



N.C. Medicaid Bulletin May 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**Affiliation Claim Edit and Edit Capability – Clarification**

Note: This article rescinds the articles titled *Affiliation Claim Edit* and *Affiliation Edit Capabilities* previously published in the *April 2017 Medicaid Bulletin*.

NCTracks requires rendering providers to be affiliated with billing providers who submit professional claims on their behalf. Previously, the disposition of the edit was set to “pay and report.” The claim did not deny, but an informational Explanation of Benefit (EOB) 07025 was posted on the provider’s Remittance Advice (RA).

EOB 07025:

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

The intent was to alert providers to situations in which affiliation relationships do not exist. This allows rendering providers to initiate an abbreviated Manage Change Request (MCR) to add the affiliation to the provider record.

Effective May 1, 2017, providers will notice two changes:

1. **The claim edit disposition will change from “pay and report” to “pend.”** Once the disposition is changed, a professional claim failing the edit will pend for 60 days.
 - a. The MCR to establish or change a provider affiliation must be initiated by the Office Administrator (OA) of the individual rendering provider. A group or organization that acts as a billing provider cannot alter affiliations in NCTracks.
 - b. **If the affiliation relationship is updated in NCTracks within 60 days, the claim will auto-recycle for payment.** No action is required on the provider’s part.
 - c. **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.
2. The Affiliated Provider Information web page on NCTracks will be updated to allow individual providers to:
 - a. Affiliate to active, suspended, and terminated organizations in enrollment, re-enrollment and MCR applications

- b. Edit the “begin date” when adding new affiliations in MCR and re-enrollment applications
- c. Edit the “begin date” of existing affiliations in an MCR application
- d. Back-date the “begin date” of the affiliation in an MCR application

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

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 Policies](#) web pages.

- 1A-13, *Ocular Photodynamic Therapy* (May 1, 2017)
- 3K-2, *Community Alternatives Program for Disabled Adults (CAP/DA)* (April 18, 2017)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Provider Qualifications and Requirements Checklist

Beginning July 30, 2017, the Provider Qualifications and Requirements Checklist located on the NCTracks Provider Enrollment page will be replaced with an Excel spreadsheet. Providers will be able to apply filters to the spreadsheet to locate information on program requirements and qualifications specific to taxonomy codes. An instruction sheet for applying the Excel filters also will be available.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone) or NCTracksprovider@nctracks.com.

CSRA, 1-800-688-6696

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Attention: All Providers**M**edicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks

Note: This article is being republished with updates. **It repeals all previously published articles.**

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.

According to [42 CFR 455.434\(b\)](#), providers who meet the following criteria must submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA:

- 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\(g\)](#), and,
- Any person with a 5 percent or more direct or indirect ownership interest in the organization - those terms are defined in [42 CFR 455.101](#).

This will be implemented on 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 North Carolina’s CHIP.

Providers required to submit fingerprints will be notified through the NCTracks provider portal. Locations in North Carolina where fingerprinting services are offered will be posted on the NCTracks website.

Per [42 CFR 455.416\(e\)](#), providers subject to the fingerprinting requirement who fail to submit sets of fingerprints as required within the 30-day timeframe will be terminated from, or denied enrollment in, the N.C. Medicaid and NCHC programs.

Providers who fail to comply with the fingerprinting requirement are subject to a “for cause” denial or termination. A “for cause” action is one related to program compliance, fraud, integrity, or quality. DMA is required to report providers terminated or denied for cause to CMS.

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.

Questions regarding this new requirement, or requests for additional assistance, can be directed to the NCTracks Call Center at 800-688-6696 or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

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Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2017**

Note: This article is being republished monthly. It 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 N.C. 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 the following statuses to avoid payment suspension:

- In Review
- Returned
- Approved
- 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**. 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.

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC Medicaid Electronic Health Record Incentive Program Announcement

Program Year 2016 Update

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program is no longer accepting Program Year 2016 attestations.

Program Year 2016 attestations are being processed in the order they were received. Attestations received in March and April may take up to 20 weeks to process from the date the signed attestation was received. Providers may check the status of their attestation at any time on the Status Page at [N.C. Medicaid Incentive Payment System \(NC-MIPS\)](#).

CMS Hardship Exceptions

If providers are unable to meet Meaningful Use (MU) in Program Year 2016, they can file a [Hardship Exception Application](#) with the Centers for Medicare & Medicaid Services (CMS) to avoid Medicare payment adjustments. The Hardship Exception Application needs to be filed with CMS no later than **July 1, 2017**.

N.C. Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov

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

Registration is open for two instructor-led training courses for providers that will be held in May 2017. The duration varies depending on the course. Following are details on the courses, including dates, times, and instructions for how to enroll.

Dental Helpful Hints (WebEx)

- Wednesday, May 17 – 1 to 3 p.m.

This course will provide users with tips for requesting Dental Prior Approval (PA) and dental claim submission within NCTracks.

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

- Identify the three methods for submitting a PA request
- Identify how to upload documents when submitting a new PA request or supplementing an existing PA request
- Avoid common errors when completing the American Dental Association form
- Avoid common errors that trigger requests for PA additional information
- Avoid common errors when submitting dental claims

This course is taught via WebEx. Providers can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Prior Approval - Pharmacy (On-Site)

- Thursday, May 25 – 1 to 3 p.m.

This course will cover submitting Pharmacy Prior Approval (PA) requests, to aid in complying with N.C. Medicaid clinical coverage policy and medical necessity. It will also cover PA inquiry to check on the status of the Pharmacy PA Request.

The course is being offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor**

Led Training (ILT). The courses can be found in the sub-folders labeled **ILTs: On-site** 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

Next Regional NCTracks Seminar is May 18

The next Regional NCTracks Seminar will be on Thursday, May 18, at the Halifax County Center, 359 Ferrell Lane, Halifax, N.C. 27839.

Regional NCTracks Seminars teaches new providers and new billing staff of existing providers how to use NCTracks. It also offers a refresher for current and experienced provider staff. These seminars are offered on various dates and locations across the state. Each seminar runs from 9 a.m. to 4 p.m. and includes a Provider Help Center.

For more information – including registration information, dates, and locations of other regional seminars – see the [March 10 announcement](#) on the NCTracks Provider Portal.

CSRA, 1-800-688-6696

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Attention: All Providers**P**rior Approval Requirement for Spinal Surgeries Delayed

Note: This is an update to an article previously published in April 2017.

[Session Law 2011-145, HB 200](#) Section 10.37(a)(11)(g)(4) required the Division of Medical Assistance (DMA) to implement prior approval for spinal surgery for selective diagnoses and require that all other therapies have been exhausted prior to granting approval. Currently, only cervical laminoplasty (CPT Codes 63050 and 63051) requires prior approval.

In the April 2017 Medicaid Bulletin article, *New Coverage and Prior Approval Requirements for Spinal Surgeries*, an implementation date of July 1, 2017, was announced. However, the implementation has been delayed. **Until the change is implemented, prior approval will not be required for spinal surgeries apart from CPT codes 63050 and 63051.**

DMA will provide updates through future Medicaid Bulletin articles and provider notifications in NCTracks. Refer to the [April 2017 Medicaid Bulletin](#) for information regarding which surgical procedures require prior approval, as well as which diagnoses are exempt from prior approval.

**Practitioner and Facility Services and Policy Development
DMA, 919-855-4320**

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Attention: All Providers**Sterilization Procedure Codes**

N.C. Division of Medical Assistance (DMA) has determined some sterilization-related claims billed with CPT procedure codes 88302 [surgical pathology, gross and microscopic examination] and 00952 [anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography] have processed in error, since July 1, 2013. These codes have **not** been processed though sterilization editing, as they were with the previous N.C. Department of Health and Human Services fiscal contractor.

All provider types submitting claims for reimbursement, including any associated services following sterilization, **will be denied or recouped** if the sterilization consent form on file is invalid or missing. Providers billing for sterilization procedures with CPT procedure codes 88302 and 00952 should ensure that they bill with the modifier directed in clinical coverage policy 1E-3, *Sterilization Procedures*.

A provider notification is posted when claim reprocessing is required.

For more information, providers should refer to clinical coverage policy 1E-3, *Sterilization Procedures*, on [DMA's Obstetrics and Gynecology Clinical Coverage Policy web page](#).

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or NCTracksprovider@nctracks.com.

Clinical Policy and Programs
DMA, 919-855-4260

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Attention: Community Care of North Carolina/Carolina ACCESS Providers**Reminder about Community Care of NC/Carolina ACCESS Payment Authorization**

Note: This is a revision to the article, *Carolina ACCESS Payment Authorization*, which was posted in the [November 2016 Medicaid Bulletin](#)

Effective with dates of service Nov. 1, 2016, Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers shall **not**:

- Enter a National Provider Identifier (NPI) as the CCNC/CA payment authorization number for claims processing.
- Use the NCTracks Provider Portal to make referrals for CCNC/CA enrollees; This functionality will not be available effective May 1, 2017, or,
- Make requests to NCTracks for CCNC/CA overrides for services provided after Oct. 31, 2016.

Providers should not receive claims denials due to CCNC/CA payment authorization for dates of service after Oct. 31, 2016. Providers must still adhere to the CCNC/CA coordination of care protocols.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksProvider@nctracks.com.

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

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Attention: Dental Providers**New American Dental Association Procedure Code**

Effective with date of service **Jan. 1, 2017**, the following dental procedure code was added for the N.C. Medicaid and N.C. Health Choice dental programs. This addition is a result of the Current Dental Terminology (CDT) 2016 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, *Dental Services*, will be updated to reflect these changes.

CDT 2016-2017 Code	Description and Limitations	PA Indicator
D1354	<ul style="list-style-type: none"> • Interim caries arresting medicament application • Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure • Limited to beneficiaries ages 1 to 5 • Allowed once per beneficiary per six calendar month period for the same provider • Limited to a total of four applications prior to age 6 • Allowed once per date of service • Recommended for beneficiaries who are deemed to be at risk for progression of disease to pulpal infection • Since the potential for staining of carious enamel and dentin exists, providers must obtain informed consent from the beneficiary's parent or caregiver prior to rendering the service • Reapplication of the caries arresting medicament at recall visits is only indicated if the carious lesions do not appear arrested • Treated carious lesions can be restored after treatment with a caries arresting medicament • Reimbursement rate of \$24.18 	N

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

Dental Program
DMA, 919-855-4280

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Attention: Dental Providers**Revision of Dental Procedure Code D9410 (House/Extended Care Facility Call)**

N.C. Medicaid and N.C. Health Choice coverage of the following dental procedure code has been revised effective May 1, 2017. Clinical Coverage Policy 4A, *Dental Services*, will be updated to reflect these changes.

CDT 2017 Code	Description and Limitations	PA Indicator
D9410	House/extended care facility call <ul style="list-style-type: none"> • Includes visits to nursing facilities, long-term care facilities, adult care homes, hospice sites, institutions, etc. • A dentist can be reimbursed for one facility call per date of service for each beneficiary treated in the facility • Must be billed with other definitive treatment (other CDT codes) rendered on that date of service • Procedure codes for treatment must be billed on the detail lines before D9410 on the dental claim • Not allowed for post-surgical follow-up care or initial six months post-delivery care for appliances when other definitive treatment is not being rendered • Reimbursement rate of \$71.16 (General Dentist) 	N

Prior to May 1, 2017, providers were reimbursed for only one facility call per facility per date of service, regardless of the number of beneficiaries treated on that day. That policy still applies for dates of service **prior to May 1, 2017**.

Effective with date of service May 1, 2017, providers can be reimbursed for a facility call (D9410) for each beneficiary receiving definitive dental treatment.

Example of Billing with Procedure Code D9410 (treatment in a nursing facility)

Visit	Treatment Rendered	Procedure Codes Billed
Visit No. 1	Initial exam	D0150, D9410
Visit No. 2	Extraction of teeth No. 8 and No. 9	D7140 X 2, D9410
Visit No. 3	Impressions for U/L dentures	None
Visit No. 4	Jaw relations/centric relation bite	None
Visit No. 5	Wax try-in	None
Visit No. 6	Delivery of U/L dentures	D5110, D5120, D9410
Visit No. 7	Follow-up adjustment of dentures (initial six months post-delivery care)	None

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

Dental Program
DMA, 919-855-4280

Attention: Durable Medical Equipment Providers

Update to Manual Pricing Calculation for Complex Rehab Technology Durable Medical Equipment Prior Approval Requests and Claims Processing

Note: This is an update to an *April 2016 Special Medicaid Bulletin*. The fourth bullet under “Exceptions” (highlighted) is the change.

Manual Pricing Calculations

Manual pricing calculation for Durable Medical Equipment (DME) Prior Approval requests approved according to the appropriate clinical policy procedures are:

- Providers must submit an invoice or quote (or an estimate if the request is for non-warranty repair) with DMA 372-131 form (Certificate of Medical Necessity/Prior Approval or CMN/PA) when requesting prior approval for a manually priced item.
- The maximum allowable rate will be the vendor’s invoice or quote amount, **net** of all discounts, **plus** 20 percent. When freight is allowed, it will be added to the reimbursement at actual cost. If there are multiple items on the same invoice, the freight component of the maximum allowable rate will be the total freight charge divided by the number of items billed on the invoice.

Exceptions:

- **Wheelchairs and wheelchair accessories** are the **only** medical equipment supplies where the maximum allowable rate may be based on MSRP for prior approval purposes.
- **External insulin pumps** are covered in a separate pricing policy.
- **For procedure code A9999 - Farrell valves**, the designated maximum allowable rate is \$8.48, until a memo is submitted changing the designated rate.
- **Effective with dates of service beginning May 1, 2017**, the maximum allowable rate for manually priced complex rehab technology procedure codes E0328, E0637, E0641, E8000, E8001, E8002, and E1399/W4047 pediatric bath system (E0240) will be the vendor’s invoice or quote amount, net of all discounts, plus 35 percent.

All other DME policies, such as paying lower of billed versus maximum allowable rate still apply. Provider should bill their usual and customary charge.

Except for wheelchairs, wheelchair accessories and Farrell valves, claims submitted for services which were authorized prior to Nov. 6, 2015 must include an invoice.

Additional Resources

For more information about the new specified facilities discharge process on select DME codes, consult [Clinical Coverage Policy 5A, Durable Medical Equipment and Supplies](#).

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

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Attention: Nurse Practitioners, Physicians Assistants and Physicians

Bezlotoxumab injection, for intravenous use (Zinplava) HCPCS code J3590: Billing Guidelines

Effective with date of service **Feb. 1, 2017**, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover bezlotoxumab injection for intravenous use (Zinplava) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified biologics. Zinplava is currently commercially available as a 1000 mg/40 mL (25 mg/mL) solution in a single-dose vial. Zinplava is indicated to reduce recurrence of *Clostridium difficile* infection (CDI) in patients 18 years of age and older who are receiving antibacterial drug treatment for CDI and are high risk for CDI recurrence.

Limitation of Use

Zinplava is not indicated for the treatment of CDI. Zinplava is not an antibacterial drug. Zinplava should only be used in conjunction with antibacterial drug treatment of CDI.

The recommended dose of Zinplava is a single dose of 10 mg/kg administered as an intravenous infusion over 60 minutes. The safety and efficacy of repeat administration of Zinplava in patients with CDI have not been studied. Dilute prior to intravenous infusion.

See package insert for full prescribing information for warnings and precautions.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Zinplava is A04.7 - Enterocolitis due to *Clostridium difficile*.
- Providers must bill Zinplava with HCPCS code J3590 – Unclassified biologics.
- One Medicaid unit of coverage for Zinplava is one milligram (mg). The maximum reimbursement rate per unit is: \$4.10.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Zinplava are: 00006-3025-00 and 00006-3025-01.
- The NDC units for Zinplava should be reported as “UN1”.
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on the N.C. Division of Medical Assistance (DMA) 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 amount 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

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Attention: Personal Care Service Providers**P**ersonal Care Services Regional Provider Trainings

Personal Care Services (PCS) regional training sessions will be held May 1- 15, 2017 from 9 a.m. to 1 p.m. Training topics and materials will be available to registered participants on the Liberty Healthcare of N.C. website. Providers can register through the Liberty Healthcare Corporation of N.C. Medicaid PCS website. There is no cost to attend trainings, but registration is required.

Providers with additional questions may contact Liberty Healthcare Corporation of N.C. at 1-855-740-1400 or the N.C. Division of Medical Assistance at 919-855-4360.

Event Dates and Locations

- **Monday, May 1, 2017 - Greenville**

Holiday Inn-Greenville, *Ballroom*

- **Friday, May 5, 2017 - Raleigh**

Jane S. McKimmon Conference and Training Center-NCSU, *Room will be posted at Information Desk*

- **Tuesday, May 9, 2017 - Asheville**

Doubletree by Hilton-Biltmore, *Burghley Room*

- **Wednesday, May 10, 2017 - Charlotte**

Great Wolf Lodge Convention Center, *White Pine I & II*

- **Thursday, May 11, 2017 - Greensboro/Winston-Salem**

Greensboro-High Point Marriott Airport, *Grand Ballroom*

- **Monday, May 15, 2017 - Fayetteville**

Holiday Inn Fayetteville I95 South, *Grande Ballroom*

ICD-10 Transition Form (DMA 3137) - Required for all State Plan Personal Care Services Beneficiaries

PCS policy requires documentation of each PCS beneficiary's medical diagnosis or diagnoses, related medical information that results in the unmet need for PCS, and the current diagnosis codes associated with the identified medical diagnosis. In addition to these requirements, PCS policy states that beneficiaries must be under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitation.

To ensure that PCS policy requirements are met, DMA has asked that all PCS beneficiaries receiving services on or after October 2015 to submit an [ICD-10 Transition Form](#) to Liberty

Healthcare of N.C. **no later than the date of their scheduled annual assessment.** The ICD-10 Form must be completed by the beneficiary's primary care physician or the practitioner providing care for the medical, physical, or cognitive condition causing the functional limitation.

To date, we have approximately **9,000 beneficiaries** who **have not** submitted ICD-10 transition forms, a requirement implemented in October 2015.

Once the beneficiary's practitioner completes the form in its entirety, the provider or practitioner may submit the form to Liberty Healthcare Corporation of N.C., the beneficiary, or the beneficiary's PCS provider. **Forms not submitted prior to Jan. 31, 2017 deadline are past due.**

Providers with beneficiaries who do not have a completed ICD-10 Transition Form on file will be subject to denial of payment and referral to DMA Program Integrity.

Providers may identify beneficiaries missing the ICD-10 transition form by viewing their "Case Load Report" in QiReport. Additional questions may be directed to Liberty Healthcare of N.C. at 1-800-740-1400.

**Long-Term Services and Supports
DMA, 919-855-4340**

Attention: Pharmacists and Prescribers

Change to Early Refill Threshold for Opioids and Benzodiazepines

The N.C. Division of Medical Assistance is increasing the Early Refill Threshold from 75 to 85 percent for opioids and benzodiazepines effective May 1, 2017. NCTracks programming will be changed to alert pharmacies when a patient's opioid and benzodiazepine medication history indicates greater than 15 percent of the previously dispensed days' supply remains.

This change is being implemented as part of an ongoing effort to help North Carolina combat the current opioid epidemic. For more information on the effort to combat the opioid epidemic, see Secretary Cohen's March 7, 2017, [Message on Opioids](#).

CSRA, 1-800-688-6696

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Attention: Pharmacists and Prescribers

New to Market Drug Additions to the Preferred Drug List

Effective April 1, 2017, new to market drugs in the N.C. Medicaid Preferred Drug List (PDL) classes will be updated quarterly and posted to the N.C. Division of Medical Assistance (DMA) [PDL web page](#). They will be listed as “NR” (not reviewed). This is to clarify PDL placement for “new to market drugs.”

Per policy, “new to market drugs” default to non-preferred status until they can be reviewed by the PDL Review Panel during its annual meeting in the Fall.

CSRA, 1-800-688-6696

Attention: Pharmacists and Prescribers

Preferred Drug List Update: Addition of New Drug Class

Effective May 1, 2017, the N.C. Medicaid and N.C. Health Choice PDL will be updated to include a new PDL drug class (Neuropathic Pain). This new PDL drug class also will include drugs that were previously listed under Topical Anesthetics. There are no changes in the preferred and non-preferred status for the drugs in this new PDL drug class.

This update is intended to better identify the preferred and non-preferred drug options for the treatment of neuropathic pain.

NEUROPATHIC PAIN	
Preferred	Non-Preferred
duloxetine capsule (generic for Cymbalta) gabapentin capsule / solution (generic for Neurontin)	<p style="text-align: center;">Clinical criteria apply to Lidoderm®</p> Cymbalta Capsule Gralise Starter Pack / Tablet Horizant Irenka Lyrica Capsule / Solution Neurontin Capsule / Solution / Tablet Savella Tablet / Titration Pack Dermacin RX PHN PAK lidocaine patch (generic for Lidoderm) Lidoderm Patch Qutenza Kit

CSRA, 1-800-688-6696

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Attention: Pharmacists and Prescribers**Clinical Pharmacist Practitioner – Update**

Note: The implementation date previously posted in the *April 2017 Medicaid Bulletin* has been delayed. DMA will notify providers of the new implementation date in future bulletin articles.

Authorized by 21 N.C.A.C. 46.3101, a Clinical Pharmacist Practitioner (CPP) is an N.C. licensed pharmacist approved to provide drug therapy management – including controlled substances – under the direction or supervision of a licensed physician. Only a pharmacist approved by the N.C. Board of Pharmacy may legally be identified as a CPP.

CPP individual providers shall directly enroll in the N.C. Medicaid and N.C. Health Choice (NCHC) programs through NCTracks, using the taxonomy code 1835P0018X. The application fee is \$100 and covers costs associated with processing the enrollment application. The \$100 application fee is required for initial enrollments and during each five-year re-credentialing process.

To enroll, CPPs must have full and unrestricted:

- Licenses to practice as pharmacists in North Carolina
- Certificates to practice as CPPs in North Carolina at the N.C. Board of Pharmacy.

A variety of Job Aids can be found on the [NCTracks Provider User Guides and Training web page](#). For more information on reenrolling in NCTracks, refer to the Job Aid, *How to Enroll in North Carolina Medicaid as an Individual*.

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

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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 N.C. 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 because 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 May 1, 2017, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
1-I, Dietary Evaluation and Medical Lactation Services	04/27/17	05/12/17
1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring	04/27/17	06/11/17
Preferred Drug List (PDL) Neuropathic Pain	04/06/17	05/21/17
Preferred Drug List (PDL) Exceptions	04/06/17	05/21/17
Prior Approval Criteria:Topical Anti-Inflammatory Medications Eucrisa	04/06/17	05/21/17
Prior Approval Criteria:Spinraza	04/06/17	05/21/17

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Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
May 2017	05/04/17	05/09/17	05/10/17
	05/11/17	05/16/17	05/17/17
	05/18/17	05/23/17	05/24/17
	05/25/17	05/31/17	06/01/17
June 2017	06/01/17	06/06/17	06/07/17
	06/08/17	06/13/17	06/14/17
	06/08/17	06/20/17	06/21/17
	No checkwrite week of June 19 – 23, 2017		
	06/29/17	07/05/17	07/06/17

* 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

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