Medical Assistance
HEALTH AND HUMAN SERVICES

# N.C. Medicaid Bulletin
# March 2017

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# Attention: All Providers

# NC Medicaid Electronic Health Record Incentive Program Announcement

## 90-day Meaningful Use 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 Year 2017. Providers may attest in the N.C. Medicaid Incentive Payment System (NC-MIPS) using a 90-day MU reporting period.

## The Final Countdown: Two Months Left to Start Participating

There are only **two** months left to begin participating in the N.C. Medicaid Electronic Health Record (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 NC-MIPS is accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and 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 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.

### '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. These webinars can be found 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 (email preferred)**

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## Attention: All Providers

# Affordable Care Act Fee Increase for Provider Enrollment

**Note:** This article was previously published in the *January 2017 Medicaid Bulletin*.

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

# NCTracks Provider Training Available in March 2017

Registration for several instructor-led training courses hosted in March 2017 has opened for providers. The duration varies depending on the course. All of the courses being offered in March will be taught via WebEx. Providers can attend remotely from any location with a telephone, computer and internet connection. Each WebEx will be limited to 115 participants.

**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.

### New Office Administrator (WebEx)

- Friday, March 3 - 9 to 11 a.m.

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

At the end of training, authorized users will be able to:

- Update the OA for an individual provider or organization, and,
- Upgrade existing users to "Managing Relationships"

### Enrollment Specialist User Roles, Abbreviated Managed Change Requests and Upload Documents (WebEx)

- Wednesday, March 8 - 1 to 4 p.m.

This course will guide providers through the following enhancements to the provider enrollment application processes:

- "Enrollment Specialist" user role
- Upload supporting documents
- Abbreviated Manage Change Request (MCR) applications

### Create and Submit a Prior Approval for Durable Medical Equipment and Home Health Supplies Using Electronic Signature (WebEx)

- Thursday, March 16 - 1 to 3 p.m.

The e-signature process allows the requesting provider to answer all of the questions related to the recipient's medical status when they enter a Prior Approval (PA) request on the secure provider portal. The PA request will then be sent to the prescribing provider for review. The providing provider will sign

an attestation statement saying that he/she is in agreement with the information entered by the requesting provider.

At the end of training, the participant 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 with an electronic signature
- Reject a PA request and send back to the requesting provider
- Revise a PA request and re-assign to the prescribing provider

### How to Add/Update Credentials (WebEx)

- Tuesday, March 21 - 1 to 3 p.m.

Some taxonomy codes require specialized providers to be licensed, accredited or certified according to specific laws and regulations. This course will provide instructions for adding and updating licensing or certifications to the provider's record in NCTracks.

### Provider Re-Credentialing/Re-Verification Refresher (WebEx)

- Thursday, March 23 – 1:00 to 2:30 p.m.

This is a refresher course on completing the re-verification process through NCTracks. It also covers the steps to enter information and submit a Manage Change Request (MCR) in the event the user is prompted to complete an MCR during re-verification/re-credentialing. (The terms re-credentialing and re-verification are used interchangeably in NCTracks.)

At the end of training, providers will be able to:

- Explain what provider re-verification is and why it is required
- Explain each phase of re-verification
- Complete the re-verification process in NCTracks
- Complete an MCR for invalid or missing provider data

### Submitting an Ambulance Claim (WebEx)

- Friday, March 24 – 10 a.m. to noon

This course describes the process of submitting ambulance claims using the professional (CMS-1500/837P) or institutional (UB-04/837I) claim form.

At the end of training, Providers will be able to:

- Create a professional or institutional claim
- Submit a professional or institutional claim
- View results of a claim submission

### Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Log on to the secure NCTracks provider portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folder labeled **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**

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## Attention: All providers

## Update to Recoupment Price of Fluxelvax

The article *Influenza Vaccine and Reimbursement Guidelines for 2016-2017* in the *October 2016 Medicaid Bulletin* referred providers to a fee schedule which had an error. In that fee schedule the price per dose of the Flucelvax vaccine, CPT code 90674, was listed as $43.46. This rate of $43.46 was incorrect and has resulted in overpayment of claims. The correct rate for Flucelvax is $21.73.

The correct rate for Flucelvax has been entered into NCTracks with an effective date of Sept. 30, 2016.

Providers who administered vaccines under the Vaccines for Children (VFC) program will not see any reimbursement changes. Claims previously paid at the incorrect rate will be systematically reprocessed by NCTracks at a later date. Additional information, including the timing, will be posted in upcoming Medicaid Bulletins.

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

## Attention: All Providers

# Medicaid Resolution Inquiry Form No Longer Required for Time Limit Overrides

Effective Feb. 5, 2017, the **Medicaid Resolution Inquiry Form will no longer be required** if a claim requiring a time limit override is submitted electronically through the NCTracks Provider Portal or through a batch X12 transaction. Providers are encouraged to use this method because the Medicaid Resolution Inquiry Form will eventually be phased out.

To provide the required documentation for a time limit override through the NCTracks Provider Portal, follow these steps:

1. Enter the claim electronically through the NCTracks Provider Portal

2. Include the "Delay Reason Code (DRC)" in the "Additional Claims Information" section

    a. Third Party Processing Delay (#7)
    b. Original claims rejected or denied due to a reason unrelated to the billing limitation rules (#9)

3. The Explanation of Benefits or Remittance Advice must be attached to the claim

4. The Attachment Type 'EB' must be used to identify the attachment as an Explanation of Benefits or a Remittance Advice.

5. Upload the proof of timely filing documentation. If you are unable to electronically upload the documentation, print out the cover sheet that will be used to connect your documentation to your request. Mail the printed cover sheet and corresponding documentation to the P.O. Box address noted on the cover sheet

**Note:** Each submission requires a DRC code, the EB Attachment Type, and copies of documentation (explanation of benefits, vouchers and attachments). Since these documents are scanned, attach only single-sided documents to the inquiry. **Do not attach double-sided documents to the inquiry.**

Claims submitted with a "Delay Reason Code 7 or 9" and an "Attachment Type EB" will pend for manual review and will be noted with a new Explanation of Benefits (EOB) Code:

EOB 05102 - MANUAL REVIEW OF ATTACHED DOCUMENTATION FOR TIMELY FILING

If the claim submitted does not have documentation with proof of timely filing, the claim will pend for 30 days. If no documentation is received after 30 days, the claim will deny.

The implementation of this new process in NCTracks will include a new EOB code:

EOB 05103 - OVERRIDE REQUEST FOR TIMELY FILING IS MISSING DOCUMENTATION

Refer to the Job Aids below, located on the Provider User Guides and Training page, for assistance on the time limit override criteria and process.

- How to Add an Attachment to a Claim
- Provider Adjustment, Time limit & Medicare Override Job Aid (coming soon)

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

## Attention: All Providers

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

**Note:** This article was previously published in the *January 2017 Medicaid Bulletin*.

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 on the 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

# Upload Documents in NCTracks Provider Portal

**Note:** This article was previously published in the *January 2017 Medicaid Bulletin*.

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

# 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 Division of Medical Assistance 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 National Provider Identifier (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 (email).

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

## Attention: All Providers

# Affiliation Claim Edit - Update

**Note:** This article was originally published as part of the January 2017 Special Medicaid Bulletin, *Changes to Implementation Date for Affiliation Claims Edits & Rendering Service Locations Edit*

One of the requirements associated with NCTracks is the attending/rendering providers must be affiliated with the billing providers who are submitting claims on their behalf. Currently, the disposition of the edit is 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 informs providers:

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 an abbreviated Manage Change Request (MCR) to add the affiliation to the provider record.

It was previously announced as of Feb. 5, 2017, the disposition of the edit would change to "pend" the claim while the provider submits an MCR to update the provider record. However, the N.C. Division of Medical Assistance (DMA) has decided to delay the disposition change to **May 1, 2017. Effective May 1, 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: Providers are encouraged to take advantage of this extension to submit MCRs that are needed to ensure the attending/rendering provider are affiliated to the billing provider.** The MCR to establish or change a provider affiliation must be initiated by the Office Administrator (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: Nurse Practitioners, Physicians Assistants and Physicians

## Olaratumab injection, for intravenous use (Lartruvo™) HCPCS code J9999: Billing Guidelines

Effective with date of service Dec. 1, 2016, the N.C. Medicaid and Health Choice programs cover olaratumab injection, for intravenous use (Lartruvo™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 – Chemotherapy not otherwise classified, antineoplastics. Lartruvo is currently available as a 500 mg/50 mL (10 mg/mL) solution in a single-dose vial for injection.

Lartruvo is indicated in combination with doxorubicin, for the treatment of adult patients with soft tissue sarcoma (STS) with a histologic subtype for which an anthracycline-containing regimen is appropriate and which is not amenable to curative treatment with radiotherapy or surgery. This indication is approved under accelerated approval. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trial.

Administer Lartruvo at 15 mg/kg as an intravenous infusion over 60 minutes on days one and eight of each 21-day cycle until disease progression or unacceptable toxicity. For the first eight cycles, Lartruvo is administered with doxorubicin. Premedicate with diphenhydramine and dexamethasone intravenously, prior to Lartruvo on day one of cycle one. For intravenous infusion only. Do not administer as an intravenous push or bolus. See full prescribing information for detailed preparation and administration instructions.

### For Medicaid and NCHC Billing

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

    - C49.0 Malignant neoplasm of connective and soft tissue of head, face and neck
    - C49.10 Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder
    - C49.11 Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder; C49.12 Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder
    - C49.20 Malignant neoplasm of connective and soft tissue of unspecified lower limb, including hip; C49.21 Malignant neoplasm of connective and soft tissue of right lower limb, including hip
    - C49.22 Malignant neoplasm of connective and soft tissue of left lower limb, including hip
    - C49.3 Malignant neoplasm of connective and soft tissue of thorax
    - C49.4 Malignant neoplasm of connective and soft tissue of abdomen
    - C49.5 Malignant neoplasm of connective and soft tissue of pelvis
    - C49.6 Malignant neoplasm of connective and soft tissue of trunk, unspecified
    - C49.8 Malignant neoplasm of overlapping sites of connective and soft tissue
    - C49.9 Malignant neoplasm of connective and soft tissue, unspecified
    - C47.0 Malignant neoplasm of peripheral nerves of head, face and neck
    - C47.10 Malignant neoplasm of peripheral nerves of unspecified upper limb, including shoulder
    - C47.11 Malignant neoplasm of peripheral nerves of right upper limb, including shoulder
    - C47.12 Malignant neoplasm of peripheral nerves of left upper limb, including shoulder

- C47.20 Malignant neoplasm of peripheral nerves of unspecified lower limb, including hip
- C47.21 Malignant neoplasm of peripheral nerves of right lower limb, including hip
- C47.22 Malignant neoplasm of peripheral nerves of left lower limb, including hip
- C47.3 Malignant neoplasm of peripheral nerves of thorax
- C47.4 Malignant neoplasm of peripheral nerves of abdomen
- C47.5 Malignant neoplasm of peripheral nerves of pelvis
- C47.6 Malignant neoplasm of peripheral nerves of trunk, unspecified
- C47.8 Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system
- C47.9 Malignant neoplasm of peripheral nerves and autonomic nervous system, unspecified
- C48.0 Malignant neoplasm of retroperitoneum
- C48.1 Malignant neoplasm of specified parts of peritoneum
- C48.2 Malignant neoplasm of peritoneum, unspecified
- C48.8 Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum

- Providers must bill Lartruvo with HCPCS code J9999 – Chemotherapy not otherwise classified, antineoplastics

- One Medicaid unit of coverage for Lartruvo is 1 mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per one unit is $50.98

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Lartruvo is: 00002-8926-01.

- The NDC units for Lartruvo 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, Physicians Assistants and Physicians

## Infliximab-dyyb for injection, for intravenous use (Inflectra™) HCPCS code Q5102: Billing Guidelines

Effective with date of service Jan. 12, 2017, the N.C. Medicaid and Health Choice (NCHC) programs cover infliximab-dyyb injection for intravenous use (Inflectra™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code Q5102 – Injection, infliximab, biosimilar, 10 mg. Inflectra is currently commercially available for injection as 100 mg of lyophilized infliximab-dyyb in a 20 mL vial for intravenous infusion.

Inflectra is indicated for:

**Crohn's Disease:**

- Reducing signs and symptoms, and inducing and maintaining clinical remission, in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

- Reducing the number of draining enterocutaneous and rectovaginal fistulas, and maintaining fistula closure, in adult patients with fistulizing disease.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every eight weeks. Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response.

**Pediatric Crohn's Disease:**

- Reducing signs and symptoms, and inducing and maintaining clinical remission, in pediatric patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every eight weeks.

**Ulcerative Colitis:**

- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every eight weeks.

**Rheumatoid Arthritis** in combination with methotrexate:

- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active disease.

- DOSAGE: In conjunction with methotrexate, 3 mg/kg at zero, two and six weeks, then every eight weeks. Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every four weeks.

**Ankylosing Spondylitis:**

- Reducing signs and symptoms in patients with active disease.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every six weeks.

**Psoriatic Arthritis:**

- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every eight weeks.

**Plaque Psoriasis:**

- Treatment of adult patients with chronic severe (i.e., extensive and /or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

- Inflectra is administered by intravenous infusion over a period of not less than two hours.

- DOSAGE: 5 mg/kg at zero, two and six weeks, then every eight weeks.

## For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Inflectra 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;
  - K50.111 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;
- K50.80 Crohn's disease of both small and large intestines without complications;
- K50.811 Crohn's disease of both small and large intestines with rectal bleeding;
- K50.812 Crohn's disease of both small and large intestines with intestinal obstruction;
- K50.813 Crohn's disease of both small and large intestines with fistula;
- K50.814 Crohn's disease of both small and large intestines with abscess;
- K50.818 Crohn's disease of both small and large intestines with other complication;
- K50.819 Crohn's disease of both small and large intestines with unspecified complications;
- K50.90 Crohn's disease, unspecified 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;
- K51.00 - Ulcerative Colitis Ulcerative (chronic) pancolitis without complications;
- K51.011 Ulcerative (chronic) pancolitis with rectal bleeding;
- K51.012 Ulcerative (chronic) pancolitis with intestinal obstruction;
- K51.013 Ulcerative (chronic) pancolitis with fistula;
- K51.014 Ulcerative (chronic) pancolitis with abscess;
- K51.018 Ulcerative (chronic) pancolitis with other complication;
- K51.019 Ulcerative (chronic) pancolitis with unspecified complications;
- K51.20 Ulcerative (chronic) proctitis without complications;
- K51.211 Ulcerative (chronic) proctitis with rectal bleeding;
- K51.212 Ulcerative (chronic) proctitis with intestinal obstruction;
- K51.213 Ulcerative (chronic) proctitis with fistula;
- K51.214 Ulcerative (chronic) proctitis with abscess;
- K51.218 Ulcerative (chronic) proctitis with other complication;
- K51.219 Ulcerative (chronic) proctitis with unspecified complications;
- K51.30 Ulcerative (chronic) rectosigmoiditis without complications;
- K51.311 Ulcerative (chronic) rectosigmoiditis with rectal bleeding;
- K51.312 Ulcerative (chronic) rectosigmoiditis with intestinal obstruction;
- K51.313 Ulcerative (chronic) rectosigmoiditis with fistula;
- K51.314 Ulcerative (chronic) rectosigmoiditis with abscess;
- K51.318 Ulcerative (chronic) rectosigmoiditis with other complication;
- K51.319 Ulcerative (chronic) rectosigmoiditis with unspecified complications;
- K51.50 Left sided colitis without complications;
- K51.511 Left sided colitis with rectal bleeding;
- K51.512 Left sided colitis with intestinal obstruction;
- K51.513 Left sided colitis with fistula;
- K51.514 Left sided colitis with abscess;
- K51.518 Left sided colitis with other complication;
- K51.519 Left sided colitis with unspecified complications;

- K51.80 Other ulcerative colitis without complications;
- K51.811 Other ulcerative colitis with rectal bleeding;
- K51.812 Other ulcerative colitis with intestinal obstruction;
- K51.813 Other ulcerative colitis with fistula;
- K51.814 Other ulcerative colitis with abscess;
- K51.818 Other ulcerative colitis with other complication;
- K51.819 Other ulcerative colitis with unspecified complications;
- K51.90 Ulcerative colitis, unspecified without complications;
- K51.911 Ulcerative colitis, unspecified with rectal bleeding;
- K51.912 Ulcerative colitis, unspecified with intestinal obstruction;
- K51.913 Ulcerative colitis, unspecified with fistula;
- K51.914 Ulcerative colitis, unspecified with abscess;
- K51.918 Ulcerative colitis, unspecified with other complication;
- K51.919 Ulcerative colitis, unspecified with unspecified complications;

**Rheumatoid Arthritis:**

- M05.00 Felty's syndrome, unspecified site;
- M05.011 Felty's syndrome, right shoulder;
- M05.012 Felty's syndrome, left shoulder;
- M05.019 Felty's syndrome, unspecified shoulder;
- M05.021 Felty's syndrome, right elbow;
- M05.022 Felty's syndrome, left elbow;
- M05.029 Felty's syndrome, unspecified elbow;
- M05.031 Felty's syndrome, right wrist;
- M05.032 Felty's syndrome, left wrist;
- M05.039 Felty's syndrome, unspecified wrist;
- M05.041 Felty's syndrome, right hand;
- M05.042 Felty's syndrome, left hand;
- M05.049 Felty's syndrome, unspecified hand;
- M05.051 Felty's syndrome, right hip;
- M05.052 Felty's syndrome, left hip;
- M05.059 Felty's syndrome, unspecified hip;
- M05.061 Felty's syndrome, right knee;
- M05.062 Felty's syndrome, left knee;
- M05.069 Felty's syndrome, unspecified knee;
- M05.071 Felty's syndrome, right ankle and foot;
- M05.072 Felty's syndrome, left ankle and foot;
- M05.079 Felty's syndrome, unspecified ankle and foot;
- M05.09 Felty's syndrome, multiple sites;
- M05.60 Rheumatoid arthritis of unspecified site with involvement of other organs and systems;
- M05.611 Rheumatoid arthritis of right shoulder with involvement of other organs and systems;
- M05.612 Rheumatoid arthritis of left shoulder with involvement of other organs and systems;
- M05.619 Rheumatoid arthritis of unspecified shoulder with involvement of other organs/systems;

- M05.621 Rheumatoid arthritis of right elbow with involvement of other organs and systems;
- M05.622 Rheumatoid arthritis of left elbow with involvement of other organs and systems;
- M05.629 Rheumatoid arthritis of unspecified elbow with involvement of other organs/systems;
- M05.631 Rheumatoid arthritis of right wrist with involvement of other organs and systems;
- M05.632 Rheumatoid arthritis of left wrist with involvement of other organs and systems;
- M05.639 Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems;
- M05.641 Rheumatoid arthritis of right hand with involvement of other organs and systems;
- M05.642 Rheumatoid arthritis of left hand with involvement of other organs and systems;
- M05.649 Rheumatoid arthritis of unspecified hand with involvement of other organs and systems;
- M05.651 Rheumatoid arthritis of right hip with involvement of other organs and systems;
- M05.652 Rheumatoid arthritis of left hip with involvement of other organs and systems;
- M05.659 Rheumatoid arthritis of unspecified hip with involvement of other organs and systems;
- M05.661 Rheumatoid arthritis of right knee with involvement of other organs and systems;
- M05.662 Rheumatoid arthritis of left knee with involvement of other organs and systems;
- M05.669 Rheumatoid arthritis of unspecified knee with involvement of other organs and systems;
- M05.671 Rheumatoid arthritis of right ankle and foot with involvement of other organs/systems;
- M05.672 Rheumatoid arthritis of left ankle and foot with involvement of other organs/systems;
- M05.679 Rheumatoid arthritis of unspecified ankle/foot with involvement of other organs/systems;
- M05.69 Rheumatoid arthritis of multiple sites with involvement of other organs and systems;
- M05.70 Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement;
- M05.711 Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement;
- M05.712 Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement;
- M05.719 Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement;
- M05.721 Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement;
- M05.722 Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement;
- M05.729 Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement;
- M05.731 Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement;
- M05.732 Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement;
- M05.739 Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement;
- M05.741 Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement;

- M05.742 Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement;
- M05.749 Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement;
- M05.751 Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement;
- M05.752 Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement; M05.759 Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement;
- M05.761 Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement;
- M05.762 Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement;
- M05.769 Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement;
- M05.771 Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement;
- M05.772 Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement;
- M05.779 Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement;
- M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement;
- M05.80 Other rheumatoid arthritis with rheumatoid factor of unspecified site;
- M05.811 Other rheumatoid arthritis with rheumatoid factor of right shoulder;
- M05.812 Other rheumatoid arthritis with rheumatoid factor of left shoulder;
- M05.819 Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder;
- M05.821 Other rheumatoid arthritis with rheumatoid factor of right elbow;
- M05.822 Other rheumatoid arthritis with rheumatoid factor of left elbow;
- M05.829 Other rheumatoid arthritis with rheumatoid factor of unspecified elbow;
- M05.831 Other rheumatoid arthritis with rheumatoid factor of right wrist;
- M05.832 Other rheumatoid arthritis with rheumatoid factor of left wrist;
- M05.839 Other rheumatoid arthritis with rheumatoid factor of unspecified wrist;
- M05.841 Other rheumatoid arthritis with rheumatoid factor of right hand;
- M05.842 Other rheumatoid arthritis with rheumatoid factor of left hand;
- M05.849 Other rheumatoid arthritis with rheumatoid factor of unspecified hand;
- M05.851 Other rheumatoid arthritis with rheumatoid factor of right hip;
- M05.852 Other rheumatoid arthritis with rheumatoid factor of left hip;
- M05.859 Other rheumatoid arthritis with rheumatoid factor of unspecified hip;
- M05.861 Other rheumatoid arthritis with rheumatoid factor of right knee;
- M05.862 Other rheumatoid arthritis with rheumatoid factor of left knee;
- M05.869 Other rheumatoid arthritis with rheumatoid factor of unspecified knee;
- M05.871 Other rheumatoid arthritis with rheumatoid factor of right ankle and foot;
- M05.872 Other rheumatoid arthritis with rheumatoid factor of left ankle and foot;
- M05.879 Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot;
- M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites;

- M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified;
- M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site;
- M06.011 Rheumatoid arthritis without rheumatoid factor, right shoulder;
- M06.012 Rheumatoid arthritis without rheumatoid factor, left shoulder;
- M06.019 Rheumatoid arthritis without rheumatoid factor, unspecified shoulder;
- M06.021 Rheumatoid arthritis without rheumatoid factor, right elbow;
- M06.022 Rheumatoid arthritis without rheumatoid factor, left elbow;
- M06.029 Rheumatoid arthritis without rheumatoid factor, unspecified elbow;
- M06.031 Rheumatoid arthritis without rheumatoid factor, right wrist;
- M06.032 Rheumatoid arthritis without rheumatoid factor, left wrist;
- M06.039 Rheumatoid arthritis without rheumatoid factor, unspecified wrist;
- M06.041 Rheumatoid arthritis without rheumatoid factor, right hand;
- M06.042 Rheumatoid arthritis without rheumatoid factor, left hand;
- M06.049 Rheumatoid arthritis without rheumatoid factor, unspecified hand;
- M06.051 Rheumatoid arthritis without rheumatoid factor, right hip;
- M06.052 Rheumatoid arthritis without rheumatoid factor, left hip;
- M06.059 Rheumatoid arthritis without rheumatoid factor, unspecified hip;
- M06.061 Rheumatoid arthritis without rheumatoid factor, right knee;
- M06.062 Rheumatoid arthritis without rheumatoid factor, left knee;
- M06.069 Rheumatoid arthritis without rheumatoid factor, unspecified knee;
- M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot;
- M06.072 Rheumatoid arthritis without rheumatoid factor, left ankle and foot;
- M06.079 Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot;
- M06.08 Rheumatoid arthritis without rheumatoid factor, vertebrae;
- M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites;
- M06.80 Other specified rheumatoid arthritis unspecified site;
- M06.811 Other specified rheumatoid arthritis, right shoulder;
- M06.812 Other specified rheumatoid arthritis, left shoulder;
- M06.819 Other specified rheumatoid arthritis, unspecified shoulder;
- M06.821 Other specified rheumatoid arthritis, right elbow;
- M06.822 Other specified rheumatoid arthritis, left elbow;
- M06.829 Other specified rheumatoid arthritis, unspecified elbow;
- M06.831 Other specified rheumatoid arthritis, right wrist;
- M06.832 Other specified rheumatoid arthritis, left wrist;
- M06.839 Other specified rheumatoid arthritis, unspecified wrist;
- M06.841 Other specified rheumatoid arthritis, right hand;
- M06.842 Other specified rheumatoid arthritis, left hand;
- M06.849 Other specified rheumatoid arthritis, unspecified hand;
- M06.851 Other specified rheumatoid arthritis, right hip;
- M06.852 Other specified rheumatoid arthritis, left hip;
- M06.859 Other specified rheumatoid arthritis, unspecified hip;
- M06.861 Other specified rheumatoid arthritis, right knee;
- M06.862 Other specified rheumatoid arthritis, left knee;
- M06.869 Other specified rheumatoid arthritis, unspecified knee;
- M06.871 Other specified rheumatoid arthritis, right ankle and foot;

- M06.872 Other specified rheumatoid arthritis, left ankle and foot;
- M06.879 Other specified rheumatoid arthritis, unspecified ankle and foot;
- M06.88 Other specified rheumatoid arthritis, vertebrae;
- M06.89 Other specified rheumatoid arthritis, multiple sites;
- M06.9 Rheumatoid arthritis, unspecified

**Ankylosing Spondylitis:**

- M45.0 - Ankylosing spondylitis of multiple sites in spine;
- M45.1 - Ankylosing spondylitis of occipito-atlanto-axial region;
- M45.2 - Ankylosing spondylitis of cervical region;
- M45.3 - Ankylosing spondylitis of cervicothoracic region;
- M45.4 - Ankylosing spondylitis of thoracic region;
- M45.5 - Ankylosing spondylitis of thoracolumbar region;
- M45.6 - Ankylosing spondylitis lumbar region;
- M45.7 - Ankylosing spondylitis of lumbosacral region;
- M45.8 - Ankylosing spondylitis sacral and sacrococcygeal region;
- M45.9 - Ankylosing spondylitis of unspecified sites in spine;

**Psoriatic Arthritis:**

- L40.50 - Arthropathic psoriasis, unspecified;
- L40.51 - Distal interphalangeal psoriatic arthropathy;
- L40.52 - Psoriatic arthritis mutilans;
- L40.53 - Psoriatic spondylitis;
- L40.59 - Other psoriatic arthropathy;
- L40.0 - Psoriasis vulgaris.

- Providers must bill Inflectra with HCPCS code Q5102 - Injection, infliximab, biosimilar, 10 mg.

- One Medicaid unit of coverage for Inflectra is 10 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $100.31

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Inflectra is: 00069-0809-01.

- The NDC units for Inflectra 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: Personal Care Service Providers

# Short-Term Increase Request Process for Personal Care Services (PCS) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

When Medicaid beneficiaries under 21 years of age require a short-term increase in their currently authorized hours for Personal Care Services (PCS), primary caregivers, legal guardians, Powers of Attorney (POA) and providers may request the increase by completing the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Short-Term Increase Request Form (DMA 3116). Medicaid's EPSDT benefit may cover these short term increases when they are determined to be medically necessary.

A short-term increase in hours may be requested for the following reasons:

- Extended school holidays (may include teacher work days or early release)
- Summer and track-out sessions
- Primary caregiver temporarily unable to provide care due to extenuating circumstances (hospitalization, surgery, etc.) – Medical documentation must accompany request

Requests must be submitted **14 business days** prior to the start date of the requested increase.
A work schedule and disability verification is required for any and all legally responsible individuals (e.g. mother, father, legal guardian, etc.).

Work verification must be on company letterhead and include the specific work days and hours for the parent, legal guardian, or other responsible individual. The work verification must include the supervisor's contact information and signature. The employer will be contacted and employment verified. Disability verification must be completed and signed by a physician with an explanation of the parent, legal guardian or other responsible individual's inability to perform the hands-on-care needs of the child.

The requestor must indicate the increase in hours requested, the time requested for each day and the start and end date of the request. The responsible party will be asked if there are other adults residing in the home that are available, on a regular basis, to meet the beneficiary's need for personal care. Additional information may be requested to determine if there is an unmet need for PCS based on presence of adults residing in the home.

Medicaid does not cover PCS when other family members or other informal caregivers are willing, able, and available on a regular basis to meet the need for PCS. Requests submitted without work schedule or disability verification will be denied. All requests are to be submitted to the Division of Medical Assistance (DMA) via fax at 919-715-0102. Requestors may contact DMA EPSDT nurse consultants with questions at 919-855-4360.

The PCS EPSDT Short-Term Increase Request Form (DMA 3116) is available on the DMA PCS web page and the Liberty Healthcare website.

**Facility, Home, and Community Based Services**
**DMA, 919-855-4340**

# 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.

**As of March 1, 2017,** the following policies are open for public comment:

| Proposed Policy | Date Posted | Comment Period End Date |
|---|---|---|
| 1A-30, Spinal Surgeries | 01/23/17 | 03/09/17 |
| 9, Outpatient Pharmacy | 02/09/17 | 03/26/17 |
| 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older | 02/24/17 | 03/05/17 |
| 3G-2, Private Duty Nursing for Beneficiaries under 21 years of Age | 02/24/17 | 03/05/17 |

**Checkwrite Schedule**

| Month | Checkwrite Cycle Cutoff Date* | Checkwrite Date | EFT Effective Date |
|---|---|---|---|
| **March 2017** | 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 |
| **April 2017** | 04/06/17 | 04/11/17 | 04/12/17 |
| | 04/13/17 | 04/18/17 | 04/19/17 |
| | 04/20/17 | 04/25/17 | 04/26/17 |
| | 04/27/17 | 05/02/17 | 05/03/17 |

* 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**