



Medical Assistance  
HEALTH AND HUMAN SERVICES

## N.C. Medicaid Bulletin February 2017

### In this Issue.....Page

#### All Providers

Affordable Care Act Fee Increase for Provider Enrollment.....	1
OB Ultrasound Claims from Pregnancy Medical Home Providers to Bypass Service Limitations.....	3
NC Medicaid Electronic Health Record (EHR) Incentive Payment Announcement.....	4
Clinical Coverage Policies.....	5
Payment Error Rate Measurement (PERM).....	6
Re-credentialing Due Dates for Calendar Year 2017.....	7
Upload Documents in NCTracks Provider Portal.....	9
Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks.....	10
NCTracks Provider Training Available in February 2017.....	11
Changes to Prior Approval Process for CAP Participants.....	14
New Provider Portal Inquires for Dental, Optical, DME/O&P and Physician Fluoride Varnish Benefit Limits.....	16

#### Dental Providers

New American Dental Association Procedure Codes.....	17
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#### Enhanced Behavioral Health Services Providers

Intensive In-Home Service.....	19
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#### Nurse Practitioners, Physicians, and Physicians Assistants

Immune globulin subcutaneous (Human), 20 Percent solution (Cuvitru™) HCPCS code J3590: Billing Guidelines.....	20
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## **Attention: All Providers**

### **A**ffordable Care Act Fee Increase for Provider Enrollment

The Centers for Medicare & Medicaid Services (CMS) announced an increase in the Affordable Care Act (ACA) provider enrollment application fee. The application fee has increased to \$560 for calendar year (CY) 2017 for applications received starting on Jan. 1, through Dec. 31, 2017.

The fee is required for **any institutional providers** who are newly enrolling, re-enrolling, re-credentialing or adding a new practice location. It does not apply to individual physicians or non-physician practitioners. To learn more visit the [ACA Application Fee FAQ page](#) on the NCTracks Provider Portal.

After the submission of the enrollment application, an invoice of the fee will occur. Providers are requested to wait for their invoice before submitting payment.

The Federal Register published the [fee notice](#) on Nov. 7, 2016. For additional information about the application fee, visit the [ACA Application Fee FAQ page](#) on the NCTracks Provider Portal.

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

## **Attention: All Providers**

# **O**B Ultrasound Claims from Pregnancy Medical Home Providers to Bypass Service Limitations

NCTracks will update its website on Feb. 5, 2017, to allow claims submitted for obstetrical ultrasounds to bypass service limitations when the provider has a Pregnancy Medical Home (PMH) indicator on their provider record for the service date. This provision includes professional claims where the rendering or ordering NPI is identified as a PMH provider and institutional claims where the billing or referring NPI is identified as a PMH provider.

Since the removal of the Prior Approval (PA) and registration requirements for PMHs, claims submitted might have denied with the Explanation of Benefits (EOB) 00762 – MEDICAL NECESSITY NOT APPARENT; SUBMIT CLAIM WITH RECORDS INDICATING MEDICAL NECESSITY when the service limit for obstetrical ultrasounds for the recipient had already been met.

Obstetrical ultrasound claims adjudicated after this update implementation will be subject to the new service limitation bypass if the service date is Jan. 1, 2016, or after.

For more information regarding service limit exceptions for PMH providers, refer to the Pregnancy Medical Home Clinical Coverage Policy 1E-6 on [DMA's Obstetrics and Gynecology Clinical Coverage Policy web page](#). Providers may also consult with their PMH primary point of contact within their local network.

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

## 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 MU reporting period** in Program Years 2016 and 2017. Providers may attest in the N.C. Medicaid Incentive Payment System (NC-MIPS) using a 90-day MU reporting period.

### The Countdown Continues: Three Months Left to Start Participating

There are only **three** months left to begin participating in the N.C. Medicaid EHR Incentive Program. Since 2011, the N.C. Medicaid EHR Incentive Program has paid more than \$300 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.

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 [the interview](#) with Dr. Karen Smith, 2017 American Academy of Family Physicians Family Physician of the Year, where she shares her experience with EHRs and the N.C. Medicaid EHR Incentive Program.

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.

**Program Year 2016 is the last year to start participating and earn the first year payment of \$21,250.** Through April 30, 2017, the N.C. Medicaid Incentive Payment System ([NC-MIPS](#)) is accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and Meaningful Use (MU) attestations.

Providers will have until the end of the attestation tail period, **April 30, 2017**, to submit a complete and accurate attestation. **After that, no changes can be made.** There is no guarantee attestations submitted within 30 days of the close of the tail period will be reviewed before April 30, 2017. To address any discrepancies, providers are highly encouraged to submit their attestation no later than March 30, 2017.

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](mailto:NCMedicaid.HIT@dhhs.nc.gov).

### **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**. For more information, visit the [N.C. Medicaid EHR Incentive Program website](#).

### **‘Quick Tip’ Webinar Series**

Providers who are short on time but want to learn more about the program can review the “Quick Tip” webinar series. These webinars are between two and five minutes long. Webinars cover a wide variety of topics such as registering on the CMS Registration and Attestation System and MU in Program Year 2016. Providers can find these webinars on the [NC Medicaid EHR Incentive Program web page](#) under the “Resources and Webinars” tab.

**N.C. Medicaid EHR Incentive Program**  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) (email preferred)

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## **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 [N.C. Division of Medical Assistance \(DMA\) clinical coverage policy web pages](#).

- 1A-41, *Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone (2/1/17)*
- 1N-1, *Allergy Testing, (2/1/17)*

These policies supersede previously published policies and procedures.

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

## Attention: All Providers

# Payment Error Rate Measurement (PERM)

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) and related guidance issued by the U.S. Office of Management and Budget (OMB). The PERM program examines eligibility determinations and claim payments made by Medicaid and the Children's Health Insurance Programs (CHIP) for accuracy and estimates the amount of improper payments (error rate) within each state's Medicaid and CHIP program.

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

Error rates are reported to the states and to Congress. Error rates are not considered a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements. The current PERM cycle spans a review of claims paid during federal fiscal year 2016 (FFY2016), which runs from Oct. 1, 2015, to Sept. 30, 2016.

CNI Advantage, LLC is the CMS Review Contractor examining the supporting documentation for the claims sampled from FFY 2016. All provider types delivering services for N.C. Medicaid and NCHC are subject to receiving a request from CNI Advantage for documentation supporting claims paid during this period. Providers are encouraged to submit all documents as soon as possible. Providers who have moved or changed their agency address must update their contact information in NCTracks.

For more information about the PERM program, visit the [CMS PERM Providers web page](#). Providers who still have questions should contact Sue Helmke 919-814-0122 or Susan Bryan 919-814-0154 at the NC Division of Medical Assistance (DMA), Office of Compliance and Program Integrity.

**Office of Compliance and Program Integrity  
DMA, 919-814-0122**

## 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
- 4) Payment Pending

Providers are required to complete the re-credentialing application after the full MCR is completed. Payment will be suspended if the provider does not complete the process **by the due date** In order to lift payment suspension, the provider must submit a re-credentialing application or the full MCR (if required).

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 resets 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](mailto:NCTracksprovider@nctracks.com) (email).

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



## **Attention: All Providers**

### **U**pload Documents in NCTracks Provider Portal

Effective April 1, 2017, providers must submit all attachments to the following applications electronically through the NCTracks Secure Provider Portal Status and Management web page:

- Enrollment
- Re-enrollment
- Manage Change Request (MCR)
- Change Office Administrator (OA)
- Maintain eligibility
- Re-verification

CSRA will not process any mailed, faxed or emailed documents received on or after April 1, 2017.

The NCTracks “Upload Documents” option allows an authorized user to submit attachments electronically after an application has been submitted. If CSRA requests additional information, providers will be required to upload the requested additional documentation.

The Office Administrator (OA) is able to access the “Upload Documents” button from the Final Steps page of the application or from the Upload Documents hyperlink on the Status and Management web page. The Enrollment Specialist (ES) can access the Upload Documents hyperlink from the Status and Management page. Those with additional questions can contact the NCTracks Operations Contact Center at 1-800-688-6696.

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

## Attention: All Providers

# Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks

In accordance with [42 CFR 455.410\(a\)](#), the Centers for Medicare & Medicaid Services (CMS) requires state Medicaid agencies to screen enrolled providers for “categorical risk” according to the provisions of Part 455 subpart E.

Under 42 CFR 455.450, state Medicaid agencies are required to screen all applications for “categorical risk”, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation.

In addition, under [42 CFR 455.434\(b\)](#), N.C. Medicaid and Children Health Insurance Program (CHIP) providers designated as “high categorical risk” under [42 CFR 424.518\(c\)](#) and [N.C.G.S. 108C-3\(g\)](#), or any person with a 5 percent or more direct or indirect ownership interest in the organization - as those terms are defined in [42 CFR 455.101](#) - will be required to submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA. **Implementation will be July 30, 2017, and is retroactively effective for providers enrolled or revalidated on or after Aug. 1, 2015.**

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

Providers will receive a notification via the NCTracks provider portal if they are required to submit fingerprints. All locations offering fingerprinting services in North Carolina will be posted NCTracks website.

**Note:** Providers who have already undergone fingerprint-based criminal background checks for Medicare or another state’s Medicaid or CHIP program are **not** required to submit new ones. Future Medicaid bulletins will provide additional information.

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

## **Attention: All Providers**

# **NCTracks Provider Training Available in February 2017**

Registration for several instructor-led training courses hosted in February of 2017 has opened for providers. The duration varies depending on the course.

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

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

### **Prior Approval - Dental and Orthodontic (WebEx)**

- Wednesday, Feb. 1 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) requests for dental and orthodontic procedures to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of the PA request. This is a WebEx course and providers can attend from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **Submitting Dental and Orthodontic Claims (WebEx)**

- Wednesday, Feb. 1 – 1 to 4 p.m.

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 is a WebEx based course and providers can attend from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **Submitting Institutional Prior Approvals (On-site)**

- Thursday, Feb. 2 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) requests with a focus on nursing facilities, to ensure compliance with Medicaid clinical coverage policy and medical necessity. It also covers PA inquiry to check on the status of a PA request. This is an in-person course offered at the CSRA facility at 2610 Wycliff Road in Raleigh and is limited to 45 participants.

**Note:** This course includes hands-on training.

### **Submitting Institutional Claims (On-site)**

- Thursday, Feb. 2 – 1 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

This is an in-person course offered at the CSRA facility at 2610 Wycliff Road in Raleigh and is limited to 45 participants.

**Note:** This course includes hands-on training.

### **Provider Web Portal Applications (WebEx)**

- Wednesday, Feb. 15 – 1 to 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks provider portal. At the end of this training, providers will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks provider portal
- Complete processes for provider enrollment, Manage Change Requests (MCR), re-enrollment, re-verification and maintain eligibility, and,
- Track and submit applications using the NCTracks Status and Management page

This is a WebEx based course and providers can attend from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **Prior Approval - Medical (Professional) (On-site)**

- Tuesday, Feb. 21 - 9:30 a.m. to noon

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

This is an in-person course offered at the CSRA facility at 2610 Wycliff Road in Raleigh and is limited to 45 participants.

**Note:** This course includes hands-on training.

### **Submitting a Professional Claim (On-site)**

- Tuesday, Feb. 21 – 1 to 4 p.m.

This course will focus on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to:

- Enter a professional claim
- Save a draft claim
- Use the Claims Draft Search tool, and,
- Submit a claim and view the results of a claim submission

This is an in-person course offered at the CSRA facility at 2610 Wycliff Road in Raleigh and is limited to 45 participants.

**Note:** This course includes hands-on training.

### **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 are located 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 NCTracks 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

### Changes to PA Process for CAP Participants

Changes are coming to the Prior Approval (PA) process for the Community Alternatives Program (CAP) waiver programs, including CAP/Children (CAP/C), CAP/Choice (CAP/CO), and CAP/Disabled Adult (CAP/DA). As of Feb. 5, 2017, providers will no longer submit PA requests to NCTracks for CAP waiver program participants. Following is an outline of the changes to CAP.

#### **CAP/CO and CAP/DA**

Currently, VieBridge makes the level of care (LOC) determination for CAP/CO and CAP/DA participants and sends the Service Review Form (SRF) to the provider. The provider then submits a PA request to NCTracks with the SRF attached, enabling NCTracks to capture the information.

Providers will no longer need to submit a PA request to NCTracks once the changes take effect. An adjudicated PA with LOC determination and the SRF for CAP/CO and CAP/DA recipients will be transmitted to NCTracks by VieBridge.

#### **CAP/C**

Currently, providers submit a PA request to NCTracks for CAP/C recipients and the CSRA Fiscal Agent Operations team makes the LOC determination.

VieBridge will make the LOC determination for CAP/C recipients and transmit the information to NCTracks in an adjudicated PA after the changes take effect.

#### **All CAP Programs**

Historically, NCTracks has not received Plan of Care (POC) information for any CAP recipients. Beginning with date of service Feb. 5, 2017, VieBridge will transmit the POC for CAP/CO, CAP/DA and CAP/C recipients to NCTracks. The NCTracks system will use the information to validate that submitted claims do not exceed the authorized limits associated with services provided through the waiver programs.

These enhancements will eliminate the manual effort currently required by both providers and NCTracks. CSRA will no longer accept CAP PAs from providers after the implementation of this enhancement; **however, all CAP PAs will process if received prior to implementation.** VieBridge will submit changes to existing PAs for CAP/CO, CAP/DA and CAP/C to NCTracks as needed if the recipient's circumstances change. Providers can do a search for the CAP PAs on the secure NCTracks provider portal as long as their NPI is associated with the PA record.

If the CAP PA is not on file, the claim for CAP services will deny. After Feb. 5, 2017, refer any issues with CAP PAs to VieBridge for resolution.

For more information on CAP services, refer to the [CAP web page](#) on the N.C. Division of Medical Assistance (DMA) website.

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

## Attention: All Providers

### **New Provider Portal Inquiries for Dental, Optical, DME/O&P and Physician Fluoride Varnish Benefit Limits**

Enhanced functionality is coming to NCTracks, which will allow N.C. Medicaid and N.C. Health Choice (NCHC) providers to inquire about additional services and procedures that are subject to benefit limits. Currently, providers use the NCTracks portal to obtain the last service date for an eye refraction and certain dental procedure codes.

On Feb. 5, 2017, providers will also be able to use the portal to obtain the following recipient benefit information:

- Inquire about additional dental services, including dental prophylaxis and topical fluoride treatments, periodontal services and orthodontic services
- Receive additional information with the refraction confirmation inquiry
- Inquire about eyeglasses
- Inquire about durable medical equipment (DME) and orthotic/prosthetic (O&P) services
- Inquire about physician fluoride varnish services

This functionality will allow providers to determine whether recipients have reached their benefit limits prior to rendering the service. The provider inquiry web page for dental, DME/O&P, and physician fluoride varnish will display claims history by CDT, HCPCS or CPT procedure code, recipient ID, and date of service. There will be a “Search by Similar” option on the DME/O&P Service History web page, which includes claims history for related codes. The eyeglass inquiry is matched against prior approval (PA) records and will display the last date complete eyeglasses were approved.

Information regarding these services is provided for informational purposes only and is not a guarantee of payment. Payment for services is subject to criteria and limitations documented in N.C. Medicaid and NCHC [clinical coverage policies](#).

As with the current benefit limit inquiries, this new functionality will be available through the Prior Approval drop-down menu on the secure NCTracks Provider Portal. Access to the secure provider portal requires a login from [North Carolina Identity \(NCID\) Services](#). Providers or staff without an NCID to access the NCTracks secure provider portal should contact the office administrator for their NPI.

To assist with using the new benefit limit functionality, NCTracks is developing new Instructor-Led Training (ILT), Computer-Based Training (CBT) courses and a Job Aid. The courses and Job Aid will be located in SkillPort, accessible through the Provider Training button on the secure provider portal. Additionally, there are also updates coming to existing training material that references benefit limit inquiries. A follow-up announcement will be posted on the NCTracks Provider Portal when the training resources are available.

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



## Attention: Dental Providers

# New American Dental Association Procedure Codes

Effective with date of service Jan. 1, 2017, new dental procedure codes were added to NCTracks for the N.C. Medicaid and N.C. Health Choice (NCHC) dental programs. These additions are a result of the Current Dental Terminology (CDT) 2017 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, *Dental Services*, will be updated to reflect these changes.

CDT 2017 Code	Description and Limitations	PA Indicator
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report <ul style="list-style-type: none"> <li>• Use for lab reporting fee</li> <li>• Reimbursement rate of \$46.25</li> </ul>	N
D1575	Distal shoe space maintainer – fixed – unilateral <ul style="list-style-type: none"> <li>• Limited to beneficiaries under age 21</li> <li>• Limited to replacement of primary molars and canines and permanent first molars</li> <li>• Requires a quadrant indicator in the area of oral cavity field</li> <li>• Use delivery date as date of service when requesting payment</li> <li>• Reimbursement rate of \$181.53</li> </ul>	N
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation <ul style="list-style-type: none"> <li>• Limited to beneficiaries ages 13 and up</li> <li>• Reported <b><u>instead of an adult prophylaxis</u></b> for beneficiaries who have swollen, inflamed gingiva, generalized suprabony pockets and moderate to severe bleeding on probing</li> <li>• Either D1110 or D4346 is allowed once per beneficiary per six (6) calendar month period for the same provider</li> <li>• Not allowed for an individual beneficiary on the same date of service as a prophylaxis (D1110) or periodontal procedures (D4210, D4211, D4240, D4241, D4341, D4342, D4355 or D4910)</li> <li>• Reimbursement rate of \$36.21</li> </ul>	N

The following procedure codes were end-dated effective with date of service Dec. 31, 2016.

<b>Procedure Code</b>	<b>Description</b>
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image
D9630	Other drugs and/or medicaments, by report

The following procedure codes descriptions were revised effective with date of service Jan. 1, 2017.

<b>Procedure Code</b>	<b>Description</b>
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7250	Removal of residual tooth roots (cutting procedure)
D7280	Exposure of an unerupted tooth
D7485	Reduction of osseous tuberosity
D7780	Facial bones – complicated reduction with fixation and multiple approaches
D7873	Arthroscopy: Lavage and lysis of adhesions

Providers are reminded to bill their usual and customary charges rather than the N.C. Medicaid rate. For coverage criteria and additional billing guidelines, refer to Clinical Coverage Policy 4A, *Dental Services*, on the [DMA Dental Program's web page](#).

**Dental Program,  
DMA, 919-855-4280**

## **Attention: Enhanced Behavioral Health Services Providers**

### **I Intensive In-Home Service**

As previously communicated in the [October 2014 Medicaid Bulletin](#) , Session Law 2014-100, required the N.C. Department of Health and Human Services (DHHS) to submit N.C. State Plan Amendment (SPA) 14-022 to the Centers for Medicare & Medicaid Services (CMS) requesting approval to modify the service definition and rate for Intensive In-home Service (IIH).

This amendment was approved by CMS on Jan. 5, 2017, and reflects a team-to-family ratio of one IIH team to 12 families and a new rate of \$239.66 per day for the Medicaid Fee-for-Service (FFS) and N.C. Health Choice (NCHC) programs.

To allow sufficient time for providers to implement changes, updates to Medicaid Clinical Policy 8A, *Enhanced Mental Health and Substance Abuse Services*, and the new IIH rate will become effective with claims processed on or after April 1, 2017.

Claims processed and paid prior to April 1, 2017, will be reimbursed at the old rate of \$258.20.

**DMA, Clinical Policy and Programs, 919-855-4260**  
**DMA, Provider Reimbursement, 919-814-0060**

## **Attention: Nurse Practitioners, Physicians, and Physicians Assistants**

### **Immune globulin subcutaneous (Human), 20 Percent solution (Cuvitru™) HCPCS code J3590: Billing Guidelines**

Effective with date of service Nov. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover immune globulin subcutaneous (Human), 20 percent solution (Cuvitru™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified Biologics. Cuvitru is currently available as a 200 mg/mL (20 percent) protein solution for subcutaneous infusion, in 5 mL, 10 mL, 20 mL and 40 mL vials. Cuvitru is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients 2 years of age and older.

Cuvitru can be administered at regular intervals from daily up to every two weeks (biweekly). The dose should be individualized based on the patient's pharmacokinetic and clinical response. Monitor serum IgG trough levels regularly to guide subsequent dose adjustments and dosing intervals as needed. See full prescribing information for detailed dosing recommendations.

#### **For Medicaid and NCHC Billing**

The ICD-10-CM diagnosis codes required for billing Cuvitru are:

- D80.0 - Hereditary hypogammaglobulinemia
- D80.1 - Nonfamilial hypogammaglobulinemia
- D80.2 - Selective deficiency of immunoglobulin A [IgA]
- D80.3 - Selective deficiency of immunoglobulin G [IgG] subclasses
- D80.4 - Selective deficiency of immunoglobulin M [IgM]
- D80.5 - Immunodeficiency with increased immunoglobulin M [IgM]
- D80.6 - Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia; D80.8 - Other immunodeficiencies with predominantly antibody defects
- D80.9 - Immunodeficiency with predominantly antibody defects, unspecified
- D81.0 - Severe combined immunodeficiency [SCID] with reticular dysgenesis
- D81.1 - Severe combined immunodeficiency [SCID] with low T- and B-cell numbers
- D81.2 - Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
- D81.4 - Nezelof's syndrome
- D81.6 - Major histocompatibility complex class I deficiency
- D81.7 - Major histocompatibility complex class II deficiency
- D81.89 - Other combined immunodeficiencies
- D81.9 - Combined immunodeficiency, unspecified
- D82.0 - Wiskott-Aldrich syndrome;
- D82.1 - Di George's syndrome
- D82.2 - Immunodeficiency with short-limbed stature
- D82.3 - Immunodeficiency following hereditary defective response to Epstein-Barr virus;
- D82.4 - Hyperimmunoglobulin E [IgE] syndrome
- D82.8 - Immunodeficiency associated with other specified major defects
- D82.9 - Immunodeficiency associated with major defect, unspecified

D83.0 - Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function  
D83.1 - Common variable immunodeficiency with predominant immunoregulatory T-cell disorders  
D83.2 - Common variable immunodeficiency with autoantibodies to B- or T-cells  
D83.8 - Other common variable immunodeficiencies  
D83.9 - Common variable immunodeficiency, unspecified  
D84.8 - Other specified immunodeficiencies

- Providers must bill Cuvitru with HCPCS code J3590 – Unclassified Biologics.
- One Medicaid unit of coverage for Cuvitru is 100 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per one unit is \$18.14.

Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Cuvitru are:

- 00944-2850-01
  - 00944-2850-02
  - 00944-2850-03
  - 00944-2850-04
  - 00944-2850-05
  - 00944-2850-06
  - 00944-2850-07
  - 00944-2850-08
- The NDC units for Cuvitru 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**

## 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 periods will instead be 30- and 10-day periods.

### Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
<b>February 2017</b>	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
<b>March 2017</b>	03/03/17	03/07/17	03/08/17
	03/10/17	03/14/17	03/15/17
	03/17/17	03/21/17	03/22/17
	03/24/17	03/28/17	03/29/17
	03/31/17	04/04/17	04/05/17

\* Batch cutoff date is previous day

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

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**Paul Guthery**  
 Executive Account Director  
 CSRA