



North Carolina Medicaid Bulletin January 2017

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*Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers

NC Medicaid Electronic Health Record (EHR) Incentive Program Announcement

90-day MU Reporting Period in Program Years 2016 and 2017

Effective Nov. 14, 2016, the Centers for Medicare & Medicaid Services (CMS) [Hospital Outpatient Prospective Payment System \(OPPS\) Final Rule](#) allows all providers to use a **90-day Meaningful Use (MU) reporting period** in Program Years 2016 and 2017. The N.C. Medicaid Incentive Payment System (NC-MIPS) has been updated to accommodate this change.

The Countdown Continues: Four Months Left to Start Participating

There are only four months left to start participating in the N.C. Medicaid EHR Incentive Program. Since 2011, the N.C. Medicaid EHR Incentive Program has paid more than \$299 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.

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), and,
3. Have at least 30 percent Medicaid-enrolled patients.

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. For an example, read [this interview](#) with Dr. Karen Smith, 2017 American Academy of Family Physicians Family Physician of the Year, about her positive experience with EHRs and the N.C. Medicaid EHR Incentive Program.

Program Year 2016 is the last year to start participating and earn the first year payment of \$21,250. Through April 30, 2017, [NC-MIPS](#) is accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and MU attestations. Providers will have until that date 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 problems and discrepancies.

Alternate Medicare MU Attestation Registration due Feb. 15, 2017

Providers submitting an Alternate Medicare MU Attestation to avoid a Medicare payment adjustment must submit their registration on the CMS [Registration and Attestation System](#) between Jan. 3, and Feb. 15, 2017. More details are on the [N.C. Medicaid EHR Incentive Program website](#).

More Information

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 N.C. Area Health Education Centers ([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

Discontinuation of Medical/Surgical PA form DMA 372-118

As of Dec. 18, 2016, NCTracks no longer accepts Prior Approval (PA) form DMA 372-118 requests by fax or mail for the following issues. **These requests can only be submitted through the NCTracks secure provider portal:**

- Medical
- Surgical
- Out-of-state medical
- Out-of-state surgical
- Out-of-state ambulance services
- Transplants

In addition, NCTracks only accepts requests for exceptions to the legislative visit limit via the secure provider portal.

The form has been removed from the NCTracks [Prior Approval web page](#).

Providers who continue to fax or mail these forms will be sent a rejection letter stating the form is no longer accepted.

For further information on the online submission of PA requests, refer to the Computer-Based Training (CBT) and Instructor Led Training (ILT) Participant User Guides on PA available in SkillPort on the NCTracks secure provider portal.

Providers who do not have an NCID to access the NCTracks secure provider portal should contact the office administrator for their NPI.

CSRA, 1-800-688-6696

Attention: All Providers**NCTracks Provider Training Available in January 2017**

Registration is open for several courses offered to providers in January 2017. The duration varies depending on the course.

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

Prior Approval - Medical (On-site)

- Wednesday, Jan. 18 – 9:30 a.m. to noon

This course shows authorized users how to electronically submit and inquire about prior approvals for different medical services. After completing this course, authorized users will be able to:

- Submit prior approvals electronically and
- Conduct electronic inquiries about prior approvals.

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 a Professional Claim (On-site)

- Wednesday, Jan. 18 – 1 to 4 p.m.

This course will cover how to submit a professional (1500/837P) claim within the NCTracks system. At the end of training, the user will be able to:

- Submit a professional claim via NCTracks web portal
- Create a Claim
- Save a Claim Draft
- Use Claims Draft Search
- View 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.

Provider Web Service Inquiries (Webex)

- Monday, Jan. 23 – 1 to 3 p.m.
- Wednesday, Jan. 25 - 9:30 to 11:30 a.m.
- Friday, Jan. 27 - 1:30 to 3:30 p.m.
- Tuesday, Jan. 31 – 1 to 3 p.m.

This course will guide authorized users through the process of submitting prior approval service inquiries for eye refraction, dental, visual aid limitations and Durable Medical Equipment (DME)/Orthotics and Prosthetics (O&P) service history for recipients.

At the end of training the user will be able to submit a(n):

- Eyeglass confirmation request
- Refraction confirmation service request
- Dental benefit limitation service request
- Fluoride varnish limitations service request
- DME/O&P service history 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.

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

CPT Code Update: 2017

Effective with date of service Jan. 1, 2017, the American Medical Association (AMA) has added new CPT codes, deleted others and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2017 edition of Current Procedural Terminology, published by the AMA.) **Providers should note the full descriptions, as well as all associated parenthetical information, published in this edition when selecting a code for billing services to the N.C. Division of Medical Assistance (DMA).**

The state and CSRA are in the process of completing system updates to align its policies with CPT code changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that claims billed with the new codes will process and pay correctly.

Until this process is completed, claims submitted with new codes will pend for **“NO FEE ON FILE.”** These pended claims will recycle and pay when the system work is completed. No additional action will be required by providers. This process also will be applicable to the Medicare crossover claims.

To maintain cash flow, providers may wish to split claims and bill new codes on a separate claim. This will ensure that only claims billed with the new procedure codes are pended for processing.

New CPT codes that are covered by the N.C. Medicaid and N.C. Health Choice (NCHC) programs are effective with date of service Jan. 1, 2017. Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2017. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

New CPT Codes Covered by Medicaid and NCHC (effective Jan. 1, 2017)									
22853	22854	22859	27197	27198	28291	28295	31551	31552	31553
31554	31572	31573	31574	31591	31592	33390	33391	36456	36473
36474	36901	36902	36903	36904	36905	36906	36907	36908	36909
37246	37247	37248	37249	62320	62321	62322	62323	62324	62325
62326	92327	62380	76706	77065	77066	77067	84410	87483	90674
92242	93590	93591	93592	96160	99161	96377	97161	97162	97163
97164	97165	97166	97167	97168	99151	99152	99153	99155	99156
99157									

Note: CPT Code 90674 (Influenza virus vaccine) has been in NCTracks since October 15, 2016

New HCPCS Codes Covered by Medicaid and NCHC (effective Jan. 1, 2017)									
D0414	D1575	D4346	G0493	G0494	J0570	J1130	J1942	J2840	J7175
J7179	J7202	J7207	J7209	J7342	J9034	J9145	J9176	J9205	J9295
J9325	J9352								

New CPT Codes Not Covered by Medicaid and NCHC									
22867	22868	22869	22870	33340	43284	43285	58674	80305	80306
80307	81327	81413	81414	81422	81439	81539	97169	97170	97171
97172									

End-Dated CPT Codes (effective Dec. 31, 2016)									
99420	11752	21495	22305	22851	27193	27194	28290	28293	28294
31582	31588	33400	33401	33403	35450	35452	35458	35460	35471
35472	35475	35476	36147	36148	36870	62310	62311	62318	62319
75791	75962	75964	75966	75968	75978	77051	77052	77055	77056
77057	93965	97001	97002	97003	97004	99143	99144	99145	99148
99149	99150								

End-Dated HCPCS Codes (effective Dec. 31, 2016)									
A9544	A9545	D0290	J0760						

Note: All Category II and III Codes are not covered.

Moderate Sedation

In the calendar year 2016 Medicare Physician Fee Schedule (PFS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) asked for public input on approaches to address the appropriate valuation of moderate sedation related to approximately 400 diagnostic and therapeutic procedures. These include the majority of GI endoscopy procedures that had been valued with moderate sedation as an inherent part of furnishing the service.

To address this issue, the AMA Current Procedural Terminology (CPT) Editorial Panel created separate CPT codes for reporting of moderate sedation services for 2017 and have removed the moderate sedation symbol. This allows for the separate reimbursement of moderate sedation for the following codes:

10030	19298	20982	20983	22510	22511	22512	22513	22514	22515
22526	22527	31615	31622	31623	31624	31625	31626	31627	31628
31629	31632	31633	31634	31635	31645	31646	31647	31651	31648
31649	31652	31653	31654	31660	31661	31725	32405	32550	32551
32553	33010	33011	33206	33207	33208	33210	33211	33212	33213
33214	33216	33217	33218	33220	33221	33222	33223	33233	33227
33228	33229	33234	33235	33240	33230	33231	33241	33262	33263
33264	33244	33249	33282	33284	33990	33991	33992	33993	36010
36140	36200	36221	36222	36223	36224	36225	36226	36227	36228

36245	36246	36247	36248	32651	36252	36253	36254	36481	36555
36557	36558	36560	36561	36563	36565	36566	36568	36570	36571
36576	36578	36581	36582	36583	36585	36590	37183	37184	37185
37186	37187	37188	37191	37192	37193	37197	37211	37212	37213
37214	37215	37216	37218	37220	37221	37222	37223	37224	37225
37226	37227	37228	37229	37230	37231	37232	37233	37234	37235
37236	37237	37238	37239	37241	37242	37243	37244	37252	37253
43200	43201	43202	43204	43205	43206	43215	43216	43217	43211
43212	43220	43213	43214	43226	43227	43229	43231	43232	43235
43236	43237	43238	43239	43240	43241	43242	43243	43244	43245
43246	43247	43248	43249	43233	43250	43251	43252	43253	43254
43255	43266	43257	43270	43259	43260	43261	43262	43263	43264
43265	43274	43275	43276	43277	43278	43273	43453	44360	44361
44363	44364	44365	44366	44369	44370	44372	44373	44376	44377
44378	44379	44380	44382	44381	44384	44385	44386	44388	44389
44390	44391	44392	44401	44394	44402	44403	44404	44405	44406
44407	44408	44500	45303	45305	45307	45308	45309	45315	45317
45320	45321	45327	45332	45333	45334	45335	45337	45338	45346
45340	45341	45342	45347	45349	45350	45378	45379	45380	45381
45382	45388	45384	45385	45386	45389	45391	45392	45390	45393
45398	47000	47382	47383	47532	47533	47534	47535	47536	47538
47539	47540	47541	47542	47543	47544	49405	49406	49407	49411
49418	49440	49441	49442	49446	50200	50382	50384	50385	50386
50387	50430	50432	50433	50434	50592	50593	50606	50693	50694
50695	50705	50706	57155	66720	69300	77371	77600	77605	77610
77615	92953	92960	92961	92986	92987	92920	92921	92924	92925
92928	92929	92933	92934	92937	92938	92941	92943	92944	92973
92974	92975	92978	92979	93312	93313	93314	93315	93316	93317
93318	93451	93452	93453	93454	93455	93456	93457	93458	93459
93460	93461	93462	93463	93464	93505	93530	93561	93562	93563
93564	93565	93566	93567	93568	93571	93572	93582	93583	93609
93613	93615	93616	93618	93619	93620	93621	93622	93624	93640
93641	93642	93644	93650	93653	93654	93655	93656	93657	94011
94012	94013								

A bulletin article will be released listing the new codes which will be separately reimbursable by Ambulatory Surgery Centers (ASC) when that information is released by CMS in January 2017.

**Clinical Policy and Programs
DMA, 919-855-4260**

Attention: All Providers

HCPCS Code (J codes) Update 2017

Effective with the date of service Jan. 1, 2017, the Centers for Medicare & Medicaid Services (CMS) has added new HCPCS codes (J codes), deleted others and changed the description of some existing codes. (For complete information regarding all HCPCS codes and descriptions, refer to the *2017 edition of HCPCS Level II*, published by Optum).

N.C. Division of Medical Assistance (DMA) and CSRA are in the process of completing system updates to align these policies with HCPCS code (J code) changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that N.C. Medicaid and N.C. Health Choice (NCHC) claims billed with the new codes will process and pay correctly.

Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2017. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on deleted codes that were continued with the replacement code(s).

New HCPCS code (J codes) covered by Medicaid and NCHC (effective Jan. 1, 2017)	Description	Associated NDCs	Old HCPCS code (Ineffective Dec. 31, 2016)
J0570	Buprenorphine implant, 74.2 mg	58284-0100-14	J3490
J1130	Injection, diclofenac sodium, 0.5 mg	00409-1068-01	J3490
J1942	Injection, aripiprazole lauroxil, 1 mg	65757-0401-01 65757-0401-03 65757-0402-01 65757-0402-03 65757-0403-01 65757-0403-03	J3490
J2840	Injection, sebelipase alfa, 1 mg	25682-0007-01	J3590
J7175	Injection, factor x, (human), 1 i.u.	64208-7752-01 64208-7753-01 64208-7754-01 64208-7756-01	J7199
J7179	Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rc0	00944-7550-01 00944-7551-02 00944-7552-01 00944-7553-02	J7199
J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	69911-0864-02 69911-0865-02 69911-0866-02 69911-0867-02	J7199

New HCPCS code (J codes) covered by Medicaid and NCHC (effective Jan. 1, 2017)	Description	Associated NDCs	Old HCPCS code (Ineffective Dec. 31, 2016)
J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.	00944-4252-02 00944-4254-02 00944-4256-02 00944-4258-02 00944-4622-01 00944-4622-02 00944-4623-01 00944-4623-02 00944-4624-01 00944-4624-02 00944-4625-01 00944-4625-02	J7199
J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.	68982-0139-01 68982-0140-01 68982-0141-01 68982-0142-01 68982-0143-01 68982-0144-01 68982-0145-01 68982-0146-01	J7199
J7342	Installation, ciprofloxacin otic suspension, 6 mg	69251-0201-01	J3490
J9145	Injection, daratumumab, 10 mg	57894-0502-05 57894-0502-20	J9999
J9176	Injection, elotuzumab, 1 mg	00003-2291-11 00003-4522-11	J9999
J9205	Injection, irinotecan liposome, 1 mg	69171-0398-01	J9999
J9295	Injection, necitumumab, 1 mg	00002-7716-01	J9999
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	55513-0078-01 55513-0079-01	J9999
J9352	Injection, trabectedin, 0.1 mg	59676-0610-01	J9999
J9034	Injection, bendamustine hcl (bendecka), 1 mg	63459-0348-04	J9033

Clinical Policy and Programs
DMA, 919-855-4300

Attention: All Providers**Affiliation Claim Edit - Update**

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 the edit 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 Explanation of Benefit (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.” Once the disposition is changed, a claim failing the edit will pend for 60 days. Providers will continue to receive EOB 07025.

If the affiliation relationship is not established within 60 days, the claim will be denied. Providers must correct any affiliation issues immediately to continue to bill claims to NCTracks.

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**Re-credentialing Due Dates for Calendar Year 2017**

Note: This article was originally published in the [December 2016 Medicaid Bulletin](#).

List of Providers due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2017 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 MCR 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 **by the due date.** Once payment is suspended, the provider must submit a re-credentialing application or the full MCR (if required) 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); 919-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers

NCCI Update: Code Pair 77295 and 77300

On Oct. 1, 2016, Centers for Medicare & Medicaid Services (CMS) end-dated the National Correct Coding Initiative (NCCI) procedure-to-procedure edit prohibiting reimbursement for the following code pair: 77295 (therapeutic radiology simulation aided field setting: three dimensional) and 77300 (basic radiation dosimetry calculation, central axis depth dose calculation).

This change is effective for dates of service on or after Jan. 1, 2016. Providers can resubmit any denied claims for reprocessing. Claims that have not been filed to CSRA for this code pair must be filed within 365 days of the date of service.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**S**hared/split E/M Visits

A shared/split Evaluation and Management (E/M) visit is defined as a medically necessary encounter with a patient where the physician and a qualified Non Physician Practitioner (NPP) each personally perform a **substantive portion** of a face-to-face E/M visit with the same patient on the same date of service. A “substantive portion” of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.

Note: [NPP includes the terms “mid-level provider”, “Nurse Practitioner (NP)”, “Physician Assistant (PA)” and Certified Nurse Midwife (CNM)].

Every party must document the work they performed. The documentation must show a face-to-face encounter with the physician, in which case the service is billed under the physician’s National Provider Identifier (NPI). If there is no face-to-face encounter with the physician, the NPP must bill the service using the NPP’s National Provider Identifier (NPI). A notation of “seen and agreed” or “agree with above” would not qualify the situation as a shared/split visit because these statements do not support a face-to-face contact with the physician. Only the NPP could bill for the services.

According to the Centers for Medicare & Medicaid Services (CMS), shared/split visits are applicable for services rendered in the following settings:

- Hospital inpatient or outpatient
- Emergency department
- Hospital observation
- Hospital discharge
- Office or clinic

Shared/split visits are not allowed:

- In a skilled nursing facility or nursing facility setting
- For consultation services
- For critical care services (99291-99292)
- For procedures
- In a patient’s home or domiciliary site

Shared/split visits are not considered “incident to” services.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Family Planning Providers**MAFDN Beneficiary Claims Denied For Edit 00344**

Some claims for beneficiaries of Medicaid Family Planning (MAFDN) are being denied incorrectly for edit 00344 (“Family planning procedure code requires family planning diagnosis. Please correct and resubmit”).

The N.C. Division of Medical Assistance (DMA) is working to resolve this issue. Providers will be notified through NCTracks announcements and Medicaid Bulletins when the issue is resolved, at which time providers may resubmit denied claims for review. Providers should continue to file claims timely.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Nursing Facility Providers**Revised Notice of Nursing Home Transfer/Discharge and Hearing Request Forms**

N.C. Division of Medical Assistance (DMA) Nursing Home Notice of Transfer/Discharge (DMA-9050) and Hearing Request forms (DMA-9051) have been revised. They can be accessed on the [DMA Nursing Facility Forms web page](#), the Department of Health and Human Services (DHHS) [On-Line Manuals web page](#), or directly by clicking on the links below:

- [Nursing Home Hearing Request Form](#)
- [Nursing Home Notice of Transfer/Discharge](#)

Contact the Hearing Office at 919-814-0090 with questions.

Hearing Office,
DMA, 919-814-0090

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

Since the transition to NCTracks, the N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

DMA has provided instructions to NCTracks on updating the claims processing system. The following procedure code list has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

01996	16025	19357 ^(A)	20692 ^(A)	20692 ^(C)	22216 ^(A)	23615 ^(A)
23615 ^(C)	25609 ^(A)	25609 ^(C)	27236 ^(A)	27236 ^(C)	27506 ^(A)	27506 ^(C)
27535 ^(A)	27535 ^(C)	27720 ^(A)	27720 ^(C)	28445 ^(A)	28445 ^(C)	29888 ^(A)
31231	31238	31575	31579	32554	32556	32674 ^(A)
33427 ^(A)	33427 ^(C)	33508 ^(A)	33533 ^(A)	33533 ^(C)	33863 ^(A)	33863 ^(C)
44139 ^(A)	49561 ^(A)	51797	54150	56605	62272	62367
63081 ^(A)	71130 ^(E)	73564	73706	74175	74176	74177
74178	75635	76519	90945	91065	93660	93922
93930	93970	93971	94610	94620	95017	95018
95024	95044	95971	95972	96542	96922	99375
99378	99468	99469	99472	99478	99479	99480
A4580	A4590	A4614 ^(F)	A4627 ^(F)	A7003 ^(F)	A7004 ^(F)	A7005 ^(F)
A7006 ^(F)	A7015 ^(F)	E0570 ^(F)				

* Codes marked with an (A) were updated for modifiers 80 and 82 only

* Codes marked with a (C) were updated for modifier 55 only

* Codes marked with a (E) were updated for modifier TC only

* Codes marked with a (F) were updated for modifier NU only

[A complete list of accepted codes](#) can be found on the Claims and Billing Section of the DMA web site.

Note: Codes currently in process for system updates are published on the website and in the Medicaid Bulletin once system modifications are completed. New codes will be addressed as DMA Clinical Policy becomes aware of them. Claims previously denied may now be resubmitted to NCTracks.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Levonorgestrel-Releasing Intrauterine System (Kyleena™) HCPCS Code J3490: Billing Guidelines

Effective with date of service Oct. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover levonorgestrel-releasing intrauterine system (Kyleena™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified Drugs. Kyleena is currently available as a single intrauterine system consisting of a T-shaped polyethylene frame with a steroid reservoir containing 19.5 mg levonorgestrel, packaged within a sterile inserter.

Kyleena is indicated for prevention of pregnancy for up to five years.

The release rate of levonorgestrel (LNG) is 17.5 mcg/day after 24 days and declines to 7.4 mcg/day after five years; Kyleena must be removed or replaced after five years. Kyleena is to be inserted by a trained healthcare provider using strict aseptic technique. Follow insertion instructions exactly as described (see full prescribing information). The patient should be re-examined and evaluated 4 to 6 weeks after insertion; then yearly or more often if clinically indicated.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Kyleena are:
 - Z30.430 - Encounter for insertion of intrauterine contraceptive device,
 - Z30.433 - Encounter for removal and reinsertion of intrauterine contraceptive device.
- Providers must bill Kyleena with HCPCS code J3490 – Unclassified Drugs.
- One Medicaid unit of coverage for Kyleena is 1 sterile intrauterine system. For NCHC claims, follow the Medicaid billing guidance. The maximum reimbursement rate per one unit is \$909.83.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Kyleena is 50419-0424-01.
- The NDC units for Kyleena should be reported as “UN1”.
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on DMA’s [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Ustekinumab Injection, 130 Mg/26 MI High-Dose for Intravenous Use (Stelara®) HCPCS Code J3590: Billing Guidelines

Effective with date of service Sept. 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ustekinumab injection for intravenous use (Stelara) 130 mg/ 26 mL high-dose for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified biologics. Stelara is currently commercially available in a high-dose 130 mg/26 mL solution (5 mg/mL) in a single-dose vial.

Stelara 130 mg/26 mL formulation is indicated for treatment of adult patients with moderately to severely active Crohn's disease (CD) who have failed or were intolerant to treatment with immunomodulators or corticosteroids, but never failed a Tumor Necrosis Factor (TNF) blocker or failed or were intolerant to treatment with one or more TNF blockers.

The recommended initial dose for a person with Crohn's disease weighing greater than 85 kg is 520 mg as a single intravenous infusion.

- For a person weighing more than 55 kg up to 85 kg, the recommended initial dose is 390 mg as a single intravenous infusion.
- For a person weighing up to 55 kg, the recommended initial dose is 260 mg as a single intravenous infusion.

After initial intravenous infusion, patients should be switched to the subcutaneous dose formulation for maintenance of 90 mg administered eight weeks after the initial intravenous dose, then every eight weeks thereafter.

See package insert for full prescribing information.

Note: The **45 mg and 90 mg syringes for subcutaneous** use of Stelara are billed under **J3357**.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Stelara are:
 - K50.00 Crohn's disease of small intestine without complications
 - K50.011 Crohn's disease of small intestine with rectal bleeding
 - K50.012 Crohn's disease of small intestine with intestinal obstruction
 - K50.013 Crohn's disease of small intestine with fistula
 - K50.014 Crohn's disease of small intestine with abscess
 - K50.018 Crohn's disease of small intestine with other complication
 - K50.019 Crohn's disease of small intestine with unspecified complications
 - K50.10 Crohn's disease of large intestine without complications
 - K50.811 Crohn's disease of both small and large intestine with rectal bleeding

- K50.812 Crohn's disease of both small and large intestine with intestinal obstruction
 - K50.813 Crohn's disease of both small and large intestine with fistula
 - K50.814 Crohn's disease of both small and large intestine with abscess
 - K50.818 Crohn's disease of both small and large intestine with other complication
 - K50.819 Crohn's disease of both small and large intestine with unspecified complications
 - K50.80 Crohn's disease of both small and large intestine without complications
 - K50.911 Crohn's disease, unspecified, with rectal bleeding
 - K50.912 Crohn's disease, unspecified, with intestinal obstruction
 - K50.913 Crohn's disease, unspecified, with fistula
 - K50.914 Crohn's disease, unspecified, with abscess
 - K50.918 Crohn's disease, unspecified, with other complication
 - K50.919 Crohn's disease, unspecified, with unspecified complications
 - K50.90 Crohn's disease, unspecified, without complications
 - K50.111 Crohn's disease of large intestine with rectal bleeding
 - K50.112 Crohn's disease of large intestine with intestinal obstruction
 - K50.113 Crohn's disease of large intestine with fistula
 - K50.114 Crohn's disease of large intestine with abscess
 - K50.118 Crohn's disease of large intestine with other complication
 - K50.119 Crohn's disease of large intestine with unspecified complications
- Providers must bill Stelara with HCPCS code J3590 – Unclassified biologics.
 - One Medicaid unit of coverage for Stelara is one mg. For NCHC claims, follow the Medicaid billing guidance. The maximum reimbursement rate per unit is \$13.29.
 - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Stelara is: 57894-0054-27.
 - The NDC units for Stelara should be reported as “UN1”.
 - For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
 - For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA’s website.
 - Providers shall bill their usual and customary charge for non-340-B drugs.
 - PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost.

Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.

- The fee schedule for the PDP is available on DMA’s [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Granisetron Extended-Release Injection, for Subcutaneous Use (Sustol®) HCPCS Code J3490: Billing Guidelines**

Effective with date of service Oct. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover granisetron extended-release injection for subcutaneous use (Sustol®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified Drugs. Sustol is currently available as 10 mg/0.4 mL in single-dose, pre-filled syringes.

Sustol is indicated in combination with other antiemetics in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of Moderately Emetogenic Chemotherapy (MEC) or Anthracycline and Cyclophosphamide (AC) combination chemotherapy regimens. Sustol is for subcutaneous injection only and intended for administration by a healthcare provider.

The recommended dosage of Sustol is 10 mg administered subcutaneously. Administer Sustol in combination with dexamethasone at least 30 minutes before initiation of MEC or AC combination chemotherapy. Administer Sustol on day one of chemotherapy and not more frequently than once every seven days because of the extended-release properties of the formulation.

Review the package insert for complete dosing instructions.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Sustol are:
 - R11.0 – Nausea
 - R11.10 - Vomiting, unspecified
 - R11.11 - Vomiting without nausea
 - R11.12 - Projectile vomiting
 - R11.2 - Nausea with vomiting, unspecified
 - Z51.11 - Encounter for antineoplastic chemotherapy
 - Z51.12 - Encounter for antineoplastic immunotherapy
 - T45.1X5A - Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter
 - T45.1X5D - Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter
 - T45.1X5S - Adverse effect of antineoplastic and immunosuppressive drugs, sequela
- Providers must bill Sustol with HCPCS code J3490 – Unclassified Drugs
- One Medicaid unit of coverage for Sustol is one syringe. For NCHC claims, follow the Medicaid billing guidance. The maximum reimbursement rate per one unit is \$534.60.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Sustol is 47426-0101-06.
- The NDC units for Sustol should be reported as “UN1”.
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA’s website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on DMA’s [PDP web page](#).

CSRA 1-800-688-6696

Attention: Private Duty Nursing Providers**P**rior Authorization: Online Submission through the NCTracks Provider Portal

Private Duty Nursing (PDN) providers now have the ability to enter prior approval (PA) requests and submit documentation for new admissions and service reauthorizations using NCTracks. This functionality allows providers to enter required information and upload documents for submission through the secure NCTracks Provider Portal.

Information on the NCTracks PA process is available under the [Prior Approval](#) and [Provider User Guides and Training](#) sections of the NCTracks portal. For specific information regarding how to submit or inquire about a PA request, refer to the PA Computer Based Training (CBT) courses in SkillPort, the NCTracks Learning Management System.

Providers are encouraged to begin entering PA requests through the NCTracks Provider Portal immediately. This process will become the required submission modality effective March 1, 2017.

**Home Care Services Community Based Services
DMA, 919-855-4380**

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
January 2017	01/06/17	01/10/17	01/11/17
	01/13/17	01/18/17	01/19/17
	01/20/17	01/24/17	01/25/17
	01/27/17	01/31/17	02/01/17
February 2017	02/02/17	02/07/17	02/08/17
	02/09/17	02/14/17	02/15/17
	02/16/17	02/22/17	02/23/17
	02/23/17	02/28/17	03/01/17

* Batch cutoff date is previous day

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

Paul Guthery
 Executive Account Director
 CSRA