



NC Medicaid Bulletin

January 2019

All Providers

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ATTENTION: ALL PROVIDERS**Clinical Coverage Policies**

The following new or amended clinical coverage policies are available on NC Medicaid's [clinical coverage policies web page](#):

- 8J, Children's Developmental Service Agencies (CDSAs) – Dec. 15, 2018
- 1A-5, Child Medical Evaluation and Medical Team Conference for Child Maltreatment – Jan. 1, 2019
- 1G-2, Skin Substitutes – Jan. 1, 2019
- 1N-2, Allergy Immunotherapy – Jan. 1, 2019
- 1S-4, Genetic Testing – Jan. 1, 2019
- 1T-2, Special Ophthalmological Services – Jan. 1, 2019
- 1E-7, Family Planning Services – Jan. 1, 2019

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

NC Medicaid Clinical Policy, 919-855-4260

ATTENTION: ALL PROVIDERS**Prior Approval Reminders**

As a reminder, providers are to request and obtain proper prior authorization (PA) before services are scheduled or rendered. Contractually, GDIT (NC Medicaid's fiscal vendor) has five business days (excluding holidays and weekends) to process a medical PA request once all required information is obtained. Pharmacy PAs are processed within 24 hours. Medical necessity cannot be determined with a partial or incomplete clinical picture.

Failure to obtain PA, rendering services before PA is granted, or the inappropriate use of diagnosis codes or modifiers to bypass the PA requirement will result in claim denials or potential recoupments.

[North Carolina Administrative Code 22J .0106](#) prohibits the billing of Medicaid beneficiaries when a claim is denied due to a provider failing to follow program regulations or if a claim is denied due to lack of medical necessity.

Not all procedures and services require prior approval. Providers will find current PA requirements for each clinical coverage policy on the Medicaid [Clinical Coverage Policy web page](#).

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS**Updates to the NC Medicaid Electronic Health Record (EHR) Incentive Program****Program Reminders**

There are only four months left to submit an attestation for Program Year 2018. Attestations submitted after Feb. 28, 2019 are **not** guaranteed to be reviewed by program staff prior to close of Program Year 2018. Providers have until April 30, 2019 to submit a complete and accurate attestation for Program Year 2018. **After that no changes can be made.**

In Program Year 2018, providers have the option to attest to Modified Stage 2 Meaningful Use (MU) or Stage 3 MU. For objective and measure requirements, providers should refer to the CMS Specification Sheets.

- [Click here](#) for CMS's Modified Stage 2 MU Specification Sheets
- [Click here](#) for CMS's Stage 3 MU Specification Sheets

When attesting in Program Year 2018, an eligible professional's (EP) Promoting Interoperability (PI) reporting period must be from calendar year 2018 and may be any continuous 90-day period or full calendar year in which a provider successfully demonstrates MU of certified EHR technology (CEHRT).

Providers who were paid for Program Year 2017 using a 90-day patient volume reporting period from calendar year 2017, may use the same patient volume reporting period to attest for Program Year 2018.

The attestation guides are updated each year, so providers are encouraged to use the updated attestation guide every year they attest. The attestation guides may be found on the right-hand side of [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 can 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.

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For assistance, please email the NC Medicaid EHR Incentive Program's dedicated help desk at NCMedicaid.HIT@dhhs.nc.gov. Help desk hours are 8 a.m. to 4 p.m., Monday through Friday.

Program Year 2019 clinical quality measures have been updated and are published on the [eCQI website](#).

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

ATTENTION: ALL PROVIDERS

Update to Clinical Policy 1E-7, Family Planning Services

Clinical Policy 1E-7, *Family Planning Services*, has been revised effective Jan. 1, 2019.

Contraceptive patch Ortho Evra is no longer available. Norelgestromin and ethinyl estradiol transdermal system has been added to Clinical Policy 1E-7 Family Planning Services as an acceptable contraceptive patch for MAFDN eligible beneficiaries.

Diagnosis A63.0 (anogenital (venereal) warts) has been added as an acceptable diagnosis for MAFDN eligible beneficiaries.

As directed in the [November 2018 Medicaid bulletin](#):

- Effective Dec. 31, 2018, CPT code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) will no longer be covered by NC Medicaid.
- Effective May 1, 2019, CPT code 58340 (catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography) will no longer be covered by NC Medicaid.

For more information, providers should refer to the [Clinical Coverage Policy 1E-7, Family Planning Services](#). Providers with questions can contact the GDIT Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS**NCTracks Provider Training Available in January 2019**

Registration is open for the January 2019 instructor-led provider training courses listed below. Slots are limited.

WebEx courses can be attended remotely from any location with a telephone, computer and internet connection. **Please note that the WebEx information has changed.** See the Training Enrollment Instructions below for details.

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)

Jan. 4, 2019, 1 p.m. – 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

Provider Re-Verification (WebEx)

Jan. 9, 2019, 1:00 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:

- 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 the Re-Verification application process

Submitting Institutional Prior Approvals (On-Site)

Jan. 15, 2019, 9:30 a.m. - noon

This course will cover submitting Prior Approval (PA) Requests with a focus on nursing facilities, to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It will also cover PA inquiry to check on the status of a PA Request. The course is being offered in-person. It includes hands-on training and will be limited to 45 participants.

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Submitting Institutional Claims (On-Site)

Jan. 15, 2019, 1:00 p.m. - 4:30 p.m.

This course will focus on how to submit an institutional claim via the NCTracks Provider Portal with emphasis on long term care and secondary claims. At the end of training, providers will be able to enter an institutional claim, save a draft claim, use the Claims Draft Search tool, submit a claim, and view the results of a claim submission. The course is being offered in-person. It includes hands-on training and will be limited to 45 participants.

Submitting Medical Prior Approvals (On-Site)

Jan. 17, 2019 and Jan. 29, 2019, 9:30 a.m. - noon

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. The course is being offered in-person. It includes hands-on training and will be limited to 45 participants.

Submitting Professional Claims (On-Site)

Jan. 17, 2019 and Jan. 29, 2019, 1:00 p.m. - 4:30 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 and view the results of a claim submission. The course is being offered in-person. It includes hands-on training and will be limited to 45 participants.

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

To access WebEx online training sessions:

1. From an internet browser, enter <https://srameeting.webex.com/meet/paynet>
2. Enter your first and last name
3. Enter your email address

If this is your first time using the new CSRA Web Meeting, it is suggested that you begin the process 15 minutes prior to the start of the call. This will allow you sufficient time to download the required software to access the Web Meeting. To hear the audio portion of the class, dial: 1-800-747-5150. Enter access code 8700322.

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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.

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Allergy immunotherapy 1N-2

Clinical Coverage Policy (CCP) [1N-2, Allergy Immunotherapy](#) has been revised effective Jan. 1, 2019 to reflect changes in unit dosing. To align with Medicare billing, a billing unit is described as 1.0 cubic centimeter (cc) of solution from a multi-dose vial.

Providers must bill 1.0 cc equals one unit. For example: A provider can bill five 1.0 cc doses from a five-cubic centimeter vial. This applies to venom and non-venom antigen codes.

For information more regarding claims and testing limitations please refer to **Attachment A: Claims-Related Information**

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS

CPT Code Update 2019

Effective with date of service Jan. 1, 2019, the American Medical Association (AMA) has added new CPT codes, deleted others and changed descriptions of some existing codes. For complete information regarding all CPT codes and descriptions, refer to the 2019 edition of Current Procedural Terminology, published by the AMA.

Providers should note the full descriptions as well as all associated parenthetical information published in this edition when selecting a code for billing services to the NC Medicaid.

New CPT codes that are covered by the NC Medicaid program are effective with date of service Jan. 1, 2019. Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2019. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

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HCPCS codes for Drugs Administered Other Than Oral Method (J Codes) are anticipated to be in NCTracks Jan. 6, 2019 retroactive to Jan. 1, 2019. Claims may be submitted prior to Jan. 6, 2019; however, claims will pend for “no rate on file” until rates and updates are complete. Covered codes are listed in a table at the end of this article.

New CPT Codes Covered by Medicaid and NCHC (effective Jan. 1, 2019)									
10004	10005	10006	10007	10008	10009	10010	10011	10012	11102
11103	11104	11105	11106	11107	20932	20933	20934	27369	33285
33286	33440	33866	36572	36573	38531	43762	43763	50436	50437
76978	76979	77046	77047	77048	77049	92273	92274	95976	95977
95983	95984	96112	96113	96136	96137	96138	96139	96146	

New HCPCS Codes Covered by Medicaid and NCHC (effective Jan. 1, 2019)									
D1516	D1517	D5876	D9613	G2011	Q2042	Q4186	Q5108		

The following codes for BRCA gene analysis and adaptive behavior treatment are still under review by NC Medicaid. Coverage determination and medical necessity criteria will be published at a later date:

New CPT Codes Still Under Review by Medicaid									
81163	81164	81165	81166	81167	97151	97152	97153	97154	95155
97156	97157								

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New CPT Codes Not Covered by Medicaid and NCHC									
99451	99452	99453	99454	99457	99491	33274	33275	33289	53854
76391	76981	76982	76983	81171	81172	81204	81173	81174	81177
81178	81179	81180	81181	81182	81183	81233	81184	81185	81186
81187	81188	81189	81190	81234	81239	81236	81237	81284	81285
81286	81289	81271	81274	81305	81306	81312	81320	81343	81329
81336	81337	81334	81345	81333	81443	81518	0018U	0019U	0020U
0021U	0022U	0023U	0024U	0025U	0026U	0027U	0028U	0029U	0030U
0031U	0032U	0033U	0034U	0035U	0036U	0037U	0038U	0039U	0040U
0041U	0042U	0043U	0044U	0045U	0046U	0047U	0048U	0049U	0050U
0051U	0052U	0053U	0054U	0055U	0056U	0057U	0058U	0059U	0060U
0061U	90689	93264	95836	97158					

End-Dated CPT Codes (effective Dec. 31, 2018)									
10022	11100	11101	20005	27370	31595	33282	33284	41500	43760
46762	50395	61332	61480	61610	61612	63615	64508	66220	76001
77058	77059	78270	78271	78272	92275	95974	95975	95978	95979
96101	96111	96118							

End-Dated HCPCS Codes (effective Dec. 31, 2018)									
D1515	J0833	J9310	Q2040	Q4131	Q5102	Q9993	Q9995		

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New J codes Effective Jan. 1, 2019	Description	Associated NDCs	HCPCS code End-dated Dec. 31, 2018
J0185	aprepitant injection (Cinvanti™) 1 mg	47426-0201-01	J3490
J0567	cerliponase alfa injection, for intraventricular use (Brineura®) 1 mg	68135-0811-02	J3590
J0584	burosumab-twza injection, for subcutaneous use (Crysvita®) 1 mg	69794-0102-01 69794-0203-01 69794-0304-01	J3590
J0841	crotalidae immune f(ab') ₂ (equine), lyophilized powder for solution for injection for intravenous use (Anavip®) 120 mg	66621-0790-01 66621-0790-02	J3590
J1301	edaravone injection, for intravenous use (Radicava®) 1 mg	70510-2171-01 70510-2171-02	J3590
J1454	Fosnetupitant 235 mg and palonosetron 0.25 mg for injection, for intravenous use (Akynzeo®)	69639-0102-01	J3490
J1746	ibalizumab-uiyk injection, for intravenous use (Trogarzo™) 10 mg	62064-0122-02	J3590
J2797	rolapitant injection, emulsion for intravenous use (Varubi®) 0.5 mg	69656-0102-10	J3490
J3304	triamcinolone acetanide extended-release injectable suspension, for intra-articular use (Zilretta™) 1 mg	70801-0003-01	Q9993
J3316	triptorelin for extended-release injectable suspension, for intramuscular use (Triptodur™) 3.75 mg	24338-0150-20	J3490

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New J codes Effective Jan. 1, 2019	Description	Associated NDCs	HCPCS code End-dated Dec. 31, 2018
J3397	vestronidase alfa-vjbk injection, for intravenous use (Mepsevii™) 1 mg	69794-0001-01	J3590
J7170	emicizumab-kxwh injection, for subcutaneous use (Hemlibra®) 0.5 mg	50242-0920-01 50242-0921-01 50242-0922-01 50242-0923-01	Q9995
J7177	fibrinogen concentrate (human) lyophilized powder for reconstitution (Fibryga®) 1 mg	68982-0347-01 68982-0348-01	J3590
J7203	coagulation factor IX (recombinant), glycoPEGylated, lyophilized powder for solution for intravenous injection (Rebinyn®) 1 iu	00169-7901-01 00169-7902-01 00169-7905-01	J7199
J9057	copanlisib injection, for intravenous use (Aliqopa™) 1 mg	50419-0385-01	J9999
J9153	daunorubicin 1 mg and cytarabine 2.27 mg liposome injection, for intravenous use (Vyxeos™)	68727-0745-01 68727-0745-02 68727-0745-05	J9999
J9173	durvalumab injection, for intravenous use (Imfinzi®) 10 mg	00310-4500-12 00310-4611-50	J3590
J9229	inotuzumab ozogamicin injection, for intravenous use (Besponsa™) 0.1 mg	00008-0100-01	J9999
J9311	rituximab and hyaluronidase human injection, for subcutaneous use (Rituxan Hycela®) 10 mg	50242-0108-01 50242-0109-01	J9999
J9312	rituximab injection for intravenous use (Rituxan®) 10 mg	50242-0051-21 50242-0053-06	J9310

Note: All Category II and III Codes are not covered.

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A bulletin article will be published listing the new codes that will be separately reimbursable by Ambulatory Surgery Centers (ASC) when that information is released by the Centers for Medicare & Medicaid Services (CMS) in January 2019.

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS

**Crotalidae Immune f(ab')₂ (equine), lyophilized powder for solution for injection for intravenous use (Anavip®)
HCPCS code J3590: Billing Guidelines**

Effective with date of service Nov. 2, 2018, the NC Medicaid and Health Choice (NCHC) programs cover crotalidae immune f(ab')₂ (equine), lyophilized powder for solution for injection for intravenous use (Anavip®) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J3590 - Unclassified biologics.

Each vial of Anavip contains a sterile, lyophilized preparation containing not more than 120 milligrams total protein and not less than the indicated number of mouse LD50 neutralizing units:

- Bothrops asper (snake species used for standardization): 780 minimum mouse LD50 units per vial
- Crotalus durissus (snake species used for standardization): 790 minimum mouse LD50 units per vial

Anavip is indicated for the management of adult and pediatric patients with North American rattlesnake envenomation. The initial dose of Anavip is 10 vials properly diluted (see package insert for instructions) and infused intravenously over 60 minutes.

Additional 10 vial doses can be administered if needed to arrest the progressive symptoms and repeat every hour. There is no known maximum dose. Re-emerging symptoms including coagulopathies may be suppressed with additional four vial doses as needed. See full prescribing information for further detail.

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For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are: T63.011A - Toxic effect of rattlesnake venom, accidental (unintentional), initial encounter; T63.011D - Toxic effect of rattlesnake venom, accidental (unintentional), subsequent encounter; T63.011S - Toxic effect of rattlesnake venom, accidental (unintentional), sequela; T63.012A - Toxic effect of rattlesnake venom, intentional self-harm, initial encounter; T63.012D - Toxic effect of rattlesnake venom, intentional self-harm, subsequent encounter; T63.012S - Toxic effect of rattlesnake venom, intentional self-harm, sequela; T63.013A - Toxic effect of rattlesnake venom, assault, initial encounter; T63.013D - Toxic effect of rattlesnake venom, assault, subsequent encounter; T63.013S - Toxic effect of rattlesnake venom, assault, sequela; T63.014A - Toxic effect of rattlesnake venom, undetermined, initial encounter; T63.014D - Toxic effect of rattlesnake venom, undetermined, subsequent encounter; T63.014S - Toxic effect of rattlesnake venom, undetermined, sequela
- Providers must bill with HCPCS code: J3590 - Unclassified biologics
- One Medicaid and NCHC unit of coverage is: 1 vial
- The maximum reimbursement rate per unit is: \$1,317.60
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 66621-0790-01, 66621-0790-02
- 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 PADP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on NC Medicaid's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

ICD-10-CM Manual. American Medical Association, 2018 manual.

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS**Moxetumomab Pasudotox-tdfk for Injection, for intravenous use (Lumoxiti™) HCPCS code J9999: Billing Guidelines**

Effective with date of service Oct. 22, 2018, the NC Medicaid and Health Choice (NCHC) programs cover moxetumomab pasudotox-tdfk for injection, for intravenous use (Lumoxiti™) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J9999 - Not Otherwise Classified, antineoplastic drugs.

Lumoxiti is available for injection as 1 mg lyophilized cake or powder in a single-dose vial for reconstitution and further dilution.

It is indicated for the treatment of adult patients with relapsed or refractory hairy cell leukemia (HCL) who received at least two prior systemic therapies, including treatment with a purine nucleoside analog (PNA). Lumoxiti is not recommended in patients with severe renal impairment ($\text{CrCl} \leq 29 \text{ mL/min}$).

Recommended Dose: 0.04 mg/kg as an intravenous infusion over 30 minutes on days one, three and five of each 28-day cycle.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are: C91.40 - Hairy cell leukemia not having achieved remission or C91.42 - Hairy cell leukemia, in relapse in combination with Z92.21 - Personal history of antineoplastic chemotherapy
- Providers must bill with HCPCS code: J9999 - Not Otherwise Classified, Antineoplastic Drugs
- One Medicaid and NCHC unit of coverage is: 1 mg
- The maximum reimbursement rate per unit is: \$2,250.00
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 00310-4700-01
- 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 PADP, refer to the [PADP Clinical Coverage Policy No. 1B](#), Attachment A, H.7.

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- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

*Information current as of Nov. 28, 2018 and is not a substitute for professional judgment. For full prescribing information, please refer to current package insert or other appropriate sources prior to making clinical judgments.

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS

Filgrastim-aafi injection, for subcutaneous or intravenous use (Nivestym™) HCPCS code Q5110: Billing Guidelines

Effective with date of service Oct 3, 2018, the NC Medicaid and Health Choice (NCHC) programs cover filgrastim-aafi injection, for subcutaneous or intravenous use (Nivestym) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code Q5110 - Injection, Filgrastim-aafi, Biosimilar, (Nivestym), 1 microgram. Nivestym is available in a single-dose prefilled syringe containing either 300 mcg/0.5 mL or 480 mcg/0.8 mL.

It is indicated to:

- Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
- Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML).
- Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT).

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- Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.
- Reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Recommended Dose:

- Patients with cancer receiving myelosuppressive chemotherapy or induction and/or consolidation chemotherapy for AML: Recommended starting dose is 5 mcg/kg/day subcutaneous injection, short intravenous infusion (15 to 30 minutes), or continuous intravenous infusion.
- Patients with cancer undergoing bone marrow transplantation: 10 mcg/kg/day given as an intravenous infusion no longer than 24 hours.
- Patients undergoing autologous peripheral blood progenitor cell collection and therapy: 10 mcg/kg/day subcutaneous injection for at least four days before first leukapheresis procedure and continue until last leukapheresis.
- Patients with congenital neutropenia: Recommended starting dose is 6 mcg/kg as a subcutaneous injection twice daily.
- Patients with cyclic or idiopathic neutropenia: Recommended starting dose is 5 mcg/kg as a single subcutaneous injection daily.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code(s) required for billing are: Do not restrict based on ICD-10 for oncology diagnosis. Cancer therapy and related ICD-10 codes may include C00 - D49; T86.5 Complications of stem cell transplant (complications from stem cells from peripheral blood, umbilical blood); T86.00 - Unspecified complication of bone marrow transplant, T86.01 - bone marrow transplant rejection, T86.02 - bone marrow transplant failure, T86.03 - bone marrow transplant infection, T86.09 - other complications of bone marrow transplant; D70.0 - Congenital agranulocytosis; D70.1 - Agranulocytosis secondary to cancer chemotherapy; D70.2 - Other drug-induced agranulocytosis; D70.3 - Neutropenia due to infection; D70.4 - Cyclic neutropenia; D70.8 - Other neutropenia; D70.9 - Neutropenia, unspecified; T45.1X5A - Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter; T45.1X5D - Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter; T45.1X5S - Adverse effect of antineoplastic and immunosuppressive drugs, sequela
- Providers must bill with HCPCS code: Q5110 - Injection, Filgrastim-aafi, Biosimilar, (Nivestym), 1 microgram
- One Medicaid and NCHC unit of coverage is: 1 microgram

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- Maximum reimbursement rate per unit is: \$0.79
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 00069-0291-01, 00069-0291-10, 00069-0292-01, 00069-0292-10
- 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 PADP, refer to the [PADP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on NC Medicaid's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

*Information current as of Nov. 26, 2018 and is not a substitute for professional judgment. For full prescribing information, please refer to current package insert or other appropriate sources prior to making clinical judgments.

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS

Immune globulin intravenous, human - ifas (Panzyga®) HCPCS code J1599: Billing Guidelines

Effective with date of service Oct. 16, 2018, the NC Medicaid and Health Choice programs cover immune globulin intravenous, human - ifas (Panzyga®) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J1599 - Injection, Immune Globulin, Intravenous, Non-lyophilized (e.g. liquid), Not Otherwise Specified, 500 mg.

Panzyga solution contains 10% IgG (100 mg/mL) in 10 mL, 25 mL, 50 mL, 100 mL, 200 mL, and 300 mL single-use bottles.

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It is indicated for the treatment of:

- Primary Humoral Immunodeficiency (PI) in patients 2 years of age and older.
- Chronic Immune Thrombocytopenia (ITP) in adults.

Recommended Dose:

- Treatment of PI: 300 to 600 mg/kg administered every three to four weeks
- Treatment of ITP in Adults: 1 g/kg daily for two consecutive days

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are: D69.3 - Immune thrombocytopenic purpura; D80.0 - Hereditary hypogammaglobulinemia; D80.1 - Nonfamilial hypogammaglobulinemia; D81.0 - Severe combined immunodeficiency [SCID] with reticular dysgenesis; D81.1 - Severe combined immunodeficiency [SCID] with low T- and B-cell numbers; D81.2 - Severe combined immunodeficiency [SCID] with low or normal B-cell numbers; D81.3 - Adenosine deaminase [ADA] deficiency; D82.0- Wiskott-Aldrich syndrome; D83.0 - Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function; D83.1 - Common variable immunodeficiency with predominant immunoregulatory T-cell disorders; D83.2 - Common variable immunodeficiency with autoantibodies to B- or T-cells; D83.8 - Other common variable immunodeficiencies; D83.9 - Common variable immunodeficiency, unspecified
- Providers must bill with HCPCS code: J1599 - Injection, Immune Globulin, Intravenous, Non-lyophilized (e.g. liquid), Not Otherwise Specified, 500 mg.
- One Medicaid and NC Health Choice unit of coverage is: 500 mg
- The maximum reimbursement rate per unit is: \$89.64
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 68982-0820-01, 68982-0820-02, 68982-0820-03, 68982-0820-04, 68982-0820-05, 68982-0820-06, 68982-0820-81, 68982-0820-82, 68982-0820-83, 68982-0820-84, 68982-0820-85, 68982-0820-86
- 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 PADP, refer to the [PADP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on the NC Medicaid website.

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- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

*Information current as of Nov. 28, 2018 and is not a substitute for professional judgment. For full prescribing information, please refer to current package insert or other appropriate sources prior to making clinical judgments.

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS

Risperidone for extended-release injectable suspension, for subcutaneous use (Perseris™) HCPCS code J3490: Billing Guidelines

Effective with date of service Nov. 19, 2018, the NC Medicaid and Health Choice (NCHC) programs cover risperidone for extended-release injectable suspension, for subcutaneous use (Perseris™) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J3490 - Unclassified drugs.

Perseris is available as a 90 mg single-dose kit and a 120 mg single-dose kit. Perseris is indicated for the treatment of schizophrenia in adults.

Recommended Dose: For adult patients who have never taken risperidone, establish tolerability with oral risperidone prior to starting. Then, initiate Perseris at a dose of 90 mg or 120 mg once monthly by abdominal subcutaneous injection. See full prescribing information for further detail.

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For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code(s) required for billing is/are:
 - F20.0 - Paranoid schizophrenia
 - F20.1 - Disorganized schizophrenia
 - F20.2 - Catatonic schizophrenia
 - F20.3 - Undifferentiated schizophrenia
 - F20.5 - Residual schizophrenia
 - F20.89 - Other schizophrenia
 - F20.9 - Schizophrenia, unspecified
- 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: \$20.52
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 12496-0090-01, 12496-0120-01
- 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 PADP, refer to the [PADP](#), Attachment A, H.7 on NC Medicaid's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS**Elapegademase-lvlr injection, for intramuscular use
(Revcovi™) HCPCS code J3590: Billing Guidelines**

Effective with date of service Nov. 28, 2018, the NC Medicaid and Health Choice (NCHC) programs cover elapegademase-lvlr injection, for intramuscular use (Revcovi™) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J3590 - Unclassified biologics.

Revcovi is available as 2.4 mg/1.5 mL (1.6 mg/mL) in a single-dose vial. It is indicated for the treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients.

Recommended Dose:

Patients transitioning from Adagen to Revcovi:

- If a patient's weekly Adagen dose is unknown, or a patient's weekly Adagen dose is at or lower than 30 U/kg, the recommended minimum starting dose is 0.2 mg/kg, intramuscularly, once a week.
- If a patient's weekly Adagen dose is above 30 U/kg, an equivalent weekly Revcovi dose (mg/kg) should be calculated using the following conversion formula: Adagen dose in U/kg divided by 150.

Adagen-naïve patients:

The starting dose is 0.4 mg/kg weekly based on ideal body weight, divided into two doses (0.2 mg/kg twice a week), intramuscularly for a minimum of 12 to 24 weeks until immune reconstitution is achieved.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code(s) required for billing is/are: D81.3 - Adenosine deaminase [ADA] deficiency
- Providers must bill with HCPCS code: J3590 - Unclassified biologics
- One Medicaid and NCHC unit of coverage is: 1 mg
- The maximum reimbursement rate per unit is: \$4,435.20
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 57665-0002-01
- The NDC units should be reported as "UN1".
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).

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- For additional information regarding NDC claim requirements related to the PADP, refer to the [PADP](#), Attachment A, H.7 on NC Medicaid's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 PADP is available on NC Medicaid's [PADP web page](#).

GDIT, 1-800-688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS, AND NURSE PRACTITIONERS

**Elapegademase-lvlr injection, for intramuscular use
(Revcovi™) HCPCS code J3590: Billing Guidelines**

Effective with date of service Oct. 22, 2018, the NC Medicaid and Health Choice (NCHC) programs cover eravacycline for injection, for intravenous use (Xerava) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J3490 - Unclassified Drugs. Xerava is available as a 50 mg single-dose vial.

It is indicated for the treatment of complicated intra-abdominal infections in patients 18 years of age and older. Xerava is not indicated for the treatment of complicated urinary tract infections (cUTI).

Recommended Dose:

- Administer 1 mg/kg by intravenous infusion over approximately 60 minutes every 12 hours for a total duration of four to 14 days.
- Severe Hepatic Impairment (Child Pugh C): 1 mg/kg every 12 hours on day one, then 1 mg/kg every 24 hours starting on day two for a total duration of four to 14 days.
- Concomitant Use of a Strong Cytochrome P450 Isoenzymes (CYP)3A Inducer: 1.5 mg/kg every 12 hours for a total duration of four to 14 days.

See full prescribing information for further detail.

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For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code(s) required for billing are: A04.0 - Enteropathogenic *Escherichia coli* infection; A04.1 - Enterotoxigenic *Escherichia coli* infection; A04.2 - Enteroinvasive *Escherichia coli* infection; A04.3 - Enterohemorrhagic *Escherichia coli* infection; A04.4 - Other intestinal *Escherichia coli* infections; A04.8 - Other specified bacterial intestinal infections; A04.9 - Bacterial intestinal infection, unspecified; A49.9 - Bacterial infection, unspecified; B96.1 - *Klebsiella pneumoniae* [*K. pneumoniae*] as the cause of diseases classified elsewhere; A49.01 - Methicillin susceptible *Staphylococcus aureus* infection, unspecified site; A49.1 - Streptococcal infection, unspecified site; A49.8 - Other bacterial infections of unspecified site; B95.0 - Streptococcus, group A, as the cause of diseases classified elsewhere; B95.1 - Streptococcus, group B, as the cause of diseases classified elsewhere; B95.2 - Enterococcus as the cause of diseases classified elsewhere; B95.4 - Enterococcus as the cause of diseases classified elsewhere; B95.5 - Unspecified streptococcus as the cause of diseases classified elsewhere; B95.61 - Methicillin susceptible *Staphylococcus aureus* infection as the cause of diseases classified elsewhere; B95.62 - Methicillin resistant *Staphylococcus aureus* infection as the cause of diseases classified elsewhere; B95.7 - Other staphylococcus as the cause of diseases classified elsewhere; B95.8 - Unspecified staphylococcus 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; B96.6 - *Bacteroides fragilis* [*B. fragilis*] as the cause of diseases classified elsewhere; B96.7 - *Clostridium perfringens* [*C. perfringens*] as the cause of disease classified elsewhere; B96.89 - Other specified bacterial agents as the cause of diseases classified elsewhere; K25.1 - Acute gastric ulcer with perforation; K25.2 - Acute gastric ulcer with both hemorrhage and perforation; K25.5 - Chronic or unspecified gastric ulcer with perforation; K25.6 - Chronic or unspecified gastric ulcer with both hemorrhage and perforation; K26.1 - Acute duodenal ulcer with perforation; K26.2 - Acute duodenal ulcer with both hemorrhage and perforation; K26.5 - Chronic or unspecified duodenal ulcer with perforation; K26.6 - Chronic or unspecified duodenal ulcer with both hemorrhage and perforation; K27.1 - Acute peptic ulcer, site unspecified, with perforation; K27.2 - Acute peptic ulcer, site unspecified, with both hemorrhage and perforation; K27.5 - Chronic or unspecified peptic ulcer, site unspecified, with perforation; K27.6 - Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation;

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K28.1 - Acute gastrojejunal ulcer with perforation; K28.2 - Acute gastrojejunal ulcer with both hemorrhage and perforation; K28.5 - Chronic or unspecified gastrojejunal ulcer with perforation; K28.6 - Chronic or unspecified gastrojejunal ulcer with both hemorrhage and perforation; K35.20 - Acute appendicitis with generalized peritonitis, without abscess; K35.21 - Acute appendicitis with generalized peritonitis, with abscess; K35.30 - Acute appendicitis with localized peritonitis, without perforation or gangrene; K35.31 - Acute appendicitis with localized peritonitis and gangrene, without perforation; K35.32 - Acute appendicitis with perforation and localized peritonitis, without abscess; K35.33 - Acute appendicitis with perforation and localized peritonitis, with abscess; K35.80 - Unspecified acute appendicitis; K35.890 - Other acute appendicitis without perforation or gangrene; K35.891 - Other acute appendicitis without perforation, with gangrene; K36 - Other appendicitis; K37 - Unspecified appendicitis; K57.00 - Diverticulitis of small intestine with perforation and abscess without bleeding; K57.01 - Diverticulitis of small intestine with perforation and abscess with bleeding; K57.12 - Diverticulitis of small intestine without perforation or abscess without bleeding; K57.13 - Diverticulitis of small intestine without perforation or abscess with bleeding; K57.20 - Diverticulitis of large intestine with perforation and abscess without bleeding; K57.21 - Diverticulitis of large intestine with perforation and abscess with bleeding; K57.32 - Diverticulitis of large intestine without perforation or abscess without bleeding; K57.33 - Diverticulitis of large intestine without perforation or abscess with bleeding; K57.40 - Diverticulitis of both small and large intestine with perforation and abscess without bleeding; K57.41 - Diverticulitis of both small and large intestine with perforation and abscess with bleeding; K57.52 - Diverticulitis of both small and large intestine without perforation or abscess without bleeding; K57.53 - Diverticulitis of both small and large intestine without perforation or abscess with bleeding; K57.80 - Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding; K57.81 - Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding; K57.92 - Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding; K57.93 - Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding; K63.0 - Abscess of intestine; K63.1 - Perforation of intestine (nontraumatic); K65.0 - Generalized (acute) peritonitis; K65.1 - Peritoneal abscess; K65.2 - Spontaneous bacterial peritonitis; K65.3 - Choleperitonitis; K65.4 - Sclerosing mesenteritis; K65.8 - Other peritonitis; K65.9 - Peritonitis, unspecified; K68.11 - Postprocedural retroperitoneal abscess; K68.12 - Psoas muscle abscess; K68.19 - Other retroperitoneal abscess; K68.9 - Other disorders of retroperitoneum; K80.00 - Calculus of gallbladder with acute cholecystitis without obstruction; K80.01 - Calculus of gallbladder with acute cholecystitis with obstruction; K80.10 - Calculus of gallbladder with chronic cholecystitis without obstruction; K80.11 - Calculus of gallbladder with chronic cholecystitis with obstruction;

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- K80.12 - Calculus of gallbladder with acute and chronic cholecystitis without obstruction; K80.13 - Calculus of gallbladder with acute and chronic cholecystitis with obstruction; K80.18 - Calculus of gallbladder with other cholecystitis without obstruction; K80.19 - Calculus of gallbladder with other cholecystitis with obstruction; K80.40 - Calculus of bile duct with cholecystitis, unspecified, without obstruction; K80.41 - Calculus of bile duct with cholecystitis, unspecified, with obstruction; K80.42 - Calculus of bile duct with acute cholecystitis without obstruction; K80.43 - Calculus of bile duct with acute cholecystitis with obstruction; K80.44 - Calculus of bile duct with chronic cholecystitis without obstruction; K80.45 - Calculus of bile duct with chronic cholecystitis with obstruction; K80.46 - Calculus of bile duct with acute and chronic cholecystitis without obstruction; K80.47 - Calculus of bile duct with acute and chronic cholecystitis with obstruction; K80.60 - Calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction; K80.61 - Calculus of gallbladder and bile duct with cholecystitis, unspecified, with obstruction; K80.62 - Calculus of gallbladder and bile duct with acute cholecystitis without obstruction; K80.63 - Calculus of gallbladder and bile duct with acute cholecystitis with obstruction; K80.64 - Calculus of gallbladder and bile duct with chronic cholecystitis without obstruction; K80.65 - Calculus of gallbladder and bile duct with chronic cholecystitis with obstruction; K80.66 - Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction; K80.67 - Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction; K81.0 - Acute cholecystitis; K81.1 - Chronic cholecystitis; K81.2 - Acute cholecystitis with chronic cholecystitis; K81.9 - Cholecystitis, unspecified
- Providers must bill with HCPCS code: J3490 - Unclassified drugs
 - One Medicaid and NCHC unit of coverage is: 1 mg
 - Maximum reimbursement rate per unit is: \$0.95
 - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 71773-0050-01, 71773-0050-05, 71773-0050-12
 - 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 PADP, refer to the [PADP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on NC Medicaid's website.
 - Providers shall bill their usual and customary charge for non-340B drugs.
 - PADP 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.

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- The fee schedule for the PADP is available on NC Medicaid's [PADP web page](#).

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