



**North Carolina Medicaid Bulletin
November 2016**

In this Issue Page

All Providers

N.C. Medicaid Electronic Health Record (EHR) Incentive Program Announcement 2

Clinical Coverage Policies.....3

NPIs and Service Facilities3

NCTracks Provider Trainings Available in November 2016.....4

Action on Unresolved Accounts Receivable.....7

Managed Care Auto-Assignment of Specific Medicaid Beneficiaries
to CCNC/CA Providers.....7

Ordering, Prescribing and Referring Providers Reminder.....8

Carolina ACCESS Payment Authorization.....9

Claim Edit for Rendering Provider Service Location.....10

Affiliation Claim Edit.....12

NCTracks – General Updates.....13

Re-credentialing Due Dates for Calendar Year 2016.....14

NC Medicaid and N.C. Health Choice Preferred Drug List Changes.....15

Durable Medical Equipment Providers

Durable Medical Equipment Update.....16

Hospital Providers

Sterilization Claims Pended with ICD-10 Procedure Code 0UB70ZZ.....16

NC Health Choice Hospital Outpatient Cost Settlement.....17

Nurse Practitioners, Physician Assistants and Physicians

Von Willebrand Factor (Recombinant) for Intravenous Injection, Lyophilized
Powder for Solution (Vonvendi™) HCPCS Code J7199: Billing Guidelines.....18

*Providers are responsible for informing their billing agency of information in this bulletin.
CPT codes, descriptors and other data only are copyright 2016 American Medical Association.
All rights reserved. Applicable FARS/DFARS apply.*

Attention: All Providers**N.C. Medicaid Electronic Health Record (EHR) Incentive Program
Announcement****Six Months Remaining to Participate in the EHR program**

Since 2011, the N.C. Medicaid EHR Incentive Program has paid more than \$285 million in incentives to N.C. providers for adopting, implementing or upgrading to a certified EHR technology and meaningfully using that technology in their practice. Only six months remain to begin participating in the program, so providers who are interested should begin the process now.

In addition to earning \$63,750 over six years, 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 [CMS-certified EHR](#)
2. Are Medicaid physicians, nurse practitioners, certified nurse midwives or dentists (some physician assistants also qualify)
3. Have at least 30 percent Medicaid-enrolled patients

Program Year 2016 is the last year to start participating and earn the first year payment of \$21,250. The N.C. Medicaid Incentive Payment System ([NC-MIPS](#)) is accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and Meaningful Use (MU) attestations through April 30, 2017. Providers will have until April 30, 2017 to submit a complete and accurate attestation. **After that, no changes can be made.** Providers are encouraged to attest as soon as possible to give time to address any attestation problems and discrepancies.

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 free onsite support for meeting MU criteria, and guidance in registering and attesting, from our technical assistance partners at the regional [NC AHECs](#).

For more information on how to start participating, visit the [N.C. Medicaid EHR Incentive Program web page](#), or send an email to NCMedicaid.HIT@dhhs.nc.gov.

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

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>:

- 5A, *Durable Medical Equipment (11/1/16)*
- 8P, *NC Innovations (11/1/16)*
- 9, *Outpatient Pharmacy Program (10/1/16)*
- 10A, *Outpatient Specialized Therapies (11/1/16)*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**NPIs and Service Facilities**

The N.C. Division of Medical Assistance (DMA) has reassessed the rules around the requirement for a service facility's National Provider Identifiers (NPI) to be submitted on claims. Because there are scenarios where it would not be appropriate to submit the service facility's NPI, NCTracks will not be modified to enforce this requirement as previously indicated on page 5 of the [September 2016 NC Medicaid Special Bulletin](#), *Fed. Reg 42 CFR 455.410 - Attending, Rendering, Ordering, Prescribing, Referring Providers & NPI*

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**NCTracks Provider Trainings Available in November 2016**

Registration is open for several provider training courses which will be held in November. The courses are instructor-led and duration varies depending on the course.

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

Submitting Pharmacy Prior Approvals

- Tuesday, Nov. 8 - 9:30 a.m. to noon (WebEx)
- Tuesday, Nov. 29 - 1 to 3 p.m. (WebEx)

This course shows participants how to electronically submit and inquire about pharmacy Prior Approval (PA) requests using the NCTracks provider portal. 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 Prior Approval (Medical)

- Thursday, Nov. 10 - 9:30 a.m. to noon (On-site)

This course shows authorized users how to electronically submit and inquire about PA requests for a variety of medical services. After completing this course, authorized users will be able to:

- Submit PA and managed care referrals electronically
- Conduct electronic inquiries about PAs

The course is being 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 Professional Claims

- Thursday, Nov. 10 - 1 to 4 p.m. (On-Site)

This course will focus on how to submit professional claims using the NCTracks provider portal. At the end of training, providers will be able to:

- Enter professional claims
- Save draft claims
- Use the claims draft search tool
- Submit claims
- View the results of claim submissions

The course is being 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.

Provider Web Portal Applications – NEMT

- Monday, Nov. 14 - 1 to 4 p.m. (WebEx)

This course will explain changes to reimbursement procedures for Non-Emergency Medical Transportation (NEMT) providers, as well as provide an overview of the provider enrollment application. At the end of this course, users will be able to:

- Explain the changes that will affect NEMT providers
- Understand the Provider Enrollment Application process
- Navigate to the NCTracks provider portal's status and management page
- Access SkillPort, the NCTracks Learning Management System, for additional provider training opportunities

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.

Create and Submit a PA for DME and Home Health Supply Using Electronic Signature

- Tuesday, Nov. 15 - 10 a.m. to noon (WebEx)

This course will guide users through the process that allows the requesting providers to enter a Prior Approval (PA) request on the NCTracks provider portal and route it through NCTracks to the prescribing provider for review and approval using an electronic signature (PIN). At the end of training, users will be able to:

- Assign a user role to a provider
- Assign a Durable Medical Equipment (DME) PA request to the prescribing provider
- Assign a Home Health Supply PA request to the prescribing provider
- Access the notification of the PA request within NCTracks provider portal message center
- Accept a PA request and confirm it with an electronic signature
- Reject a PA request and send it back to the requesting provider
- Revise a PA request and re-assign it to the prescribing provider

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 Institutional Prior Approvals

- Thursday, Nov. 17 - 9:30 a.m. to noon (On-Site)

This course will cover submitting and inquiring about Prior Approval (PA) requests – **with a focus on nursing facilities** – to ensure compliance with Medicaid clinical coverage policy and medical necessity requirements. The course is being 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 Institutional Claims

- Thursday, Nov. 17 – 1 to 4 p.m. (On-Site)

This course will focus on how to submit institutional claims 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
- View the results of a claim submission

The course is being 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.

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** and **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 web page also includes a quick reference regarding Java, which is required for the use of SkillPort.

CSRA, 1-800-688-6696

Attention: All Providers**A**ction on Unresolved Accounts Receivable

An Accounts Receivable (AR) is created in NCTracks when a provider does not have sufficient paid claims in the current checkwrite to satisfy a recoupment of funds, often related to claims reprocessing. As noted in previous communication, as of May 1, 2016, recoupment of a system-generated AR begins with the subsequent checkwrite after the AR has been established.

If an AR is not satisfied within 60 days, payment to the National Provider Identifier (NPI) for which the AR was established, as well as all other NPIs associated with the same Internal Revenue Service (IRS) Taxpayer Identification Number (TIN), is suspended. A 60 Days Past Due Letter is sent only to the provider for whom the AR was established, not to any other providers who share the same IRS TIN. Impacted providers cannot be paid or submit a re-verification application as long as a balance is 60 days past due.

Providers are responsible for repaying the North Carolina Department of Health and Human Services (DHHS) payer (e.g. the Division of Medical Assistance) even if they are no longer filing claims to NCTracks.

For more information, providers can refer to the DHHS Provider Administrative Participation Agreement, which can be found on the NCTracks [Terms and Conditions page](#). A list of Frequently Asked Questions (FAQs) regarding the AR process can be found on the [FAQ page](#).

CSRA, 1-800-688-6696

Attention: All Providers**M**anaged Care Auto-Assignment of Specific Medicaid Beneficiaries to CCNC/CA Providers

In November 2016, changes will be made allowing NCTracks to work with NC FAST in order to meet requirements for auto-assignment of beneficiaries to a Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP). These changes include updates to the “North Carolina Medicaid/Health Choice Notification of Intent to Enroll Letter” that is sent to beneficiaries informing them of their auto-assigned provider and giving instructions to change providers, if desired.

The auto-assignment process will follow state business rules that take into consideration factors such as whether the beneficiary has already been treated by a CCNC provider that meets the auto-assignment criteria, as well as gender and ages served by the provider location.

CSRA, 1-800-688-6696

Attention: All Providers

Ordering, Prescribing and Referring Providers Reminder

As the N.C. Division of Medical Assistance (DMA) announced in previous Medicaid Bulletins, effective with date of service Nov. 1, 2016, certain claim types will require an attending, rendering, ordering, prescribing, referring or operating provider NPI be included on the claim. The edits for attending, rendering and prescribing providers have already been implemented, but the disposition of the edits will change on Nov. 1. For additional details regarding the claim types and specific rules, see the [September 2016 Special Medicaid Bulletin](#).

The following rules apply to *attending, rendering, ordering, prescribing, referring or operating* provider NPIs:

- If an attending, rendering, ordering, prescribing, referring or operating provider NPI is required for the claim type, the claim will **deny** if the appropriate provider NPI is **not** present on the claim.
- The attending, rendering, ordering, prescribing, referring or operating provider NPI submitted on the claim must be enrolled in N.C. Medicaid or N.C. Health Choice (NCHC) or the claim will **suspend** for 90 days to allow time for the provider to enroll.

The following rules apply to *referring and ordering* provider NPIs:

- The referring or ordering provider must be an **individual** provider. If a claim is submitted with a group provider NPI in the “referring or ordering provider” field, the claim will **deny**.

Note: Many of the CCNC/CA PCP NPIs are organizations. Failure to adhere to the guidance to discontinue billing the NPI of the CCNC/CA PCP organizations in the “referring provider” field (mentioned above) will result in claim denials for billing a referring provider who is not an individual.

Billing providers are encouraged to check the enrollment of the attending, rendering, ordering, prescribing, referring or operating provider prior to rendering service. Billing providers can look up current enrollment information regarding other providers using the [Enrolled Practitioner Search Page](#) on the NCTracks Provider Portal. For more information, see the [September Special Medicaid Bulletin](#) and the [OPR FAQs](#) on the NCTracks Provider Portal.

Certain provider types, such as residents and interns enrolled in Graduate Dental and Medical Programs and Area Health Education Centers, are exempt from these requirements. For guidance regarding these exceptions, see the [June Special Medicaid Bulletin](#).

CSRA, 1-800-688-6696

Attention: All Providers**C**arolina ACCESS Payment Authorization

Historically, the National Provider Identifier (NPI) of the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP) has been used in the “referring provider” field of a claim as payment authorization. Recently, it was indicated that providers would need to use the online managed care referral process; however, that guidance from the N.C. Division of Medical Assistance (DMA) has changed, as noted in the [September Medicaid Special Bulletin](#).

Effective with date of service Nov. 1, 2016:

- Providers will no longer put the NPI of the CCNC/CA PCP in the “referring provider” field of the claim
- Providers will not be required to use the online CCNC/CA referral process on the NCTracks provider portal
- CCNC/CA overrides will no longer be required

Claims for dates of service prior to Nov. 1, 2016, will still require the NPI of the CCNC/CA PCP in the “referring provider” field of the claim or a CCNC/CA override must be obtained. Providers are still expected to adhere to coordination of care practices associated with CCNC/CA.

If providers include the NPI of the CCNC/CA PCP in the “referring provider” field of the claim for dates of service after Nov. 1, the claim will be subject to the edits associated with the ordering, prescribing or referring provider (OPR) changes.

Note: Some computer billing systems may automatically plug the PCP NPI on the claim.

CSRA, 1-800-688-6696

Attention: All Providers**C**laim 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.

This is the revised implementation date: 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 pending 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**Affiliation Claim Edit**

Note: This is a reposting of an article from the [June 2016 Medicaid Bulletin](#) with 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. Currently, 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.

This is the revised implementation date: 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 60 days, 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

NCTracks – General Updates

2017 Checkwrite Schedules Posted

The 2017 checkwrite schedules for the N.C. Division of Medical Assistance (DMA) and the N.C. Division of Mental Health, Division of Public Health and Office of Rural Health (DMH/DPH/ORH) have been posted to the NCTracks website. They can be found under the Quick Links on the right side of the [Provider Portal home page](#).

A Reminder about Unsubscribing from NCTracks Email Listserv

NCTracks has a listserv for email communication with providers, associations, and trading partners. Anyone can sign up for the listserv by going to the [Provider Communications page](#) on the provider portal and using the link in the upper-right corner that says “click here to join mailing list”.

Those who do not wish to receive email from NCTracks, can click on the “SafeUnsubscribe” link in the footer of any NCTracks email. However, once unsubscribed, NCTracks can no longer send **any** email communication.

Email is a key means of communicating with the provider community about important topics regarding NCTracks, such as outstanding issues, claims reprocessing, upcoming system changes, etc. A concerted effort is made to limit the number of emails sent. To keep informed, providers are encouraged to remain subscribed to NCTracks email communication.

Those who have unsubscribed from NCTracks email communication and wish to re-subscribe, can click on the link on the [Provider Communications page](#) and re-enter their email address.

NC Health Check Program Guide Available

The [N.C. Health Check Program Guide](#) is now available. It also is available as an October Special Bulletin on the on the DMA [2016 Medicaid Bulletins and Index](#) web page.

CSRA, 1-800-688-6696

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/re-validation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes NPI numbers and provider names, to compare with their provider list.

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

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

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. When it is necessary to submit a full managed change request (MCR), the provider must submit the full MCR prior to the 45th day and the application status must be in one of these 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 reverification application by the reverification 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). **A list of providers scheduled for 2017 will be made available in November on DMA's website.**

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC Medicaid and N.C. Health Choice Preferred Drug List Changes

Effective **Oct. 1, 2016**, Harvoni, Epclusa (for genotypes 2 and 3), Technivie (for genotype 4), Viekira Pak, Viekira XR, and Zepatier moved to preferred status on the North Carolina Medicaid Preferred Drug List (PDL). Harvoni, Viekira, Viekira XR, and Zepatier are all now preferred agents for genotype 1. Daklinza, Epclusa (for genotypes 1, 4, 5, and 6), Olysio, and Sovaldi will be non-preferred. **Clinical criteria (existing prior authorization criteria) will continue to apply for all Hepatitis C treatments.**

Effective **Nov. 1, 2016**, the N.C. Division of Medical Assistance (DMA) made changes approved by the Preferred Drug List Review Panel to the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL). Providers can find the current PDL on the [DMA PDL web page](#).

Below are a few highlights of the changes:

- Long Acting Insulin class - Non-preferred products require trial and failure of one preferred drug instead of two preferred drugs
- Invokamet has been moved to preferred status. (still requiring trial and failure of a metformin containing product)
- All strengths of Accuneb are preferred.
- Astelin nasal spray has been moved to non-preferred status.
- Vivitrol has been moved to preferred status.
- Exemption added to Viberzi for beneficiaries with Irritable Bowel Syndrome with Diarrhea.
- Exemption added to Epaned Solution for children under 12 years old.

CSRA, 1-800-688-6696

Attention: Durable Medical Equipment Providers**Durable Medical Equipment Update****CORRECTION - Time limits for retro-active Medicaid DME prior authorization requests**

Effective **Oct. 1, 2016**, Durable Medical Equipment (DME) providers will have up to three months after a beneficiary becomes retro-actively eligible for Medicaid to submit prior authorization requests. The three month limit will be measured from the date the retro-active Medicaid eligibility was entered into NCTracks (“**Date Added**” not “**Last Date Updated**” as previously documented in NC Medicaid’s October 2016 Monthly Bulletin).

DME providers may contact the N.C. Division of Medical Assistance (DMA) call center for the “date added” of the appropriate eligibility segment.

Additional Resources

For more information, consult [Clinical Coverage Policy 5A](#), *Durable Medical Equipment and Supplies*:

DME section, Clinical Policy and Programs
DMA, 919-855-4310

Attention: Hospitals**Sterilization Claims Pended with ICD-10 Procedure Code 0UB70ZZ**

Since the implementation of ICD-10 claims have pended for Sterilization review when ICD-10 Procedure Code 0UB70ZZ was used. Providers who have received previous sterilization claim denials when billing ICD-10 Procedure Code 0UB70ZZ, and who have kept their claims filed timely, should resubmit denied claims.

Clinical Policy and Programs
919-855-4260

Attention: Hospital Providers**NC Health Choice Hospital Outpatient Cost Settlement**

Per N.C. [Session Law 2015-241, Section 12H.26\(a\)](#), effective Oct. 1, 2015, hospital outpatient services covered by N.C. Health Choice (NCHC) shall be cost settled at 70 percent of allowable costs, using the same methodology used for Medicaid.

On Aug. 23, 2016, the Centers for Medicare & Medicaid Services (CMS) approved a Title XXI Children's Health Insurance Program (CHIP) State Plan Amendment number 15-0001 which included the language directed by the N.C. Session Law to execute outpatient settlements. Hospitals must file a Supplemental Schedule E-5 along with their annual Medicaid cost reports to calculate their applicable Medicaid settlement. The Supplemental Schedule E-5 and instructions for Acute Care Hospitals and Critical Access Hospitals have been updated to calculate applicable settlements for both Medicaid and NCHC. They are posted to the [hospital cost report page](#) of the Division of Medical Assistance (DMA) website.

NCHC Summary Provider Statistical and Reimbursement Reports (PS&Rs) are now furnished to hospital providers using the NCTracks Message Center Inbox on the same 90-day lag production schedule as the standard Medicaid Summary PS&R for each National Provider Identifier (NPI). The NCHC Summary PS&Rs are identified as NCHC on the cover page of the Summary PS&R and have an NCTracks Report Number of FR19307-R0010 on each page.

Production PS&Rs are 12-month PS&Rs based off a provider's fiscal year end (FYE) in NCTracks. Hospitals with a 2016 FYE prior to Sept. 30, 2016 may request NCHC Summary PS&Rs from the DMA Provider Audit Section by contacting 919-814-0030. These requested NCHC PS&Rs will run from the State Plan Amendment (SPA) effective date of Oct. 1, 2015, through the provider's FYE. Hospitals with fiscal years ending on or after Sept. 30, 2016 may use the standard 12-month production NCHC PS&R.

Hospital providers, which meet all of the following criteria, must file an amended Medicaid cost report. The amended cost report must be submitted for purposes of including the NCHC Supplemental E-5 Schedules. They must have:

- a. A Medicaid cost reporting period that crosses over Oct. 1, 2015,
- b. NCHC outpatient claims for dates of service on or after Oct. 1, 2015, for the cost reporting period identified in (a), and,
- c. Already filed the Medicaid cost report for the period identified in (a) without the NCHC Supplemental E-5 Schedules.

**DMA Provider Audit
919-814-0030**

Attention: Nurse Practitioners, Physician Assistants and Physicians

Von Willebrand Factor (Recombinant) for Intravenous Injection, Lyophilized Powder for Solution (Vonvendi™) HCPCS Code J7199: Billing Guidelines

Effective with date of service Aug. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover von Willebrand factor [recombinant] (Vonvendi) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified.

Each vial of Vonvendi is labeled with the actual amount of recombinant von Willebrand factor (rVWF) activity in international units (IU), as measured with the Ristocetin cofactor assay (VWF:RCo). Vonvendi is currently commercially available as a lyophilized powder in single-use vials containing nominally 650 or 1300 international units VWF:RCo.

Vonvendi is indicated for on-demand treatment and control of bleeding episodes in adults diagnosed with von Willebrand disease.

Dosing Information

Vonvendi is for intravenous use after reconstitution only.

- Initial dose is 40 to 80 international units (IU) per kg body weight. Adjust the dosage based on the extent and location of bleeding.
- For minor hemorrhage, the initial dose of Vonvendi is 40-50 IU/kg, with a subsequent dose of 40-50 IU/kg every 8-24 hours, as clinically required.
- For major hemorrhage, the initial dose of Vonvendi is 50-80 IU/kg, with a subsequent dose of 40-60 IU/kg every 8-24 hours for approximately two to three days, as clinically required.
- For each bleeding episode, administer the first dose of Vonvendi with an approved recombinant (non-von Willebrand factor containing) factor VIII if factor VIII baseline levels are below 40 percent or are unknown.
- If recombinant factor VIII is required, give recombinant factor VIII within 10 minutes of completing Vonvendi infusion at a ratio of 1.3:1 (i.e., 30 percent more Vonvendi than recombinant factor VIII, based on the approximate mean recoveries of 1.5 and 2 IU/dL for Vonvendi and recombinant factor VIII, respectively). Consult the package insert for the specific factor VIII product for dosing recommendations.

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Vonvendi is D68.0 - von Willebrand's disease.
- Providers must bill Vonvendi with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified.
- One Medicaid unit of coverage for Vonvendi is one IU. The maximum reimbursement rate per unit is \$2.14200. NCHC bills according to Medicaid units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Vonvendi are: 00944-7550-01, 00944-7551-02, 00944-7552-01 and 00944-7553-02.
- The NDC units for Vonvendi 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

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
November 2016	11/03/16	11/08/16	11/09/16
	11/10/16	11/15/16	11/16/16
	11/17/16	11/22/16	11/23/16
	11/24/16	11/29/16	11/30/16
December 2016	12/01/16	12/06/16	12/07/16
	12/08/16	12/13/16	12/14/16
	12/15/16	12/20/16	12/21/16

Sandra Terrell, MS, RN
 Director of Clinical
 Division of Medical Assistance
 Department of Health and Human Services

Paul Guthery
 Executive Account Director
 CSRA