September 2016 Medicaid Bulletin

Attention: All Providers

NCTracks and DMA Website – Back to Basics

The following "Back to Basics" chart is designed to help providers find commonly searched information on both the NCTracks portal and the N.C. Division of Medical Assistance (DMA) website.

NCTracks Resources

Web Page	Description
Getting Started with NCTracks	Step-by-step instructions for **how to obtain access** to the NCTracks secure Provider Portal
Sign Up for the NCTracks Email Newsletter	Register to receive **email newsletters** from NCTracks
Attend Provider Training	Announcements regarding upcoming provider training, including instructions for **How to Register in SkillPort**, for instructor-led and computer-based training courses, such as **Prior Approval Request and Inquiry** and **How to File a Claim**
Get Answers to Frequently Asked Questions (FAQs)	FAQs on topics including **Provider Enrollment**, **Re-verification**, **Accounts Receivable**, **Claim Submission**, **Prior Approval**, as well as an NCTracks Glossary of Terms
User Guides and Job Aids	Detailed instructions for completing common provider activities, such as "**How to Submit Claim Adjustments and Time Limit and Medicare Overrides**." Also includes information on **submitting refunds**
NCTracks Fact Sheets	Fact sheets on key provider topics, such as **Prior Approval**, **Remittance Advice (RA)** and **Features of the NCTracks Portal Help System** as well as a fact sheet for **Ambulance providers**
Check Recipient Eligibility	**Verify the eligibility of recipients** using the secure provider portal or the Automated Voice Response System (AVRS)
Provider Policies, Manuals, Guidelines and Forms	Information on making full use of NCTracks, such as the **EOB Code Crosswalk to HIPAA Standard Codes** and the **Carolina ACCESS Override Request Form**
Checkwrite Schedule – 2016 (DMA)	**Claim submission cutoff and payment dates** for each of the 50 checkwrites in 2016

Web Page	Description
Issues List	Excel spreadsheet documenting **common issues** experienced by providers using NCTracks and **how they were resolved**, updated weekly. Providers should consult the Issues List before calling NCTracks.
NCTracks Contact Information	**How to contact NCTracks** via mail, fax, and phone

N.C. DMA Resources

Clinical Coverage Policies	List of all **DMA Clinical Coverage Policies** for Medicaid and N.C. Health Choice
Fee Schedules	**Fee schedules** for services payable by NC DMA, listed by provider type
DMA Forms	**Common DMA forms used by providers**, listed by provider type
Medicaid Bulletins	Past and present **Medicaid Bulletins** published by DMA, including Special Bulletins
Pharmacy Newsletters - 2016	Monthly **newsletter for pharmacy providers**. (Newsletters from 2014 and 2015 also are available)

CSRA, 1-800-688-6696

Attention: All Providers

NCTracks Provider Training Available in September 2016

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

Courses and the day/time they are offered are subject to change.

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

Create and submit a PA for Durable Medical Equipment (DME) and Home Health Supply using an electronic physician signature (WebEx)

- Tuesday, Sept. 6 – 10:00 a.m. to noon

This course will guide users through the new process for providers when creating and submitting a PA for DME and Home Health Supply. In the new process, providers will enter a Prior Approval (PA) request on the Provider Portal and then route it through NCTracks to the prescribing provider for review and approval using an electronic signature (PIN). At the end of training, participants will be able to:

- Assign a user role to a provider,

- Assign a DME or Home Health PA request to the prescribing provider,

- Access the notification of the PA request within the NCTracks Provider Portal Message Center, and

- Accept, reject or revise a PA request electronically.

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 – Pharmacy

- Thursday, Sept. 8 - 1 p.m. to 3 p.m.

This course will explain how to submit and inquire about pharmacy PA requests on the NCTracks Provider Portal. It also will cover PA inquiry to check on the status of the pharmacy PA Request. The course is offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Prior Approval – Institutional

- Wednesday, Sept. 21 – 9:30 a.m. to noon

This course will cover submitting PA requests **with a focus on nursing facilities**, to help providers comply with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA request. This course is offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Submitting an Institutional Claim

- Wednesday, Sept. 21 - 1 p.m. to 4 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 offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Prior Approval - Dental and Orthodontic

- Tuesday, Sept. 27 – 9:30 a.m. to noon (WebEx)

This course will cover submitting PA requests for dental and orthodontic procedures to help providers comply with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of the PA request. 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.

Submitting Dental and Orthodontic Claims

- Tuesday, Sept. 27 – 1 p.m. to 4 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 draft 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.

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Log on 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

NCTracks Computer-Based Training (CBT) Course List

NCTracks has a variety of Computer-Based Training (CBT) courses that are always available to providers. Anyone with NCID access to the NCTracks secure Provider Portal can take a self-paced course.

A list of the available NCTracks CBT courses can be found here and under Quick Links on the NCTracks Provider Training page of the public Provider Portal. The list in the spreadsheet includes the title, course number, folder, course overview, and learning objectives for each CBT, as well as filters, so providers can easily find topic areas of interest. (**Note:** Some CBTs may be found in more than one folder.)

To select a CBT course in SkillPort, the NCTracks Learning Management System, log on 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 under the heading "CBTs." Refer to the Provider Training page for specific instructions on how to use SkillPort, as well as how to obtain an NCID. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

The CBT training courses are designed for both new and experienced providers and their staff who use the NCTracks system.

CSRA, 1-800-688-6696

Attention: All Providers

Non-Emergency Medical Transportation

Note: This information was originally published in a Special Medicaid Bulletin in June 2016.

Non-emergency Medical Transportation (NEMT) providers must directly enroll in the N.C. Medicaid program as required by the Affordable Care Act (ACA) and the N.C. Medicaid State Plan. Currently NEMT providers are contracted with and paid for transportation services through County Departments of Social Services (DSS). **Beginning May 1, 2016, NEMT providers can complete the NCTracks online enrollment application.**

Prior to enrolling as NEMT providers, each provider **must** have a contract with the local County DSS. The determination to grant a contract is at the discretion of the County DSS. The County DSS will submit payment authorization to the Division of Medical Assistance (DMA) for the providers it selects. This authorization allows payment of the provider's NEMT claims. If the provider enrolls prior to contracting with the local County DSS, the provider will not be authorized for any NEMT payments. In addition, the provider may not be entitled to a refund of enrollment fees.

The N.C. Medicaid enrollment fee is $100 and covers costs associated with processing the enrollment application. The $100 fee is required for initial enrollments, re-enrollments and during each five year re-credentialing process. The ACA application fee is $554 for calendar year (CY) 2016 and covers the costs associated with screening. The ACA application fee is a one-time fee.

For NEMT providers, the available taxonomy code is 343900000X-Non-emergency Medical Transport. With this taxonomy, no certification, accreditation, or license is required when completing the enrollment application. NEMT providers can only enroll in the N.C. Medicaid health plan. Before the application can be approved, the N.C. Medicaid enrollment fee, the federal ACA fee, an ACA site visit, background check and an online training are required.

Beginning Sept. 1, 2016, six counties and their contracted NEMT providers will pilot the NEMT claims process in NCTracks. The six counties are:

- Alamance
- Catawba
- Cumberland
- Franklin
- Lincoln
- Rowan

Training for the pilot counties and their NEMT providers has been completed. **After Sept. 1, 2016,** in order for NEMT providers who serve the above six counties to be reimbursed for transportation services, the providers must:

- Be enrolled in NCTracks
- Contract with the county DSS, and
- Have a payment authorization for the service in NCTracks

For the remaining 94 counties and their providers, the new NEMT claims process will begin in early 2017. NEMT providers may enroll now in preparation for the rollout to these counties. The date of implementation and training will be announced in future Medicaid Bulletins.

To enroll, NEMT providers can use a National Provider Identifier (NPI) or atypical identifier (ID), as long as the new NEMT taxonomy has been added to the NPI/atypical record. If the organization does not have an NPI, they will enroll as an atypical organization. The atypical ID or the NPI submitted on the claim must match the identifier on the PA.

Providers with questions about the NCTracks online enrollment application 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

Affiliation Claim Edit

Note: This is an update of an article from the *June 2016 Medicaid Bulletin*, **including a revised implementation date.**

One of the requirements associated with NCTracks is that attending/rendering providers must be affiliated with the billing providers who are submitting claims on their behalf. The disposition of Edit 07025 has been set to "pay and report." The "pay and report" disposition means that claims where the attending/rendering provider is **not** affiliated with the billing provider will **not** deny, but Edit 07025 and EOB 07025 will post on the provider's Remittance Advice (RA).
EOB 07025 reads:

> THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED.

The intent was to alert providers to situations in which the affiliation relationship does not exist. This allows the attending/rendering provider to initiate a Manage Change Request (MCR) to add the affiliation to the provider record.

Effective Feb. 6, 2017, the claim edit disposition will change from "pay and report" to "pend" and will no longer give the informational message. Once the disposition is changed, a claim failing the edit will suspend for 60 days. Providers will continue to receive EOB 07025:

> THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED.

If the affiliation relationship is not established within that time period, the claim will be denied. Providers must correct any affiliation issues immediately.

Note: The MCR to establish or change a provider affiliation must be initiated by the OA of the individual attending/rendering provider. A group or hospital that acts as a billing provider cannot alter affiliations in NCTracks.

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

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

Re-credentialing Due Dates for Calendar Year 2016

Note: 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 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

New CPT Codes in 2015

With the 2015 procedure code update review it was initially determined that N.C. Medicaid would not cover the following new procedure codes.

After further review, the Division of Medical Assistance (DMA) has made the decision that **for dates of service on or after Jan. 1, 2015, providers <u>can</u> bill and receive reimbursement for these procedure codes.**

Providers who have billed and received denials for these codes and have kept claims filed timely can resubmit claims for payment.

22510 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

22512 - Each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

22513 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar

22515 - Each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

CSRA, 1-800-688-6696

Attention: All Providers

NC Medicaid Electronic Health Record (EHR) Incentive Program Announcements

Program Year 2016 is the last year to begin participating

N.C. Medicaid Incentive Payment System (NC-MIPS) is accepting program year 2016 Adopt, Implement, Upgrade (AIU) and Meaningful Use (MU) attestations.

Program Year 2016 is the last year providers can begin participating in the NC Medicaid Electronic Health Record (EHR) Incentive Program. Providers who have not attested by the end of program year 2016 **will not** have another opportunity to participate. The first payment of $21,250 can only be received in the first year of participation.

In addition to receiving $63,750 over six years of successful participation, the use of certified EHR technology can help a practice achieve measurable improvements in patient health care. Providers are eligible for the incentive if they:

1. Have a Centers for Medicare and Medicaid Services (CMS)-certified EHR,
2. Are Medicaid physicians, nurse practitioners, certified nurse midwives or dentists (some physician assistants also qualify), and,
3. At least 30 percent of their patients are Medicaid-enrolled.

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 can receive onsite support for meeting MU criteria, and guidance in registering and attesting, from technical assistance partners at regional NC AHECs at no cost. Email the NC Medicaid EHR Incentive Program to get connected to the best resources to meet your needs.

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

'Quick Tip' Webinar Series

Those who want to learn more about the program but are short on time can review the "Quick Tip" webinar series. These webinars were designed with the busy practice in mind and feature high-level webinars that are less than five minutes long. Topics include registering on the CMS Registration and Attestation System and what MU looks like in program year 2016. These webinars can be found on the NC Medicaid EHR Incentive Program web page under the 'Resources and Webinars' tab.

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

Attention: All Providers

Direct Enrollment of Mid-Level Providers

The services of Mid-Level providers can be submitted as "incident to" the services of the physician claims through Oct. 31, 2016.

After Nov. 1, 2016, the services provided by mid-level providers can no longer be billed "incident to".

Mid-level providers are Physician Assistants (PAs), Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives (CNM). These mid-level providers must enroll with N.C. Medicaid and N.C. Health Choice (NCHC). All services provided must be filed to NCTracks using their National Provider Identifier (NPI) as the rendering (or attending) provider.

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

Practitioners and Facilities
DMA, 919-855-4320

Attention: All Providers

Procedures for Prior Authorization of Synagis for Respiratory Syncytial Virus (RSV) Season 2016/2017

The clinical criteria used by N.C. Medicaid for the 2016/2017 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the American Academy of Pediatrics (AAP): *2015 Report of the Committee on Infectious Diseases, 30th Edition*. This guidance for Synagis use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription.

The coverage season is Nov. 1, 2016 through March 31, 2017. Providers are encouraged to review the AAP guidance prior to the start of the RSV season. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are evaluated for Synagis requests.

Guidelines for Evidenced Based Synagis Prophylaxis

- Infants younger than 12 months at start of season with diagnosis:

    - Prematurity – born before 29 weeks 0 days gestation

    - Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32 weeks 0 days gestation and required greater than 21 percent oxygen for at least 28 days after birth)

    - Hemodynamically significant acyanotic heart disease and receiving medication to control congestive heart failure, will require cardiac surgical procedures and moderate to severe pulmonary hypertension

    - Infants with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.

- Infants during first year of life with diagnosis:

    - Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways

- Infants less than 24 months of age with diagnosis:

    - Profound immunocompromise during RSV season

- - CLD of prematurity (see above definition) and continue to require medical support (supplemental oxygen, chronic corticosteroid or diuretic therapy) during 6 month period before start of second RSV season

- - Cardiac transplantation during RSV season

Prior Approval Request

Submit all Prior Approval (PA) requests for coverage of Synagis during the coverage season electronically at www.documentforsafety.org/. (Those using Internet Explorer might get a pop-up menu and have to click "Continue to this Website.") The web-based program will process PA information in accordance with the guidelines for use. A PA request can be automatically approved based on the information submitted. The program allows a provider to self-monitor the status of a request. Up to five doses can be approved for coverage. Coverage of Synagis for neuromuscular disease or congenital anomaly that impairs ability to clear respiratory secretions from the upper airway will terminate when the beneficiary exceeds 12 months of age. Coverage of Synagis for CLD, profound immunocompromised or cardiac transplantation, will terminate when the beneficiary exceeds 24 months of age.

Dose Authorization

Each Synagis dose will be individually authorized to promote efficient product distribution. Providers must submit a "**next dose request**" to obtain an authorization for each dose. Providers should ensure the previously obtained supply of Synagis is administered before submitting a next dose request. Providers will fax each single dose authorization to the pharmacy distributor of choice.

If an infant received one or more Synagis doses prior to hospital discharge, the provider should indicate as part of the request the most recent date a dose was administered and the number of doses administered by the provider should be adjusted accordingly. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough laboratory confirmed RSV hospitalization, coverage of Synagis will be discontinued.

Pharmacy Distributor Information

Single dose vial specific authorizations, not to exceed the maximum number of doses approved for the beneficiary, will be issued by the Division of Medical Assistance (DMA). It is important for the Synagis distributor to have the appropriate single dose authorization on hand and a paid point of sale (POS) claim prior to shipping Synagis. An individual dose authorization is required for each paid Synagis claim. The drug quantity submitted on the claim should not exceed the quantity indicated on the authorization. Payment for a Synagis claim will be denied if a dose request was not done by the provider.

Synagis claims processing will begin on Oct. 26, 2016, to allow sufficient time for pharmacies to provide Synagis by Nov. 1, 2016. Payment of Synagis claims with date of service before Oct. 26, 2016, and after March 31, 2017 is not allowed. POS claims should not be submitted by the

pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound-drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment.

Physicians and pharmacy providers are subject to audits of beneficiary records by DMA. Maintain Synagis dose authorizations in accordance with required record keeping time frames.

Provider Information

Providers without internet access should contact the Medicaid Outpatient Pharmacy Program at 919-855-4300 to facilitate submission of a PA request for Synagis. More information about the Synagis program is available at www.documentforsafety.org/. (Those using Internet Explorer might get a pop-up menu and have to click "Continue to this Website.")

Submitting a Request to Exceed Policy

The provider should use the **Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age** to request Synagis doses exceeding policy or for coverage outside the defined coverage period. The form, and more information about EPSDT coverage, is available on DMA's EPSDT web page.

Technical Support

Technical support is available Monday through Friday, 8 a.m. to 5 p.m. by calling 1-855-272-6576 (local: 919-926-3986). Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Ambulatory Surgery Providers
Ambulatory Surgical Centers (ASC) Procedure Update

The Division of Medical Assistance (DMA) has become aware of codes no longer billable by Ambulatory Surgery Centers (ASC) per the Centers for Medicare & Medicaid Services (CMS). These codes were still active in NCTracks and listed on the Medicaid fee schedule for ASC.

To comply with federal regulations and align NCTracks and the N.C. Medicaid Fee Schedule for ACS with current Medicare reimbursement methodology, DMA end-dated 299 codes that are no longer separately reimbursable by ASC. Refer to the tables below regarding the effective end-dates of codes previously billable by ASC:

The following codes have an effective end-date of July 1, 2013:

15756	15757	15758	19260	19364	20660	20661	20955	20962	20969
20970	21365	21366	21385	21386	21387	21395	21422	21423	21470
21510	21620	22100	22101	22325	22326	22327	22328	24150	25170
26553	26554	26992	27030	27095	27096	27303	27507	27511	27513
27535	27715	31290	31291	31292	31293	31294	31584	31600	31620
31785	31800	32420	34101	38205	38765	38790	43351	43352	43770
43771	43772	43773	43774	44345	44346	46934	46935	46936	47001
49000	49400	49425	50020	50040	50205	50520	50684	50690	51600
51605	51610	51865	51900	51920	53853	54125	54230	54535	57310
57311	58110	58140	59325	59850	59851	59852	61556	61796	61797
61798	61799	61800	62140	62146	62258	62351	63620	63621	69802
91010	92018	92502	53853						

Note: Procedure code 30901 is end-dated effective Sept. 30, 2013.

The following codes have an effective end-date of Dec. 31, 2013:

15151	15152	15156	15157	15201	15221	15241	15261	15272	15274
15276	15278	15777	15787	15847	17003	17312	17314	17315	19001
19126	22103	26125	26861	26863	27358	27692	29826	31632	31633
31637	36476	36479	37185	37186	49568	51797	56606	57267	64480
64484	64491	64492	64494	64495	64634	64636	64727	64778	64783
64787	64832	64837	64859	64872	64874	64876	64901	64902	67225
67320	67331	67332	67334	67335	67340	11045	11046	11047	11101
11201	11732	13102	13133	13150	13153	14302	15003	15005	15101
15111	15116	15121	15131	15136					

The following codes have an effective end-date of Dec. 31, 2014:

15786	15788	15792	15793	15852	15860	16000	17110	17340	19297
20979	29125	29126	29130	29131	29240	29260	29280	29520	29530
29550	30300	31720	33225	36420	36425	36680	37222	37223	40804
42809	43753	43754	46600	51701	51702	51736	54056	64402	65205
65210	65220	65222	65430	67820	68200	68801	69200	69210	69220
76882	11200	11305	11720	11721	11740	11900	11901	11980	11981
11982	11983	12001	12002	12004	12011	12013	12014	37237	37239

The following codes have an effective end-date of Dec. 13, 2015:

11300	11301	11302	11303	11306	11308	11730	11765	16020	17000
17111	17250	17260	17261	17262	17263	17272	17280	17360	41250
41800	45520	51741	51792	53601	53661	54050	57150	91200	

ASC providers are advised that claims paid after the end dates of these procedures will have resulted in an overpayment and claims will be reversed by DMA. Refer to future bulletin articles and notifications from Provider Reimbursement regarding the recoupment process for these claims.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Nurse Practitioners, Physicians and Physician's Assistants

Antihemophilic Factor (Recombinant), Single Chain for Intravenous Injection, Powder and Solvent for Injection (Afstyla®) HCPCS Code J7199: Billing Guidelines

Effective with date of service June 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover Antihemophilic Factor (Recombinant), Single Chain for Intravenous Injection, Powder and Solvent for Injection (Afstyla®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified. Afstyla is currently commercially available in nominal strengths of 250 IU, 500 IU, 1000 IU, 2000 IU and 3000 IU.

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

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

Limitation of Use

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

Recommended Dosing

Recommended dosing (for intravenous use after reconstitution only):

- Each vial of Afstyla is labeled with the amount of recombinant Factor VIII in international units (IU or unit). One unit per kilogram body weight will raise the Factor VIII level by 2 IU/dL.

- Plasma Factor VIII levels can be monitored using either a chromogenic assay or a one-stage clotting assay – routinely used in US clinical laboratories. If the one-stage clotting assay is used, multiply the result by a conversion factor of 2 to determine the patient's Factor VIII activity level.

Calculating Required Dose:

Dose (IU) = Body Weight (kg) x Desired Factor VIII Rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL)

On-Demand Treatment and Control of Bleeding Episodes:

- **Minor bleeding episode:** Factor VIII activity level required (% or IU/dL) 20-40; repeat injection every 12-24 hours until bleeding is resolved.

- **Moderate bleeding episode:** Factor VIII activity level required (% or IU/dL) 30-60; repeat injection every 12-24 hours until bleeding is resolved.

- **Major/life-threatening bleeding episode:** Factor VIII activity level required (% or IU/dL) 60-100; repeat injection every 8-24 hours until bleeding is resolved.

Routine Prophylaxis:

- **Adults and adolescents (≥ 12 years):** The recommended starting regimen is 20 to 50 IU per kg of Afstyla administered two to three times weekly.

- **Children (< 12 years):** The recommended starting regimen is 30 to 50 IU per kg of Afstyla administered two to three times weekly. More frequent or higher doses may be required in children < 12 years of age to account for the higher clearance in this age group.

- The regimen may be adjusted based on patient response.

Perioperative Management:

- Ensure the appropriate Factor VIII activity level is achieved and maintained.

- **Minor surgery:** Factor VIII activity level required (% or IU/dL) 30-60; repeat injection every 24 hours for at least one day, until healing is achieved.

- **Major surgery:** Factor VIII activity level required (% or IU/dL) 80-100; repeat injection every 8-24 hours until adequate wound healing, then continue therapy for at least another seven days to maintain a Factor VIII activity of 30-60 percent (IU/dL).

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Afstyla is D66 - Hereditary Factor VIII deficiency.

- Providers must bill Afstyla with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified.

- One Medicaid unit of coverage for Afstyla is one IU. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $1.78.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Afstyla are: 69911-0474-02, 69911-0475-02, 69911-0476-02, 69911-0477-02 and 69911-0478-02.

- The NDC units for Afstyla 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 the Division of Medical Assistance's (DMA) 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, Physicians and Physician's Assistants

Hydroxyprogesterone Caproate Injection, for Intramuscular Use (Delalutin®) HCPCS Code J3490: Billing Guidelines

Effective with date of service June 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover hydroxyprogesterone caproate injection, for intramuscular use (Delalutin®) under in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs. Hydroxyprogesterone caproate is currently commercially available as 250 mg/mL in 5 mL vials as an oil solution, multiple dose vial.

Hydroxyprogesterone caproate is indicated for the treatment of advanced adenocarcinoma of the uterine corpus (Stage III or IV); in the management of amenorrhea (primary and secondary) and abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology, such as submucous fibroids or uterine cancer; as a test for endogenous estrogen production and for the production of secretory endometrium and desquamation.

The recommended dosage of hydroxyprogesterone caproate injection varies based on indication. Refer to package insert for various dosing regimens.

Important Note: Hydroxyprogesterone caproate (Delalutin J3490) is different from hydroxyprogesterone caproate (Makena J1725) and does not have the same reimbursement amounts. Makena J1725 is only indicated for the prevention of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. The claims will be denied if the appropriate J codes are not used with the appropriately corresponding diagnosis codes.

For N.C. Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing hydroxyprogesterone caproate (J3490) are:

  Advanced adenocarcinoma of uterine corpus (Stage III or Stage IV)
  C54.0 - Malignant neoplasm of isthmus uteri
  C54.1 - Malignant neoplasm of endometrium
  C54.2 - Malignant neoplasm of myometrium
  C54.3 - Malignant neoplasm of fundus uteri
  C54.8 - Malignant neoplasm of overlapping sites of corpus uteri
  C54.9 - Malignant neoplasm of corpus uteri, unspecified
  C79.82 - Secondary malignant neoplasm of genital organs

Management of amenorrhea (primary and secondary) and abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology, such as submucous fibroids or uterine cancer

N91.0 - Primary amenorrhea
N91.1 - Secondary amenorrhea
N91.2 - Amenorrhea, unspecified
N91.3 - Primary oligomenorrhea
N91.4 - Secondary oligomenorrhea
N91.5 - Oligomenorrhea, unspecified
N92.0 - Excessive and frequent menstruation with regular cycle
N92.1 - Excessive and frequent menstruation with irregular cycle
N92.2 - Excessive menstruation at puberty
N92.3 - Ovulation bleeding
N92.4 - Excessive bleeding in the premenopausal period
N92.5 - Other specified irregular menstruation
N92.6 - Irregular menstruation, unspecified
N95.0 - Postmenopausal bleeding
E30.1 - Precocious puberty

As a test for endogenous estrogen production and for the production of secretory endometrium and desquamation

N85.00 - Endometrial hyperplasia, unspecified
N85.01 - Benign endometrial hyperplasia
N85.02 - Endometrial intraepithelial neoplasia [EIN]

- Providers must bill hydroxyprogesterone caproate with HCPCS code J3490 - Unclassified drugs.

- One Medicaid unit of coverage for hydroxyprogesterone is 1 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $1.66.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for hydroxyprogesterone caproate is: 62559-0540-15.

- The NDC units for hydroxyprogesterone caproate 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 the Division of Medical Assistance's (DMA) 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

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 Division of Medical Assistance's 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
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
October 2016	10/06/16	10/12/16	10/13/16
	10/13/16	10/18/16	10/19/16
	10/20/16	10/25/16	10/26/16
	10/27/16	11/01/16	11/02/16

_____

Sandra Terrell, MS, RN   **Paul Guthery**
Director of Clinical   **Executive Account Director**
Division of Medical Assistance   **CSRA**
Department of Health and Human Services