Providers must bill Evomela with HCPCS code J9245 – Injection, Melphalan Hydrochloride, 50 mg.

- One Medicaid unit of coverage for Evomela is 50 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $1,492.38.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Evomela is: 68152-0109-00.

- The NDC units for Evomela 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-340B 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 web page.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Antihemophilic Factor (Recombinant) Lyophilized Powder for Solution, for Intravenous Injection (Kovaltry®) HCPCS code J7192: Billing Guidelines

Effective with date of service April 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover Antihemophilic Factor (Recombinant) Lyophilized Powder for Solution, for Intravenous Injection (Kovaltry®) under the Physician's Drug Program (PDP) when billed with HCPCS code J7192 – Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified.

Kovaltry currently is commercially available in nominal strengths of 250 IU, 500 IU, 1000 IU, 2000 IU and 3000 IU of Factor VIII activity.

Kovaltry is indicated for use in adults and children with hemophilia A (congenital Factor VIII deficiency) for:

- On-demand treatment and control of bleeding episodes
- Perioperative management of bleeding
- Routine prophylaxis to reduce the frequency of bleeding episodes

Kovaltry is not indicated for the treatment of von Willebrand disease.

The recommended dosing for control of bleeding episodes and perioperative management can be estimated using the following formulas:

- Required dose (IU) = body weight (kg) x desired Factor VIII rise (% of normal or IU/dL) x reciprocal of expected/observed recovery (e.g., 0.5 for a recovery of 2 IU/dL per IU/kg).
- Estimated increment of Factor VIII (IU/dL or % of normal) = [Total Dose (IU)/body weight (kg)] x 2 (IU/dL per IU/kg).

For routine prophylaxis:

- Adults and adolescents: 20-40 IU/kg – two or three times per week.
- Children ≤12 years old: 25-50 IU/kg – two times per week, three times per week or every other day according to individual requirements.

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Kovaltry is D66 – Hereditary factor VIII deficiency.

- Providers must bill Kovaltry with HCPCS code J7192 – Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified.

- One Medicaid unit of coverage for Kovaltry is one IU. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $1.03.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Kovaltry Vial Adapter Kits are: 00026-3821-25, 00026-3822-25, 00026-3824-25, 00026-3826-50, 00026-3828-50. Vials: 00026-4821-01, 00026-4822-01, 00026-4824-01, 00026-4826-01, 00026-4828-01.

- The NDC units for Kovaltry 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-340B 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 web page.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Ferric pyrophosphate citrate solution and powder, for hemodialysis use, (Triferic®) HCPCS code J1443: Billing Guidelines

Effective with date of service April 25, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ferric pyrophosphate citrate solution and powder, for hemodialysis use, (Triferic®) under the Physician's Drug Program (PDP) when billed with HCPCS code J1443 – Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron.

Triferic is currently commercially available as solutions of 27.2 mg of iron (III) per 5 mL ampule (5.44 mg of iron (III) per mL) and 272 mg of iron (III) per 50 mL ampule (5.44 mg of iron (III) per mL).Triferic also is commercially available as 272 mg of iron (III) per packet of Triferic powder for solution.

Triferic is indicated for the replacement of iron to maintain hemoglobin in adult patients with hemodialysis-dependent chronic kidney disease (HDD-CKD).

Limitations of use: Triferic is not intended for use in patients receiving peritoneal dialysis and has not been studied in patients receiving home hemodialysis.

Dosing Information for Triferic

> **5 mL ampule:** for Individual Bicarbonate Mix to treat a single patient in your clinic.
>
> Add one 5 mL Triferic ampule to 2.5 gallons of bicarbonate concentrate to achieve a final concentration of Triferic iron (III) in the final hemodialysate of 2 micromolar (110 mcg/L).
>
> **50 mL ampule:** for Master Bicarbonate Mix to treat multiple patients in your dialysis clinic.
>
> - Add one 50 mL ampule of Triferic solution to each 25 gallons of bicarbonate concentrate to achieve a concentration of iron (III) in the final hemodialysate of 2 micromolar (110 mcg/L), **or,**
>
> - Add one packet of Triferic powder to each 25 gallons of bicarbonate concentrate to achieve a concentration of iron (III) in the final hemodialysate of 2 micromolar (110 mcg/L).

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Triferic are: D63.1 - Anemia in chronic kidney disease **and** N18.6 - End stage renal disease.

- Providers must bill Triferic with HCPCS code J1443 - Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron.

- One Medicaid unit of coverage for Triferic is 0.1 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $0.02.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Triferic are: 57278-0314-01, 57278-0314-02, 57278-0316-01, 57278-0316-02 and 57278-0316-03. The powder packet NDCs are: 57278-0315-01 and 57278-0315-02.

- The NDC units for Triferic 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-340B drugs (excluding vaccines).

- 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 web page.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Atezolizumab injection, for intravenous use (Tecentriq™) HCPCS code J9999: Billing Guidelines

Effective with date of service May 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover atezolizumab injection for intravenous use (Tecentriq™) under the Physician's Drug Program (PDP) when billed with HCPCS code J9999 – Not otherwise classified, antineoplastic drugs. Tecentriq is currently commercially available as a single-dose vial for injection as 1200 mg/20 mL (60 mg/mL) solution.

Atezolizumab is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have:

- Disease progression during or following platinum-containing chemotherapy
- Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

The recommended dose of Tecentriq is 1200 mg administered as an intravenous infusion over 60 minutes every three weeks until disease progression or unacceptable toxicity. If the first infusion is tolerated, all subsequent infusions may be delivered over 30 minutes. Do not administer Tecentriq as an intravenous push or bolus. No dose reductions of Tecentriq are recommended; refer to the package insert for withholding Tecentriq.

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Tecentriq are:
  - C65.1 - Malignant neoplasm of right renal pelvis
  - C65.2 - Malignant neoplasm of left renal pelvis
  - C65.9 - Malignant neoplasm of unspecified renal pelvis
  - C66.1 - Malignant neoplasm of right ureter
  - C66.2 - Malignant neoplasm of left ureter
  - C66.9 - Malignant neoplasm of unspecified ureter
  - C67.0 - Malignant neoplasm of trigone of bladder
  - C67.1 - Malignant neoplasm of dome of bladder
  - C67.2 - Malignant neoplasm of lateral wall of bladder
  - C67.3 - Malignant neoplasm of anterior wall of bladder
  - C67.4 - Malignant neoplasm of posterior wall of bladder

- C67.5 - Malignant neoplasm of bladder neck
- C67.6 - Malignant neoplasm of ureteric orifice
- C67.7 - Malignant neoplasm of urachus
- C67.8 - Malignant neoplasm of overlapping sites of bladder
- C67.9 - Malignant neoplasm of bladder, unspecified
- C68.0 – Malignant neoplasm of the urethra

- Providers must bill Tecentriq with HCPCS code J9999 – Not otherwise classified, antineoplastic drugs.

- One Medicaid unit of coverage for Tecentriq is one mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $465.48.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Tecentriq is: 50242-0917-01.

- The NDC units for Tecentriq 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-340B 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 web page.

CSRA 1-800-688-6696

Attention: Optical Service Providers and Optometrists

Centers for Medicare & Medicaid Services (CMS) Relative Value Unit Update: CPT code 67228

Effective Jan. 1, 2016, the global period for CPT code 67228 (laser destruction of leaking retinal blood vessels, one or more sessions), has changed from 90 to 10 days. System updates reflecting this change have been completed and providers who had claims deny can resubmit these claims for reprocessing.

System changes completed through MP 16.469/FMR 3737

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Pharmacy Providers

Pharmacy Reimbursement Methodology Changes

On Jan. 11, 2016, the Centers for Medicare & Medicaid Services (CMS) notified the Division of Medical Assistance (DMA) that its State Plan Amendment (SPA 14-047) had been reviewed and is consistent with 42 CFR 430.20. **It was approved effective Jan. 1, 2016.**

The approved SPA proposes that the state will use an average acquisition cost (AAC) reimbursement methodology to reimburse brand and generic drug ingredient costs. The National Average Drug Acquisition Cost (NADAC) will be used to determine the AAC when NADAC is available. If NADAC pricing is not available, the state will calculate the AAC as the Wholesale Acquisition Cost (WAC) + 0 percent. Reimbursement methodology will continue to include the lesser of NADAC, or WAC in absence of NADAC, and the State Maximum Allowable Cost (SMAC) rate on file. The amendment also proposed that the state pay pharmacies a tiered dispensing fee as follows:

- $13.00 when 85 percent or more claims per quarter are for generic or preferred brand drugs,
- $7.88 when less than 85 percent of claims per quarter are for generic or preferred brand drugs, and
- $3.98 for non-preferred brand drugs

A NADAC FAQ has been posted on the [DMA website.](#)

These changes have been implemented in NCTracks on Aug. 1, 2016. Pharmacy claims paid between January 1 and July 31, 2016, will be reversed and rebilled according to the updated reimbursement methodology. A further announcement will be posted when the date for the claim reprocessing has been finalized.

Until then, pharmacies will continue to be paid according to the current reimbursement methodology. Pharmacies are advised that this may result in an overpayment once the reverse and rebilling process is completed. Any difference will be recouped against future payments.
[This is an update to the [March 2016 Medicaid Pharmacy Newsletter.](#)]

CSRA, 1-800-688-6696

Attention: Pharmacy Providers

Payment of Medicare Crossover Pharmacy Claims for QMB Recipients

Reimbursement of Medicare primary pharmacy claims for recipients with the Medicaid eligibility classification of "Q" have changed. **Beginning Aug. 1, 2016**, NCTracks pays QMB and QMB+ (a.k.a. Q class) Medicare crossover pharmacy claims according to state policy:

- Services covered by Medicaid are paid at Lesser of Logic
- Services that are non-covered by Medicaid pay the full cost-share

The determining factor regarding how the pharmacy crossover claims are reimbursed is whether or not the NDC is covered by Medicaid on the date of service. If the National Drug Code (NDC) is covered by Medicaid on the date of service, the claim will process to pay according to the Lesser of Logic pricing methodology. If the NDC is not covered by Medicaid on the date of service, it will process to pay 100 percent of Medicare cost share.

Note: For recipients who are MQBQ, Medicaid payment can only be made for services that have been approved/allowed by Medicare. There is no coverage for straight Medicaid claims for MQBQ recipients.

Medicare crossover pharmacy claims paid between March 2, 2015, and July 31, 2016, will be reprocessed to apply the state policy. A further announcement will be published once the date for reprocessing has been finalized.

For more information on the state policy regarding reimbursement of Medicare crossover claims for QMB recipients, including an explanation of Lesser of Logic, see the September 2015 Medicaid Bulletin.

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
August 2016	08/04/16	08/09/16	08/10/16
	08/11/16	08/16/16	08/17/16
	08/18/16	08/23/16	08/24/16
	08/25/16	08/30/16	08/31/16
September 2016	09/01/16	09/07/16	09/08/16
	09/08/16	09/13/16	09/14/16
	09/15/16	09/20/16	09/21/16
	09/22/16	09/27/16	09/28/16
	09/29/16	10/04/16	10/05/16

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