N.C. Medicaid Bulletin
October 2017

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Attention: All Providers

NC Medicaid Electronic Health Record Incentive Program Announcement

Updates for Program Year 2018

On Aug. 14, 2017, the Centers for Medicare and Medicaid Services (CMS) issued the Inpatient Prospective Payment System (IPPS) Final Rule. The release of this final rule made the following changes to the N.C. Medicaid Electronic Health Record (EHR) Incentive Program in Program Year 2018:

- Stage 3 Meaningful Use (MU) is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU
- Providers may choose to use a 2014 Edition Certified EHR Technology (CEHRT), 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT
- Providers will now be selecting six clinical quality measures (CQM) from a list of 53, and,
- Providers will be able to continue using a 90-day MU reporting period

Visit the N.C. Medicaid EHR Incentive Program website for additional updates as they become available.

Program Reminder

Providers need six years of successful participation to earn the full incentive payment of $63,750. This means providers who started participating in the N.C. Medicaid EHR Incentive Program in Program Year 2016 must successfully attest each remaining year of the program, through Program Year 2021, to receive full incentive payment.

The N.C. Medicaid Incentive Payment System (NC-MIPS) is currently accepting Program Year 2017 attestations and providers should submit their attestations now.

In Program Year 2017, providers have the option to attest to Modified Stage 2 MU or Stage 3 MU. For objective and measure requirements, providers should refer to the CMS Specification Sheets below:

- Click here for CMS' Modified Stage 2 MU Specification Sheets.
- Click here for CMS' Stage 3 MU Specification Sheets.

Providers should use the attestation guides when attesting to Modified Stage 2 MU and Stage 3 MU in NC-MIPS each year they attest.

Note: Providers who were paid for Program Year 2016 using a patient volume reporting period from calendar year 2016, may use the same patient volume reporting period when attesting in Program Year 2017.

For more information, visit the N.C. Medicaid EHR Incentive Program web page.

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

Attention: All Providers

Fingerprinting Process for Providers

'High risk" individual providers and provider organizations, as outlined in NC General Statute 108C-3g, and individual owners with 5 percent or more direct or indirect ownership interest in a "high risk" organization are required to submit fingerprints to the N.C. Medicaid program.

The provider's Office Administrator (OA) will receive two notifications through the NCTracks provider portal, Provider Message Center Inbox, for each person required to submit fingerprints. One notification will be a letter with instructions and the other will be a Fingerprint Submission Release of Information Form. The Office Administrator (OA) also will receive an email for each party required to submit fingerprints. The email will have the Fingerprint Submission Release of Information Form attached.

The Fingerprint Submission Release of Information form should be printed and completed by the provider prior to taking it to any one of the LiveScan locations. There is also a section on this form that **must be signed by the Official taking the fingerprints**.

Once the provider submits fingerprints and the Fingerprint Submission Release of Information form is signed at the LiveScan location, the OA will electronically upload the form to the provider's record in NCTracks by using the following steps:

1. From the Submitted Applications section of the Status and Management page, the OA will see that any NPI that has a status of "In Review" will also have a hyperlink to Upload Documents

2. Select the Upload Documents link. Once the link is selected, the OA will be able to browse for and attach the form

3. Select the Upload Documents link found under the Fingerprint Evidence Documents section.

At this point the process is complete, and the provider will be able to go to the Status and Management page for an updated application status.

Note: Individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken. It is recommended that you contact the agency to confirm the fee prior to going.

If the applicant opts to do a Fingerprinting card, rather than a live scan, they must mail the fingerprint card to the SBI for processing at NCSBI/Applicant Unit 3320 Garner Road Raleigh, NC 27626. The Electronic Submission Release of information form is still required to be uploaded to NCTracks.

Note: The Fingerprinting card should not be mailed to the address on the form. Mailing these documents will delay the application processing and could result in a for cause denial or termination.

More information on the Fingerprinting Application Process can be found in the NCTracks Fingerprinting Application Required Job Aid. This link also provides additional resources and information including answers to Frequently Asked Questions (FAQs) and locations for fingerprinting services. Providers can also refer to the Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks article in the August 2017 Medicaid Bulletin.

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

Drug Testing For Opioid Treatment and Controlled Substance Monitoring

N.C. Medicaid has drafted a new medical policy outlining the requirements and limits for drug testing for opioid treatment and chronic pain management. N.C. Medicaid held a stakeholder meeting in October 2016 and reviewed the comments, concerns, and suggestions shared by providers at that time. The new policy mirrors Palmetto Local Coverage Determination (LCD), while maintaining fiscal responsibility.

Effective **Nov. 1, 2017**, N.C. Medicaid and N.C. Health Choice (NCHC) shall cover presumptive testing up to 24 times and definitive testing up to 24 times per state fiscal year (July 1-June 30).

Testing Indications for Substance Use Disorder

Testing profiles must be determined by the ordering provider based on history and physical exam, previous laboratory findings, beneficiary report of use, prescribed medications, suspected misused substances, community usage, and substances that may produce additive or synergistic interactions with prescribed medication.

Frequency of Testing for Substance Use Disorder

Frequency is based upon consecutive days of beneficiary abstinence from illicit substances:

- 0-30 days: once per calendar week
- 31-90 days: twice per calendar month
- Greater than 90 days: once per 30 calendar days

Note: Only one presumptive and one definitive test will be reimbursed per beneficiary, per day, regardless of the number of providers performing this service.

Testing Indications for Chronic Pain

Testing profiles must be determined by the ordering provider based on complete history of pain, physical examination, previous laboratory findings, current treatment plan, prescribed medications, and risk assessment.

Frequency of Testing for Chronic Pain

Frequency is based on risk assessment:

- Low Risk Beneficiaries: Up to two times every 365 consecutive days
- Moderate Risk Beneficiaries: Up to four times every 365 consecutive days
- High Risk: Up to three times every 90 consecutive days

Note: Only one presumptive and one definitive test will be reimbursed per beneficiary, per day, regardless of the number of providers performing this service.

Reflex Testing

Reflex testing may be conducted by a reference laboratory to verify a positive presumptive result or confirm the absence of a prescribed medication listed on the physician order. Reflex testing does not require an additional physician's order.

Prior Approval

Prior approval requests for testing in excess of the annual limit will not be accepted at this time. N.C. Medicaid plans to review the current policy and utilization by the end of the current fiscal year (June 30, 2018) to determine if policy revisions are needed.

Annual Limit Responsibility

Due to increased confidentiality surrounding substance use disorders, drug testing limits and remaining tests available will not be posted on the NCTracks Provider Portal. It will be the responsibility of the prescriber to maintain an accurate beneficiary record of drug testing and to coordinate testing with other providers as necessary (reference laboratories, intensive/comprehensive outpatient programs, etc.).

Per 10A NCAC 22J .0106, a beneficiary may not be billed for services rendered unless the provider, prior to rendering the service that day, informs the beneficiary that the claim **will not** be filed to Medicaid and that the beneficiary **will be** responsible for the charge. Once a claim has been submitted to Medicaid for payment, the beneficiary cannot be billed for the service.

N.C. Medicaid will publish additional information pertaining to drug testing codes and policy updates in the Medicaid Bulletin, as needed.

Clinical Policy and Programs
DMA, 919-855-4260

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 DMA's clinical coverage policy web page:

- 10A, Outpatient Specialized Therapies – Sept. 1, 2017
- 1A-28, Visual Evoked Potential (VEP) – Oct. 1, 2017
- 1E-1, Hysterectomy – Oct. 1, 2017
- 1E-2, Therapeutic and Non-therapeutic Abortions – Oct. 1, 2017
- 1E-3, Sterilization Procedures – Oct. 1, 2017
- 9A, Over-The-Counter Products – Oct. 1, 2017

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Medicaid Required Enrollment Fees

Note: This article was previously published in the September 2017 Medicaid Bulletin. It is being republished until November 2017.

The N.C. Medicaid and N.C. Health Choice (NCHC) application fee is $100, which covers costs associated with processing enrollment applications. The $100 application fee is required for both in-state and border-area (within 40 miles) providers during initial enrollment and when providers complete the five-year verification process.

Effective Oct. 29, 2017, out-of-state providers choosing the full enrollment option also will be subject to the $100 application fee. Out-of-state providers selecting the lite enrollment option are not required to pay this state fee. (See bulletin article, *Out of State Enrollment*, in this issue)**.**

In addition, some providers are required to pay the Affordable Care Act (ACA) application fee. These providers are defined in federal regulation at 42 CFR 455.460, and in N.C. General Statute 108C-3 (e) and (g) as moderate- or high-risk. The ACA application fee is $560 for calendar year 2017, and may be adjusted annually. This fee covers the costs associated with provider screening during the enrollment process. The application fee will be collected during initial enrollment, adding a new site location, re-enrollment, and five-year reverification.

Note: Low-risk providers defined in N.C.G.S. 108C-3(c) are not subject to paying the ACA application fee. However, it the risk category changes to high- or moderate-risk, the provider will be subject to the fee. Additional information about the ACA fee can be found on the NCTracks FAQs for ACA Application Fee web page.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Diagnosis-Related Group (DRG) Grouper 35 and Associated Rates For Inpatient Institutional Claims

On Oct. 1, 2017, NCTracks will implement the Diagnosis-Related Group (DRG) Grouper 35, along with the associated rates for inpatient institutional claims with dates of discharge between Oct. 1, 2017, and Sept. 30, 2018.

A copy of the DRG Grouper Version 35 weights and thresholds in Excel format are posted to the N.C. Division of Medical Assistance (DMA) Fee Schedule web page (see header under “Hospitals”) and then click on “Grouper 35 DRG Weight Table.”

Provider Reimbursement
DMA, 919-814-0060

Attention: All Providers

Medicaid Secondary Claims Submitted with CARC Code 97 – UPDATE

The N.C. Division of Medical Assistance (DMA) is suspending the new Medicaid secondary claims editing related to Claim Adjustment Reason Code (CARC) 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated) that was communicated in the May 2017 Medicaid Special Bulletin. For 90 days, beginning Sept. 25, 2017, NCTracks will allow the claim or claim line billed with primary payer CARC 97 to process and adjudicate without denying the claim or claim line with Explanation of Benefits (EOB) 01843 – MEDICAID DENIED DUE TO INDICATION OF PRIOR PAYER DENIAL.

This is a temporary change and will be applicable for all service dates while implemented. Before the 90-day time frame expires, a follow-up communication from DMA will be posted in the Medicaid Bulletin and as an NCTracks Announcement.

Important Instruction

It is very important the primary payer Claim Adjustment Group Code (CAGC) and CARC information be submitted to NCTracks, either by X12 batch transaction or via Provider portal, **exactly** as it appears on the primary payer EOB/Remittance. This includes accurately submitting codes at the header or detail claim line.

Guides and additional information

Providers submitting claims with primary payer details on the Provider Portal are encouraged to review the NCTracks Provider User Guides and Training web page for the How to Indicate Other Payer Details on a Claims In NCTracks and Batch Submission. This guide provides instruction for entering primary payer information such as CARCs, CAGCs and the adjustment amount.

For more information, contact the CSRA Call Center at 1-800-688-6696

CSRA, 1-800-688-6696

Attention: All Providers

National Drug Code Change Each Year for Influenza Vaccines

Providers are required to use appropriate National Drug Codes (NDCs) that correspond to the vaccine used for administration and corresponding CPT code.

Influenza vaccines are licensed each year with new NDCs, so it is important to report the correct code for the products being used to avoid having claims deny with edit 00996 (Mismatched NDC) which will require the claim to be resubmitted with the correct NDC. Below are the influenza vaccine procedure (CPT) codes and corresponding NDCs that should be used for the 2017-2018 influenza season:

CPT and NDC codes for the 2017-2018 Influenza Vaccine Products

CPT Codes	NDC Codes
90630	Fluzone Intradermal Quadrivalent: 49281-0712-40, 49281-0712-48
90656	Afluria: 33332-0017-01, 33332-0017-02 Fluvirin: 70461-0120-02, 70461-0120-12
90658	Afluria: 33332-0117-10, 33332-0117-11 Fluvirin: 70461-0120-10, 70461-0120-11
90674	Flucelvax Quadrivalent:70461-0201-01, 70461-0201-11
90685	Fluzone Quadrivalent: 49281-0517-00, 49281-0517-25
90686	Afluria Quadrivalent: 33332-0317-01, 33332-0317-02 Fluarix Quadrivalent: 58160-0907-41, 58160-0907-52 FluLaval Quadrivalent: 19515-0912-41, 19515-0912-52 Fluzone Quadrivalent: 49281-0417-10, 49281-0417-50, 49281-0417-58, 49281-0417-88
90687	Fluzone Quadrivalent: 49281-0627-15, 49281-0627-78
90688	Afluria Quadrivalent: 33332-0417-10, 33332-0417-11 FluLaval Quadrivalent: 19515-0896-01, 19515-0896-11 Fluzone Quadrivalent: 49281-0627-15, 49281-0627-78

CSRA 1-866-846-8505

Attention: All Providers

NCTracks Provider Training Available in October 2017

Registration is open for several instructor-led training courses for providers that will be held in October 2017. The duration varies depending on the course. **WebEx** courses are limited to 115 participants. They can be attended remotely from any location with a telephone, computer and internet connection. **On-site** courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. Following are details on the courses, including dates, times and how to enroll.

Provider Web Portal Applications (WebEx)

- Wednesday, Oct. 4 – 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 process
- Navigate to the NCTracks Provider Portal
- Complete the process for provider enrollment, Manage Change Request (MCR), re-enrollment, and re-verification and maintain eligibility
- Track and submit applications using the Status and Management page

ES User Roles, Abbreviated MCR's and Upload Documents (WebEx)

- Monday, Oct. 9 – 10 a.m. to noon

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

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

- Friday, Oct. 13 - 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help 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.

Submitting a Professional Claim (On-site)

- Friday, Oct. 13 – 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
- Submit a claim
- View the results of a claim submission

Prior Approval - Dental and Orthodontic (WebEx)

- Monday, Oct. 16 – 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 will also cover Prior Approval Inquiry to check on the status of the PA request.

Submitting Dental and Orthodontic Claims (WebEx)

- Monday, Oct. 16 – 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
- View the results of a claim submission

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

- Thursday, Oct. 19 – 1 to 2:30 p.m.

This course serves as a refresher for the steps taken by the provider to complete 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 all about and why it is required.
- Explain each phase of re-verification.
- Complete the re-verification process in NCTracks.
- Complete a Manage Change Request for invalid or missing provider data.

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

Claims Pended for Incorrect Billing Location

Note: This article was previously published in the September 2017 Medicaid Bulletin. It is being republished until November 2017.

When the billing provider address submitted on a claim does not match the service location(s) in the NCTracks provider's record, the claim will pend in NCTracks. Providers will receive a secure message in their NCTracks Message Center Inbox with a link to update the billing provider service location. This approach prevents a claim denial due to incorrect billing provider service location.

For additional information, providers can access the "How to Update a Claim in the Pend Status resulting from an Incorrect Billing Location," User Guide posted on the NCTracks provider portal located on the NCTrack's Provider User Guides and Training page. There you will find guides to correct the:

- Location on the Pended Claim
- Source of the Incorrect Location; and,
- Location in NCTracks

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

Provider Services
DMA, 919-855-4050

Attention: All Providers

Maintain Eligibility Process

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

Effective Oct. 29, 2017, NCTracks will implement a quarterly Maintain Eligibility Process which identifies providers with no claim activity within the past 12 months. NCTracks will notify the provider via the secure provider portal mailbox. The provider must attest electronically to remain active.

When a provider is identified with having no claims activity in 12 months, a Maintain Eligibility Due Date will be set. Providers will be notified 30 days before the due date that they must submit a Maintain Eligibility Application. Upon submission of the Maintain Eligibility Application, the provider's enrollment record will be updated with the current date.

If the provider does not submit the application by the due date, the provider's participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs **will be end dated**. This will prevent fraud, waste and abuse in the N.C. Medicaid and NCHC programs.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Abbreviated Application for Ordering, Prescribing and Referring Practitioners

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

Effective Oct. 29, 2017, an abbreviated enrollment application will be available for **ordering, prescribing, and/or referring** (OPR) practitioners. As required by 42 CFR 455.410, physician and non-physician practitioners who solely order, refer, or prescribe items for NC Medicaid or NC Health Choice (NCHC) beneficiaries **must** enroll in the Medicaid program. OPR practitioners can request a retroactive effective date up to 365 days preceding the date of application.

Physician and non-physician practitioners may elect to enroll as OPR-only providers (OPR lite). Billing providers will use the NPI (National Provider Identifier) of the OPR lite provider on their claims when these providers order or refer items or services. NCTracks will not reimburse OPR lite providers when their NPI is used as rendering or attending on a claim.

The following enrollment requirements will apply to OPR lite providers:

- Revalidate every five years
- $100 application fee
- Credentialing and Background Checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they are to be reimbursed for claims.

Out-of-state and border providers are subject to the fingerprinting requirement. They may have the process completed in their home state and results stored in PECOS or verified through the state Medicaid agency. If the organization owner is out-of-state, that owner would be required to fingerprint in their home state and send the evidence to NC Medicaid.

Note: OPR lite providers may request a retroactive effective date up to 365 days preceding the date of application.

Provider Services
DMA, 919-855-4050

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. Medicaid 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 reenrollment 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 NCTracks 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

Out of State Provider Enrollment

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

Effective Oct. 29, 2017, Out of State (OOS) providers who are seeking to enroll with N.C. Medicaid or the Children's Health Insurance Program (CHIP) – also known as N.C. Health Choice (NCHC) – will have the option to enroll using a full-enrollment application or a lite-enrollment application.

If an out of state provider chooses to enroll using the lite-enrollment application the following will apply:

- The provider will complete an abbreviated application
- Enrollment is limited to one year
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- There is no application fee for lite-enrollment

If an out of state provider chooses to enroll using the full-enrollment application the following will apply:

- The provider will complete a full-enrollment application
- The provider is required to complete re-verification every five years
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- The provider will be required to pay the $100 N.C. application fee during enrollment and re-verification

Note: A provider has the option to change from lite enrollment to full enrollment by submitting a Manage Change Request (MCR). The provider will be required to pay the $100 N.C. application fee.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Proposed PDP Contraceptives and Vaccines Reimbursement Methodology Changes

On Sept. 8, 2017, the Centers for Medicare & Medicaid Services (CMS) notified the N.C. Division of Medical Assistance (DMA) that – consistent with the regulations at 42 CFR 430.20 – State Plan Amendment (SPA) TN #17-0004 had been reviewed and was approved effective July 1, 2017.

The state plan proposes revisions to the reimbursement methodology for physician administered vaccines at Wholesale Acquisition Cost (WAC) plus 3 percent and long-acting reversible contraceptives (including Depo-Provera) at WAC plus 6 percent

These reimbursement methodology changes **are not** currently programed in NCTracks. DMA projects the implementation of these changes by Nov. 1, 2017.

Reimbursement for all other physician administered drugs will remain at prices established July 1, 2015. Reimbursement rates for drugs covered in the physician's drug program (PDP) can be found on the PDP Fee Schedule.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

ICD-10 Annual Update

The 2018 ICD-10 update will be in place effective Oct. 1, 2017 through Sept. 30, 2018, for provider use. Providers can access the list of ICD-10 codes on the Centers for Medicare and Medicaid Services (CMS) website.

Click here for new, end dated or revised 2018 ICD-10-CM and ICD-10-PCS codes.

For CM Codes:

- Click on "2018 Code Descriptions in Tabular Order [ZIP, 2MB]"
- Select the file titled "icd10cm_order-addenda_2018.txt"

For PCS Codes:

- Click on "2018 ICD-10-PCS Order File (Long and Abbreviated Titles) [ZIP, 1MB]"
- Select the file titled "order_addenda_2018.txt".

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Durable Medical Equipment and Orthotics/Prosthetics Providers

Home Health Final Rule: Process for Requesting Non-covered Durable Medical Equipment and Orthotics/Prosthetics Items for Adults

As indicated in the July 2017 Medicaid Bulletin, Durable Medical Equipment and Orthotics/Prosthetics (DMEPOS) policies 5A-1, 5A-2, 5A-3 and 5B have been updated to comply with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR Part 440.70. Below are guidelines for providers when requesting medical necessity reviews for non-covered DMEPOS items for adults.

1. The general requirements and criteria set forth in clinical coverage policies 5A-1, 5A-2, 5A-3 or 5B must be met. This includes, but is not limited to:

    a. The item being requested must fit the definition of either Durable Medical Equipment (DME), medical supplies, orthotics or prosthetics; and,
    b. The beneficiary must be enrolled in the N.C. Medicaid program and be eligible for DMEPOS items; and,
    c. The provider must be enrolled in the N.C. Medicaid program with an appropriate taxonomy; and,
    d. The requested item must be safe, effective, economical and not intended for the convenience of the beneficiary, the beneficiary's caregiver, or the provider; and,
    e. The item must be medical in nature, generally recognized as an accepted method of treatment, and must not be experimental or investigational; and,
    f. The item must be ordered by a physician, physician assistant, or nurse practitioner; and,
    g. The item must be medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place; and,
    h. A documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires DME and supplies must have occurred no more than six months prior to the initiation of DME and supplies; and
    i. The beneficiary's need for DME and supplies must be reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

2. If the provider determines that the applicable requirements and criteria set forth in the related DMEPOS clinical coverage policy have been met, then the provider may submit a completed Certificate of Medical Necessity/Prior Approval (CMN/PA) and the usual supportive prior authorization documentation, including the documentation required for manual pricing (see May 2017 Medicaid Bulletin for details), to the N.C. Division of Medical Assistance (DMA) for a medical necessity review.

3. The documentation should be **faxed to DMA at 919-715-1255** with a cover sheet to the attention of the **DME unit**. **Do not** submit these requests through NCTracks.

4. The same timelines for review used by CSRA may also apply to this medical necessity review process.

5. If approved, the provider will be notified and given instructions for submitting claims.

6. If denied, the provider and beneficiary will be notified, and normal beneficiary appeal rights will apply.

7. Providers will be notified if the item requested is covered by a different N.C. Medicaid policy area or waiver program.

Additional Resources

For additional information, link to the DMA Durable Medical Equipment web page, the DMA Medical Equipment Clinical Coverage Policies web page, and the CMS final rule at 42 CFR Part 440.70.

DMA Clinical Policy and Programs
DMEPOS Section, 919-855-4310

Attention: Family Practice, Gynecologists, Internal Medicine, Obstetricians, Pediatricians and Urgent Care Providers

North Carolina Health Information Exchange Authority Hosts Monthly "How to Connect Webinars" Starting Sept. 25, 2017

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

Per Session Law (S.L.) 2015-241, as amended by S.L. 2017-57, North Carolina providers who are reimbursed by the state for providing health care services under Medicaid and NC Health Choice programs must join NC HealthConnex, the state-designated Health Information Exchange. Connection deadlines are in 2018 or 2019, depending on the type of provider.

The NC Health Information Exchange Authority (HIEA), the N.C. Department of Information Technology agency that manages NC HealthConnex, will be hosting "How to Connect" webinars on the last Monday of each month at noon to educate providers affected by this law, describe the technical and onboarding requirements, and answer questions. In the meantime, providers can learn more at nchealthconnex.gov/how-connect.

To register for the next webinar at noon on Monday, Sept. 25, 2017, and to learn more about **NC HealthConnex, visit** nchealthconnex.gov**.**

NC HealthConnex links disparate systems and existing North Carolina HIE networks together to deliver a holistic view of a patient's record. It currently houses 3.7 million unique patient records, allowing providers to access their patients' comprehensive records across multiple providers, and review consolidated lists of items including labs, diagnoses, allergies and medications.

Providers with questions can contact the NC HIEA staff at 919-754-6912 or hiea@nc.gov**.**

Provider Services
DMA, 919-855-4050

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

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

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

17266	17266 (B)	27238	27238 (B)	29823 (A)	29823 (B)	29824 (A)
29824 (B)	29826 (A)	29828 (A)	44160 (A)			

***Codes marked with an (A) were updated for modifiers 80 and 82**
***Codes marked with a (B) were updated for modifier 59**

Note: The following codes were updated:

- 17266 and 17266 with modifier 59 were updated.
- 27238 and 27238 with modifier 59 were updated.
- 29823 and 29824 were updated for modifiers 80, 82, and 59 only.
- 29826, 29828, and 44160 were updated for modifiers 80 and 82 only.

The Medicaid website has a complete list of previously denied billing codes for NP, PAs and Certified Nurse Midwives.

Note: Codes currently in process for system updates will be published once system modifications are completed. New code problems will be addressed as DMA Clinical Policy becomes aware of them.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Rituximab and hyaluronidase human injection, for subcutaneous use (Rituxan Hycel): J9999 - Not otherwise classified, antineoplastic drugs

Effective with Date of service July 17, 2017, the N.C. Medicaid Program covers rituximab and hyaluronidase human injection, for subcutaneous use (Rituxan Hycel) for use in the Physician's Drug Program (PDP)when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs. Rituxan Hycel is available in two strengths/package size(s):

- 1,400 mg rituximab and 23,400 units hyaluronidase human per 11.7 mL (120 mg/2,000 Units per mL) solution in a single-dose vial

- 1,600 mg rituximab and 26,800 units hyaluronidase human per 13.4 mL (120 mg/2,000 Units per mL) solution in a single-dose vial

Rituxan Hycela is indicated for adult patients with:

- Follicular Lymphoma (FL) – Relapsed or refractory, follicular lymphoma as a single agent previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single-agent maintenance therapy non-progressing (including stable disease), follicular lymphoma as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy

- Diffuse Large B-cell Lymphoma (DLBCL) – Previously untreated diffuse large B-cell lymphoma in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens

- Chronic Lymphocytic Leukemia (CLL) – Previously untreated and previously treated CLL in combination with fludarabine and cyclophosphamide (FC)

Recommended Doses

Note: All patients must receive at least one full dose of a rituximab product by intravenous infusion before receiving Rituxan Hycela by subcutaneous injection)

- FL/DLBCL: Administer 1,400 mg/23,400 Units (1,400 mg rituximab and 23,400 Units hyaluronidase human) subcutaneously according to recommended schedule (see full Prescribing Information)

- CLL: Administer 1,600 mg/26,800 Units (1,600 mg rituximab and 26,800 Units hyaluronidase human) subcutaneously according to recommended schedule (see full Prescribing Information)

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are:

  Follicular Lymphoma:
  - C82.00 - Follicular lymphoma grade I, unspecified site
  - C82.01 - Follicular lymphoma grade I, lymph nodes of head, face, and neck
  - C82.02 - Follicular lymphoma grade I, intrathoracic lymph nodes
  - C82.03 - Follicular lymphoma grade I, intra-abdominal lymph nodes
  - C82.04 - Follicular lymphoma grade I, lymph nodes of axilla and upper limb
  - C82.05 - Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
  - C82.06 - Follicular lymphoma grade I, intrapelvic lymph nodes
  - C82.07 - Follicular lymphoma grade I, spleen
  - C82.08 - Follicular lymphoma grade I, lymph nodes of multiple sites
  - C82.09 - Follicular lymphoma grade I, extranodal and solid organ sites
  - C82.10 - Follicular lymphoma grade II, unspecified site
  - C82.11 - Follicular lymphoma grade II, lymph nodes of head, face, and neck
  - C82.12 - Follicular lymphoma grade II, intrathoracic lymph nodes
  - C82.13 - Follicular lymphoma grade II, intra-abdominal lymph nodes
  - C82.14 - Follicular lymphoma grade II, lymph nodes of axilla and upper limb
  - C82.15 - Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
  - C82.16 - Follicular lymphoma grade II, intrapelvic lymph nodes
  - C82.17 - Follicular lymphoma grade II, spleen
  - C82.18 - Follicular lymphoma grade II, lymph nodes of multiple sites
  - C82.19 - Follicular lymphoma grade II, extranodal and solid organ sites
  - C82.20 - Follicular lymphoma grade III, unspecified, unspecified site
  - C82.21 - Follicular lymphoma grade III, unspecified, lymph nodes of head, face
  - C82.22 - Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
  - C82.23 - Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
  - C82.24 - Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
  - C82.25 - Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
  - C82.26 - Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
  - C82.27 - Follicular lymphoma grade III, unspecified, spleen
  - C82.28 - Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
  - C82.29 - Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
  - C82.30 - Follicular lymphoma grade IIIa, unspecified site
  - C82.31 - Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
  - C82.32 - Follicular lymphoma grade IIIa, intrathoracic lymph nodes
  - C82.33 - Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
  - C82.34 - Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb
  - C82.35 - Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
  - C82.36 - Follicular lymphoma grade IIIa, intrapelvic lymph nodes
  - C82.37 - Follicular lymphoma grade IIIa, spleen
  - C82.38 - Follicular lymphoma grade IIIa, lymph nodes of multiple sites
  - C82.39 - Follicular lymphoma grade IIIa, extranodal and solid organ sites
  - C82.40 - Follicular lymphoma grade IIIb, unspecified site

- C82.41 - Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
- C82.42 - Follicular lymphoma grade IIIb, intrathoracic lymph nodes
- C82.43 - Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
- C82.44 - Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
- C82.45 - Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
- C82.46 - Follicular lymphoma grade IIIb, intrapelvic lymph nodes
- C82.47 - Follicular lymphoma grade IIIb, spleen
- C82.48 - Follicular lymphoma grade IIIb, lymph nodes of multiple sites
- C82.49 - Follicular lymphoma grade IIIb, extranodal and solid organ sites
- C82.50 - Diffuse follicle center lymphoma, unspecified site
- C82.51 - Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
- C82.52 - Diffuse follicle center lymphoma, intrathoracic lymph nodes
- C82.53 - Diffuse follicle center lymphoma, intra-abdominal lymph nodes
- C82.54 - Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
- C82.55 - Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
- C82.56 - Diffuse follicle center lymphoma, intrapelvic lymph nodes
- C82.57 - Diffuse follicle center lymphoma, spleen
- C82.58 - Diffuse follicle center lymphoma, lymph nodes of multiple sites
- C82.59 - Diffuse follicle center lymphoma, extranodal and solid organ sites
- C82.60 - Cutaneous follicle center lymphoma, unspecified site
- C82.61 - Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
- C82.62 - Cutaneous follicle center lymphoma, intrathoracic lymph nodes
- C82.63 - Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
- C82.64 - Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
- C82.65 - Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
- C82.66 - Cutaneous follicle center lymphoma, intrapelvic lymph nodes
- C82.67 - Cutaneous follicle center lymphoma, spleen
- C82.68 - Cutaneous follicle center lymphoma, lymph nodes of multiple sites
- C82.69 - Cutaneous follicle center lymphoma, extranodal and solid organ sites
- C82.80 - Other types of follicular lymphoma, unspecified site
- C82.81 - Other types of follicular lymphoma, lymph nodes of head, face, and neck
- C82.82 - Other types of follicular lymphoma, intrathoracic lymph nodes
- C82.83 - Other types of follicular lymphoma, intra-abdominal lymph nodes
- C82.84 - Other types of follicular lymphoma, lymph nodes of axilla and upper limb
- C82.85 - Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
- C82.86 - Other types of follicular lymphoma, intrapelvic lymph nodes
- C82.87 - Other types of follicular lymphoma, spleen
- C82.88 - Other types of follicular lymphoma, lymph nodes of multiple sites
- C82.89 - Other types of follicular lymphoma, extranodal and solid organ sites
- C82.90 - Follicular lymphoma, unspecified, unspecified site
- C82.91 - Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
- C82.92 - Follicular lymphoma, unspecified, intrathoracic lymph nodes
- C82.93 - Follicular lymphoma, unspecified, intra-abdominal lymph nodes
- C82.94 - Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
- C82.95 - Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
- C82.96 - Follicular lymphoma, unspecified, intrapelvic lymph nodes

- C82.97 - Follicular lymphoma, unspecified, spleen
- C82.98 - Follicular lymphoma, unspecified, lymph nodes of multiple sites
- C82.99 - Follicular lymphoma, unspecified, extranodal and solid organ sites

DLBCL:

- C83.30 – Diffuse large B-cell lymphoma, unspecified site
- C83.31 – Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
- C83.32 – Diffuse large B-cell lymphoma, intrathoracic lymph nodes
- C83.33 - Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
- C83.34 - Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
- C83.35 - Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
- C83.36 - Diffuse large B-cell lymphoma, intrapelvic lymph nodes
- C83.37 - Diffuse large B-cell lymphoma, spleen
- C83.38 - Diffuse large B-cell lymphoma, lymph nodes of multiple sites
- C83.39 - Diffuse large B-cell lymphoma, extranodal and solid organ sites

CLL:

- C91.10 – Chronic lymphocytic leukemia of B-cell type not having achieved remission
- C91.12 – Chronic lymphocytic leukemia of B-cell type in relapse

- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
- One Medicaid unit of coverage is: 1 unit = 1 mg
- The maximum reimbursement rate per unit is: $4.69 per 1 mg
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 50242-0108-01, 50242-0109-01
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.
- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on DMA's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B 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

Regional Provider Trainings

Personal Care Services (PCS) regional training sessions will be held Oct. 3- 23, 2017. Registration begins at 8 a.m. and training will be held from 9 a.m. to 12:30 p.m. Providers can register through the Liberty Healthcare Corp. of N.C. Medicaid PCS Website. Prior to training, training topics and materials will be available to registered participants on Liberty's website. Training sessions are free, 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. Medicaid at 919-855-4360.

Event Dates and Locations

- **Tuesday, Oct. 3, 2017 - Concord**
  Great Wolf Lodge Convention Center, 10175 Weddington Road, *White Pine*

- **Wednesday, Oct. 4, 2017 - Greensboro/Winston-Salem**
  Greensboro-High Point Marriott Airport, 1 Marriott Drive, *Grand Ballroom*

- **Monday, Oct. 16, 2017 - Raleigh**
  Jane S. McKimmon Conference and Training Center-NCSU, 1101 Gorman St., *Room will be posted at Information Desk*

- **Tuesday, Oct. 17, 2017 - Greenville**
  Holiday Inn-Greenville, 203 Greenville Blvd SW., *Ballroom*

- **Thursday, Oct. 19, 2017 - Fayetteville**
  Doubletree by Hilton Fayetteville, 1965 Cedar Creek Road, *Grand Ballroom*

- **Monday, Oct. 23, 2017 - Asheville**
  Doubletree by Hilton-Biltmore, 115 Henderson Road, *Burghley Room*

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

Attention: Private Duty Nursing Providers

Private Duty Nursing Program: Transfer of Care

Documentation Requirements

Private Duty Nursing (PDN) service providers are reminded of the Prior Authorization (PA) documentation requirements found in Section 5.2.5 *[Changing Service Providers]* of Clinical Coverage Policies 3G-1, *Private Duty Nursing for Beneficiaries Age 21 and Older,* and 3G-2, *Private Duty Nursing for Beneficiaries Under 21 years of Age*.

Transfer of Care Between Two Different Agencies

Requests to change PDN service providers or hours staffed by PDN service providers can occur because of a beneficiary's freedom of choice.

The transfer of care shall be facilitated by the PDN service provider initiating the change, and shall be coordinated with the beneficiary's attending physician, any other current PDN service providers, and the primary caregiver.

A written notification shall be submitted to DMA prior to the transfer of care (within five business days of the request), and shall contain the following:

- Written permission from the beneficiary or legal guardian regarding the request to transfer
- Identification of the PDN service provider initiating the change, including NPI number, contact person and contact information
- Identification of any other PDN service providers involved in the beneficiary's care, and the date they are contacted. Include their NPI numbers, contact persons, and contact information.
- Details of the transfer of care, including when the transfer of care will be effective and how hours and week are to be shared.

Discharge Summary

The former PDN service provider shall forward to DMA a discharge summary that specifies the last day PDN services were provided to the beneficiary. The discharge summary is to be uploaded to the beneficiary's current PDN PA.

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

Proposed Clinical Coverage Policies

Per 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 Oct. 1, 2017, the following policies are open for public comment on the Proposed Clinical Coverage Policies web page:

Proposed Policy	Date Posted	Comment Period End Date
11C, Ventricular Assist Devises (VAD)	08/31/17	10/15/17
PA Criteria Hepatitis C Virus Medication	09/01/17	10/16/17
12B, HIV Case Management	09/06/17	10/21/17
PA Criteria Opioid Dependence Therapy Agents	09/06/17	10/21/17
PA Criteria Hepatitis C Virus Medications	09/13/17	10/28/17
Preferred Drug List (PDL) - Hepatitis C Agents	09/13/17	10/28/17

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
October 2017	10/06/17	10/11/17	10/12/17
	10/13/17	10/17/17	10/18/17
	10/20/17	10/24/17	10/2517
	10/27/17	10/31/17	11/01/17
November 2017	11/03/17	11/07/17	11/08/17
	11/10/17	11/14/17	11/15/17
	11/11/17	11/21/17	11/22/17
	11/24/17	11/28/17	11/2917

* Batch cutoff date is previous day

_____	_____
Sandra Terrell, MS, RN	**Paul Guthery**
Director of Clinical and Operations	**Executive Account Director**
Division of Medical Assistance	**CSRA**
Department of Health and Human Services	