



NC Medicaid Bulletin

October 2018

All Providers

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ATTENTION: ALL PROVIDERS

Proposed Clinical Coverage Policies for Public Comment

Proposed new or amended Medicaid and NC Health Choice clinical coverage policies are posted for comment throughout the month. Visit the [Proposed Medicaid and NC Health Choice Policies](#) for current posted policies and instructions to submit a comment.

As of Oct. 1, 2018, the following NC Medicaid policies are open for public comment:

PROPOSED POLICY	COMMENT PERIOD	
8-J, Children's Developmental Service Agencies (CDSAs)	09/27/2018	10/27/2018
6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older New policy documenting restored coverage of routine eye examinations and visual aids for Medicaid beneficiaries 21 years of age and older.	09/26/2018	11/10/2018
11A-17, CAR-T Cell Therapy	09/17/2018	11/01/2018
3L, State Plan Personal Care Services (PCS)	09/06/2018	10/21/2018
9, Outpatient Pharmacy	08/30/2018	10/14/2018
1H, Telemedicine and Telepsychiatry	08/27/2018	10/11/2018
1E-7, Family Planning Services	08/22/2018	10/06/2018

NC Medicaid Clinical Policy, 919-855-4260

ATTENTION: ALL PROVIDERS

Clinical Coverage Policies

The following new or amended Medicaid and NC Health Choice clinical coverage policies were posted since Aug. 31, 2018. Visit the [NC Medicaid website](#) to view the policies.

- 2A-1, Acute Inpatient Hospital Services – 09/07/2018
- 10-A, Outpatient Specialized Therapies – 09/13/2018
- 1A-24, Diabetes Outpatient Self-Management Education – 10/01/2018

These policies supersede previously published policies and procedures.

NC Medicaid Clinical Policy, 919-855-4260

ATTENTION: ALL PROVIDERS**Are You in Compliance with North Carolina Law?**

One of the goals of a transformed health care system is for real-time clinical and demographic data to be made available to all health care providers involved in a patient's care so that they can securely share health information concerning that patient with each other. North Carolina health care providers are required by law to connect with NC HealthConnex, North Carolina's designated health information exchange, by specific deadlines:

- **June 1, 2018.** Hospitals as defined by G.S. 131E-176(13), physicians licensed to practice under Article 1 of Chapter 90 of the General Statutes, physician assistants as defined in 21 NCAC 32S .0201, and nurse practitioners as defined in 21 NCAC 36 .0801 who provide Medicaid services and who have an electronic health record system.
- **June 1, 2019.** All other providers of Medicaid and state-funded services except dentists, ambulatory surgical centers and pharmacies.
- **Early 2019.** Prepaid Health Plans (PHPs), as defined in S.L. 2015-245 as amended, will be required to connect to the HIE per their contracts with the NC Department of Health and Human Services (NCDHHS). PHPs will be required to submit encounter and claims data by the commencement of the contract with NCDHHS.
- **June 1, 2020.** Local Management Entities/Managed Care Organizations (LMEs/MCOs) will be required to submit encounter and claims data.
- **June 1, 2021.** Dentists and ambulatory surgical centers will be required to submit clinical and demographic data (NCSL 2018-41). Pharmacies will be required to submit claims data once per day, using pharmacy industry standardized formats.

Important Note for Health Care Providers Who Did Not Connect by June 1, 2018

Hospitals, physicians, physician assistants and nurse practitioners, as described above, who did not start the connection process by June 1, 2018, are not in compliance with state law. NC Medicaid will work collaboratively with these providers to bring them into compliance, including issuing corrective action plans. At this time, noncompliant providers will continue to be enrolled in NC Medicaid and, as they file claims, will receive reimbursements for services and treatment of NC Medicaid beneficiaries.

What Does "Connected" Mean?

To meet the state's mandate, a Medicaid provider is "connected" when its clinical and demographic information pertaining to services paid for by Medicaid and other State-funded health care funds are being sent to NC HealthConnex, at least twice daily—either through a direct connection or via a hub (i.e., a larger system with which it participates,

another regional HIE with which it participates or an EHR vendor). Participation agreements signed with the designated entity would need to list all affiliate connections.

The North Carolina Health Information Exchange Authority (HIEA), the state agency managing NC HealthConnex, and NC Medicaid appreciate the many providers who have initiated a connection and are making data available through the system. Medicaid and the HIEA will continue to work closely together to ensure that NC HealthConnex develops to support health care providers and enables all of us to better serve patients and families.

To start the connection process, providers can call HIEA at the number below. Sign up [here](#) to be placed on the HIEA's distribution list for monthly updates.

NC HIEA, 919-754-6912 or hiea@nc.gov

ATTENTION: ALL PROVIDERS

Updates to the NC Medicaid Electronic Health Record (EHR) Incentive Program

Per the updated [IPPS Final Rule](#) released Aug. 2, 2018, the EHR reporting period will now be referred to as the Promoting Interoperability (PI) reporting period. The PI reporting period is any continuous 90-day period or full calendar year within the program year in which a provider successfully demonstrates meaningful use (MU) of certified EHR technology. Providers will see this change when attesting in NC-MIPS.

NC Medicaid EHR Incentive Payment System (NC-MIPS) is Open for Program Year 2018

[NC-MIPS](#) is accepting Program Year 2018 Modified Stage 2 and Stage 3 Meaningful Use attestations. (Note that the NC-MIPS Portal will be unavailable between 5 p.m. on Oct. 3, 2018 and 7 a.m. on Oct. 8, 2018 for scheduled maintenance.)

TIP: Providers paid for Program Year 2017 using a 90-day patient volume reporting period from May 1, 2017 through Dec. 31, 2017, may use the same patient volume reporting period to attest now for Program Year 2018.

In Program Year 2018, eligible professionals (EPs) may continue using a 90-day PI reporting period. EPs may attest with a 90-day Clinical Quality Measure (CQM) reporting period if they **only** attested to adopt, implement or upgrade (AIU) thus far **and** will be attesting to MU for the first time in Program Year 2018. They will see no changes to the attestation process in NC-MIPS.

However, EPs who have met MU in a previous program year will be required to use a full calendar year CQM reporting period in Program Year 2018. Since the CQM reporting period must be a full calendar year for these EPs, they will not be able to submit CQM data in NC-MIPS until Jan. 1, 2019. EPs who would like an early review of requirements, excluding CQMs, will be allowed to submit their attestation in two parts.

Part 1 of the attestation may be submitted between May 1, 2018 and Dec. 31, 2018. It includes demographic, license, patient volume and MU objective data. EPs will **not** be required to sign or email any documentation for Part 1. The signed attestation packet will be emailed only once—after submission of CQMs.

After Part 1 is submitted on NC-MIPS, program staff will conduct validations. DHHS will notify EPs of any discrepancies, giving EPs ample time to address any issues.

After Part 1 is validated, EPs may return Jan. 1, 2019 through April 30, 2019, to submit their CQM data on NC-MIPS. After submitting that information on NC-MIPS, providers will email the signed attestation packet and CQM report from the EP's EHR to NCMedicaid.HIT@dhhs.nc.gov to complete Part 2 of the attestation.

Note: This process does not increase or reduce the information being submitted but allows EPs to complete their attestation in a 12-month window instead of in four months.

EPs who attested in NC-MIPS in a previous year will be automatically directed to the appropriate page in NC-MIPS. EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting for Program Year 2018.

For those practices unsure if a new provider is able to participate in the NC Medicaid EHR Incentive Program in Program Year 2018, please email the provider's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the provider previously attested with another practice. As a reminder, EPs must have successfully participated in a Medicaid EHR Incentive Program at least once before the end of Program Year 2016 to be able to participate in program years 2017 to 2021.

Visit the [program website](#) for more information.

NC Medicaid EHR Incentive Program, NCMedicaid.HIT@dhhs.nc.gov

ATTENTION: ALL PROVIDERS

NCTracks Provider Training Available in October 2018

Registration is open for several instructor-led training courses for providers that will be held in October 2018. 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. **Onsite** courses include hands-on training

and are limited to 45 participants. They are offered in-person at the GDIT 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)

Oct. 3, 2018, 1–4 p.m.

This course will guide you through the process of submitting all types of provider applications found on the NCTracks Provider Portal. This course will also detail what to expect once your applications have been submitted. At the end of this training, you will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal and complete the following Provider Enrollment Application processes: Provider Enrollment, Manage Change Request (MCR), Re-Enrollment, Re-verification and Maintain Eligibility
- Track and submit applications using the Status and Management page

Advanced Medical Home Tier Attestation (WebEx)

Oct. 5, 2018, 9:30–11 a.m.

This course will guide the user through completing the Advanced Medical Home Tier Attestation via the secure Provider Portal.

ES User Role, Abbreviated MCRs and Upload Documents (WebEx)

Oct. 8, 2018, 10 a.m.– 12 p.m.

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

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

Prior Approvals: Dental & Orthodontic (WebEx)

Oct. 15, 2018, 9:30 a.m.–12 p.m.

This course shows authorized users how to electronically submit and inquire about prior approval requests for dental and orthodontic procedures. At the end of this training, the user will be able to:

- Submit dental prior approvals requests
- Inquire about dental prior approval requests

Submitting Dental & Orthodontic Claims (WebEx)

Oct. 15, 2018, 1 p.m.–4 p.m.

This course will focus on how to submit a Dental and Orthodontic Claims. At the end of training, as an authorized user, you will be able to manage the following:

- Create a Dental Claim via the NCTracks web portal
- Submit a Dental Claim
- Save a Draft Claim
- Use Claims Draft Search
- Submit a Claim
- View results of a Claim submission

Reverification Overview (WebEx)

Oct. 18, 2018, 1 p.m.–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. At the end of training, you will be able to:

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

- Explain why provider Re-verification is requested and what the process entails
- Complete the Re-verification process in NCTracks
- Update Owners and Managing Relationships if necessary while completing Re-verification application

Submitting Medical Prior Approval (On-Site)

Oct. 25, 2018, 9:30 a.m.–12 p.m.

This course shows authorized users how to electronically submit and inquire about prior approvals for different kinds of medical services. After completing this course, authorized users will be able to submit Prior Approvals electronically and conduct electronic inquiries about Prior Approvals

Submitting Professional Claims (On-Site)

Oct. 25, 2018, 1–4:30 p.m.

The NCTracks Provider Portal uses your NCID username and password to gain access to a secure online environment for submitting claims. This course will focus on how to submit a Professional Claim. At the end of training, as an authorized user, the user will be able to do the following:

- Submit a Professional claim

- Save a Draft
- Use Claims Draft Search
- Submit a claim
- View results of a claim submission
- Void and Replace paid claims

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-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 about downloading Java, which is required for the use of SkillPort.

NCTracks Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Reminder: Changes to the Recredentialing Process

NC Medicaid first alerted providers of changes to the recredentialing process in the [February 2018 and August 2018 Medicaid Bulletins](#).

The terms recredentialing, reverification and revalidation are synonymous.

In April 2018, the recredentialing notification and suspension process was modified. **The previous rule to extend the recredentialing due date if a Manage Change Request (MCR) Application is “In Review” has been removed. Therefore, if a change is required via an MCR, the MCR process must be completed before the recredentialing due date.**

Providers will be suspended if the recredentialing application is not submitted by their recredentialing due date. Provider will be terminated from the North Carolina Medicaid and NC Health Choice programs following 50 days of suspension.

A [list of providers](#) scheduled for recredentialing in 2018 is available on the Provider Enrollment page of the NC Medicaid website under the “Recredentialing” header. Providers can use this resource to determine their recredentialing/revalidation due date and the month to begin the recredentialing process. Organizations and systems with

multiple providers may download this list, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

Recredentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers are required to pay the \$100 application fee for recredentialing. 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. If terminated, the provider must submit a re-enrollment application to be reinstated.

NCTracks Call Center, 1-800-688-6696 or NCTracksprovider@nctracks.com

ATTENTION: ALL PROVIDERS

Update Provider Enrollment Information

Pursuant to Section 6.a. of the NCDHHS Provider Administrative Participation Agreement, providers are required to update their enrollment records in NCTracks within 30 days of a change. Commonly, affiliation and taxonomy information are overlooked. Individual providers must review their affiliations by location for accuracy. Providers should end-date any affiliations that are not current. Providers must make sure their physical addresses are correct with the accurate taxonomy.

Providers must also update their expiring licenses, certifications and accreditations. The system currently suspends and terminates providers who fail to respond within the specified time limits.

Providers can avoid processing delays by ensuring all information is accurate and up-to-date. Providers are encouraged to begin the Managed Change Request process to make necessary corrections and updates. For assistance, providers should reference the [NCTracks Provider User Guides and Training, Provider Record Maintenance](#).

NC Medicaid Provider Services, 919-855-4050

ATTENTION ALL PROVIDERS

Avoid Delays in the Processing of Applications for Providers Enrolling as Individuals

If a provider's enrollment application or Manage Change Request (MCR) does not contain errors, it will process more quickly. NC Medicaid and the NCTracks Enrollment Team frequently share information about common errors that cause delays in processing applications and MCRs.

Providers enrolling as individuals (not organizations) are not required to add themselves as Managing Relationships on each service location of their record. In fact, doing so can cause delays because background checks are prompted for each when doing so.

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.

NCTracks Call Center, 1-800-688-6696 or NCTracksProvider@nctracks.com

ATTENTION: ALL PROVIDERS

ICD-10 Update for 2019

The 2019 ICD-10 update is effective Oct. 1, 2018 through Sept. 30, 2019, for provider use. Providers can access the [list of ICD-10 codes](#) on the Centers for Medicare and Medicaid Services (CMS) website. The CMS files below include the 2019 new, deleted and revised codes.

2019 ICD-10-CM

- Go to <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html>
- Select, **2019 Code Descriptions in Tabular Order**
- Then select, **icd10cm_order-addenda_2019.txt**

2018 ICD-10-PCS

- Go to <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-PCS.html>
- Select, 2019-10-PCS Order File
- Then select, **order_addenda_2019.txt**

NCTracks Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Balloon Ostial Dilation (BOD) Services Billed with Modifier 50 (Bilateral)

Claims for balloon sinus ostial dilation billed with modifier 50 (bilateral) have been resulting in an underpayment to providers. **The issue has been resolved.** Providers with claims for the following procedures billed with modifier 50 on or after July 29, 2018, should resubmit their claims for reprocessing. The procedures are:

- 31295 (nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium),

- 31296 (nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium), and
- 31297 (nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium).

NCTracks Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Antihemophilic Factor (recombinant) PEGylated-aucl, for Intravenous use (Jivi®) HCPCS Code J7199: Billing Guidelines

Effective with date of service Sept. 5, 2018, the Medicaid and NC Health Choice programs cover antihemophilic factor (recombinant) PEGylated-aucl, for intravenous use (Jivi) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199-Hemophilia clotting factor, not otherwise classified. Jivi is commercially available as lyophilized powder in single-use vials containing nominally 500, 1000, 2000 or 3000 IU.

Jivi is indicated for use in previously treated adults and adolescents (12 years and older) with hemophilia A (congenital Factor VIII deficiency) for on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes.

Limitations of Use

- Jivi is not indicated for use in children less than 12 years of age due to a greater risk for hypersensitivity reactions.
- Jivi is not indicated for use in previously untreated patients.
- Jivi is not indicated for the treatment of von Willebrand disease.

Recommended Dose

Dosing for control and prevention of bleeding episodes—dose until bleeding is resolved

- Minor bleed: Factor VIII level required (IU/dL): 20-40, Dose: 10-20 IU/kg, Frequency of doses: 24-48 hours
- Moderate bleed: Factor VIII level required (IU/dL): 30-60, Dose: 15-30 IU/kg, Frequency of doses: 24-48 hours
- Major bleed: Factor VIII level required (IU/dL): 60-100, Dose 30-50 IU/kg, Frequency of doses: 8-24 hours

Dosing for perioperative management

- Minor surgery: Factor VIII level required (IU/dL): 30-60 (pre and post-operative), Dose: 15-30 IU/kg, Frequency of doses: 24 hours, Duration of Therapy: At least 1 day until healing is achieved.
- Major surgery: Factor VIII level required (IU/dL): 80-100 (pre- and post-operative), Dose: 40 to 50 IU/kg, Frequency of doses: 12-24 hours, Duration of Therapy: Until adequate wound healing is complete, then continue for at least another 7 days to maintain a Factor VIII activity of 30-60 (IU/dL).

Prophylaxis dosing

- The recommended initial regimen is 30–40 IU/kg twice weekly.
- Based on the bleeding episodes, the regimen may be adjusted to 45–60 IU/kg every 5 days and may be further individually adjusted to less or more frequent dosing.
- The total recommended maximum dose per infusion is approximately 6000 IU (rounded to vial size). See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is D66-Hereditary factor VIII deficiency.
- Providers must bill with HCPCS code J7199-Hemophilia clotting factor, not otherwise classified.
- One Medicaid and NC Health Choice unit of coverage is 1 IU.
- Providers may contact the North Carolina Pharmacy Help Desk at 1-800-591-1183 or NCPharmacy@mslc.com and submit their invoice to establish a reimbursement rate.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 00026-3942-25, 00026-3944-25, 00026-3946-25, 00026-3948-25, 00026-4942-01, 00026-4944-01, 00026-4946-01 and 00026-4948-01.
- 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 the NC Medicaid website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NC Health Choice 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 Physician's Drug Program is on the NC Medicaid website's PDP web page.

NCTracks Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS**Patisiran Lipid Complex Injection, for Intravenous Use (Onpattro™) HCPCS Code J3490: Billing Guidelines**

Effective with date of service Sept. 5, 2018, the Medicaid and NC Health Choice programs cover patisiran lipid complex injection, for intravenous use (Onpattro) for use in the Physicians Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. Onpattro is commercially available as 10 mg/5 mL in a single-dose vial.

Onpattro is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

Recommended Dose

For patients weighing less than 100 kg, the recommended dosage is 0.3 mg/kg every 3 weeks by intravenous infusion. For patients weighing 100 kg or more, the recommended dosage is 30 mg every 3 weeks by intravenous infusion. Premedicate with a corticosteroid, acetaminophen and antihistamines. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is E85.1 - Neuropathic hereditary amyloidosis.
- Providers must bill with HCPCS code J3490-Unclassified drugs.
- One Medicaid and NC Health Choice unit of coverage is 1 mg.
- The maximum reimbursement rate per unit is \$1026.00.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 71336-1000-01.
- 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 the NC Medicaid website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NC Health Choice 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 Physician's Drug Program is available on the NC Medicaid website's PDP web page.

NCTracks Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Plazomicin Injection, for Intravenous Use (Zemdri™) HCPCS Code J3490: Billing Guidelines

Effective with date of service Aug. 17, 2018, the Medicaid and NC Health Choice programs cover plazomicin injection, for intravenous use (Zemdri) for use in the Physician's Drug Program when billed with HCPCS code J3490-Unclassified drugs. Zemdri is commercially available as a 500 mg/10 mL (50 mg/mL) as a single-dose vial.

Zemdri is indicated for the treatment of patients 18 years of age or older with complicated urinary tract infections (cUTI) including pyelonephritis.

- As only limited clinical safety and efficacy data are available, reserve Zemdri for use in patients who have limited or no alternative treatment options.
- To reduce the development of drug-resistant bacteria and maintain effectiveness of Zemdri and other antibacterial drugs, Zemdri should be used only to treat infections that are proven or strongly suspected to be caused by susceptible microorganisms.

Recommended Dose

15 mg/kg every 24 hours by intravenous infusion over 30 minutes for 4 to 7 days to patients 18 years of age or older with creatinine clearance greater than or equal to 90 mL/min. Assess creatinine clearance in all patients prior to initiating therapy and daily

during therapy. See package insert for dosage regimens for patients with renal impairment.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing are:
 - N39.0 - Urinary tract infection, site not specified
 - N10 - Acute pyelonephritis
 - N11.0 - Nonobstructive reflux-associated chronic pyelonephritis
 - N11.1 - Chronic obstructive pyelonephritis
 - N11.8 - Other chronic tubulo-interstitial nephritis
 - N11.9 - Chronic tubulo-interstitial nephritis, unspecified
 - N12 - Tubulo-interstitial nephritis, not specified as acute or chronic
 - N16 - Renal tubulo-interstitial disorders in diseases classified elsewhere
 - N30.00 - Acute cystitis without hematuria
 - N30.01 - Acute cystitis with hematuria
 - N30.20 - Other chronic cystitis without hematuria
 - N30.21 - Other chronic cystitis with hematuria
 - N30.80 - Other cystitis without hematuria
 - N30.81 - Other cystitis with hematuria
 - N30.90 - Cystitis, unspecified without hematuria
 - N30.91 - Cystitis, unspecified with hematuria
 - B96.1 - *Klebsiella pneumoniae* [*K. pneumoniae*] as the cause of diseases classified elsewhere
 - B96.20 - Unspecified *Escherichia coli* [*E. coli*] as the cause of diseases classified elsewhere
 - B96.21 - Shiga toxin-producing *Escherichia coli* [*E. coli*] (STEC) O157 as the cause of diseases classified elsewhere
 - B96.22 - Other specified Shiga toxin-producing *Escherichia coli* [*E. coli*] (STEC) as the cause of diseases classified elsewhere
 - B96.23 - Unspecified Shiga toxin-producing *Escherichia coli* [*E. coli*] (STEC) as the cause of diseases classified elsewhere
 - B96.29 - Other *Escherichia coli* [*E. coli*] as the cause of diseases classified elsewhere

- B96.89 - Other specified bacterial agents as the cause of diseases classified elsewhere
- B96.4 - Proteus (mirabilis) (morganii) as the cause of diseases classified elsewhere
- Providers must bill with HCPCS code J3490-Unclassified drugs.
- One Medicaid and NCHC unit of coverage is 1 mg.
- The maximum reimbursement rate per unit is \$0.68.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 71045-0010-01, 71045-0010-02.
- 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 the NC Medicaid website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NC Health Choice 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 Physician's Drug Program is available on the NC Medicaid website's PDP web page.

NCTracks Call Center, 1-800-688-6696

ATTENTION: HOSPITAL PROVIDERS

Update to Reimbursement of Long Acting Reversible Contraceptives (LARCs)

Effective for dates of service on or after Oct. 1, 2018, the following DRG classifications specific to LARCs will be added to the current Grouper 36 version within NCTracks for claims reimbursement.

A copy of the DRG Grouper Version 36 weights and thresholds in Excel format will be posted to the [Hospital Fee Schedule web page](#) under “Grouper 36 DRG Weight Table” on the NC Medicaid website.

The NC Medicaid covers the insertion/implanting of Long Acting Reversible Contraceptives (LARCs) under [Clinical Policy 1E – 7 Family Planning Services](#).

New LARC DRGs

Effective Oct. 1, 2018, new LARC diagnosis and procedure codes will be implemented to DRG Version 36 of the Medicare Grouper for reimbursement of claims. The new DRG codes listed will allow hospitals and physicians to receive additional fees for LARC insertion. In addition, the new policy allows hospitals to receive reimbursement for the cost of five LARC devices listed.

Inpatient Hospital Services

The payment of LARCs is included in the DRG payment of the delivery. Since this is a covered service, the cost of the LARC is an allowable cost on the cost report, which is used in the calculation of the MRI/GAP supplemental payments.

Billing Notes

AS UPDATED in [January 2019 Special Bulletin](#), please note that effective Oct. 1, 2018 the new 4-digit Long Acting Reversible Contraceptives (LARC) DRG code is *not required to be submitted on the claim*. Once Inpatient hospital LARC services are billed, the system will *automatically* assign the appropriate LARC DRG code listed below.

1765 Cesarean Section W CC/MCC with LARC

1766 Cesarean Section W/O CC/MCC with LARC

1767 Vaginal Delivery W Sterilization &/or D&C with LARC

1768 Vaginal Delivery W O.R. Proc Except Sterile &/or D&C with LARC

1769 Postpartum & Post Abortion Diagnoses W O.R. Procedure with LARC

1770 Abortion W D&C, Aspiration Curettage or Hysterectomy with LARC

1774 Vaginal Delivery W Complicating Diagnoses with LARC

1775 Vaginal Delivery W/O Complicating Diagnoses with LARC

1776 Postpartum & Post Abortion Diagnoses W/O O.R. Procedure with LARC

1777 Ectopic Pregnancy with LARC

1779 Abortion W/O D&C with LARC

Hospital LARC claims should be billed using the following ICD-10-PCS codes:

OU.H97HZ Insertion of Contraceptive Device into Uterus, via Opening

OU.H98HZ Insertion of Contraceptive Device into Uterus, Endo

OU.HC8HZ Insertion of Contraceptive Device into Cervix, Endo

OU.HC7HZ Insertion of Contraceptive Device into Cervix, via Opening

OU.H90HZ Insertion of Contraceptive Device into Uterus, Open Approach

Hospital LARC claims should be billed using the following Healthcare Common Procedure Coding System (HCPCS) codes:

HCPCS Device

J7297 Liletta®

J7298 Mirena ®

J7300 Paragard®

J7301 Skyla®

J7307 Nexplanon ®

Outpatient Hospital Services

If the LARC is inserted/implanted during an outpatient encounter, the LARC is billed on the claim, along with the appropriate HCPCS and NDC codes. If the LARC is billed under 340B pricing, the UD modifier must be used. OMA will reimburse the hospital claim at 70% of cost. Similar to inpatient services, the cost is allowable and will be considered in the calculation of the MRI/GAP supplemental payments.

NC Medicaid Provider Reimbursement, 919-814-0060

ATTENTION: LONG-TERM SERVICES AND SUPPORTS PROVIDERS

Pre-Admission Screening and Resident Review (PASRR) Program Update

The Department of Health and Human Services is implementing the Referral Screening Verification Process (RSVP) for individuals being considered for admission to an Adult Care Home (ACH) effective Nov. 1, 2018.

RSVP will replace Pre-Admission Screening Resident Review (PASRR) for ACHs, providing a more streamlined and effective process to screen Transition to Community Living Initiative (TCLI) target populations.

Regardless of diagnosis, **all** Medicaid-eligible individuals being considered for admission to ACHs, except group homes, will require the referral screening verification be completed. The ACH PASRR will no longer exist for ACH admissions after the RSVP implementation date of Nov. 1, 2018.

Currently, for Personal Care Services expedited processing eligibility, beneficiaries admitted to an ACH (excluding 5600 facilities), **must** have an ACH PASRR number. After RSVP is implemented, the beneficiary will be required to have a referral screening verification number instead of an ACH PASRR number.

Additional information pertaining to RSVP will be communicated soon.

NC DMH/DD/SAS, TCLI Diversion Lead, 919-715-2056

ATTENTION: PERSONAL CARE SERVICES PROVIDERS

Regional Provider Trainings

Personal Care Services (PCS) regional training sessions will be held Oct. 18-Nov. 1, 2018. Registration begins at 8 a.m. and training will be held from 9 a.m. to 1 p.m. Training sessions are free, but registration is required. Providers can [register](#) through the Liberty Healthcare Corp. of North Carolina Medicaid PCS Website beginning Sept. 24, 2018. Prior to training, training topics and materials will be available to registered participants on the [Liberty website](#).

Event Dates and Locations

Thursday, Oct. 18, 2018 – Greenville

Hilton Greenville
207 SW Greenville Blvd
Ballroom

Monday, Oct. 22, 2018 – Raleigh

Jane S. McKimmon Conference and Training Center
NCSU, 1101 Gorman St.
Rooms will be posted at Information Desk

Wednesday, Oct. 24, 2018 – Fayetteville

Embassy Suites-Fort Bragg
4760 Lake Valley Drive
Ballroom

Monday, Oct. 29, 2018 – Asheville

Renaissance Asheville Hotel
31 Woodfin St.

Ballroom

Tuesday, Oct. 30, 2018 – Charlotte
Great Wolf Lodge Convention Center
10175 Weddington Rd.
White Pine Ballroom

Thursday, Nov. 1, 2018 – Greensboro
Embassy Suites by Hilton Greensboro Airport
204 Centrepoint Dr.
Ballroom

Liberty Healthcare Corporation of North Carolina, 1-855-740-1400 or NC Medicaid at 919-855-4360

ATTENTION: SPECIALIZED THERAPIES PROVIDERS

Updates to Clinical Coverage Policy 10A: Outpatient Specialized Therapies

Effective Sept. 15, 2018, Clinical Coverage Policy 10A, Outpatient Specialized Therapies, was updated to increase therapy visit limits for recipients 21 years of age and older. A summary of the most significant changes follows.

In section **3.2.1.5 Evaluation Services**, the following language was added:

An evaluation visit also incorporates any immediate treatment warranted based on the evaluation results. No prior authorization is needed for evaluation visits or for treatment rendered as part of an evaluation visit.

In section **3.2.1.8 Re-evaluation Services**, and **5.2 Prior Approval Requirements, Section 5.2.2 Specific**, the following language was deleted:

~~The re-evaluation report must report the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.~~

In section **5.2 Prior Approval Requirements, Section 5.2.2 Specific**, the following language was also deleted:

~~For audiology services (AUD) and speech/language services (ST) prior approval, a written report of an evaluation must occur within six (6) months of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report. The re-~~

~~evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.~~

In section **5.4 Visit Limitations Beneficiaries 21 Years of Age and Older**, the language specific to the annual and episodic visit limits for beneficiaries 21 years of age and older was deleted and replaced with:

The first prior approval request within a calendar year shall be for no more than three therapy treatment visits and one month. The PA review vendor will authorize these three treatment visits to begin as early as the day following the submission of the PA request. Any subsequent PA may be obtained for up to 12 therapy treatment visits and six months. A beneficiary can receive a maximum of 27 therapy treatment visits per calendar year across all therapy disciplines combined (occupational therapy, physical therapy and speech/language therapy). Each reauthorization request must document the efficacy of treatment.

In section **7.5 Requirements When the Type of Treatment Services Are the Same as Those Provided by the Beneficiary's Public School or Early Intervention Program**, the following language was deleted:

~~the combined frequency of services must be medically necessary to address the beneficiary's deficits. The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program Services~~

In **Attachment A: Claims-Related Information, Section B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**, all tables containing ICD-10-CM diagnosis codes were removed.

In **Attachment A: Claims-Related Information, Section C. Code(s)**, all tables containing surgical CPT codes were removed.

In **Attachment A: Claims-Related Information, Section E. Billing Units**, the following language was added:

Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid or NCHC beneficiary as a single visit, shall not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or

physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.

Additional Resources

The full text of Clinical Coverage Policy 10A is available at NC Medicaid's [Outpatient Specialized Therapy Services](#) web page. Additional information can also be found at the [ChoicePA](#) website.
