



NC Medicaid Bulletin

March 2019

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ATTENTION: ALL PROVIDERS**Managed Care for Providers: PHP Contracts Awarded**

On Feb. 4, 2019, the North Carolina Department of Health and Human Services announced the selection of Prepaid Health Plans that will participate in Medicaid managed care when the program launches in November 2019. The Department awarded contracts to five entities:

- Statewide PHP contracts were awarded to the following entities which will offer Standard Plans in all regions in North Carolina:
 - AmeriHealth Caritas North Carolina, Inc.
 - Blue Cross and Blue Shield of North Carolina
 - UnitedHealthcare of North Carolina, Inc.
 - WellCare of North Carolina, Inc.
- A regional PHP contract was awarded to Carolina Complete Health, a provider-led entity, which will offer plans in Regions 3 and 5.

In 2015, the General Assembly directed the transition of Medicaid to a managed care structure. In managed care, DHHS will oversee all aspects of the Medicaid and NC Health Choice programs. However, PHPs will directly manage certain health services, assume financial risk and contract with providers to provide services for beneficiaries.

About 1.6 million Medicaid and NC Health Choice beneficiaries will enroll in a Standard Plan, which will provide integrated physical health, behavioral health and pharmaceutical services. To ease the transition to Medicaid Managed Care, Standard Plans will launch in two phases. The first phase will launch in November 2019 for beneficiaries in the following 27 counties: Alamance, Alleghany, Ashe, Caswell, Chatham, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin. Standard Plans will launch in the remaining counties in February 2020.

In the coming months, the Department will work with each PHP to implement managed care consistent with the Department's expectations as outlined in the PHP RFP. Over the summer and fall, the PHPs will complete a readiness review to demonstrate their ability to meet state, federal and contractual requirements. Once implemented, the PHPs will be subject to rigorous oversight by DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers among aspects of a successful managed care program.

A fact sheet with more information can be found at <https://files.nc.gov/ncdhhs/medicaid/Medicaid-Factsheets-PHP-2.4.19.pdf>. For additional information about Medicaid Transformation, please visit <https://ncdhhs.gov/medicaid-transformation>.

ATTENTION: ALL PROVIDERS**Credentialing Updates from the NC Medical Board**

NCTracks receives files from the North Carolina Medical Board the first week of every month. The files list all licenses issued and renewed **during the previous month** for Physicians (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Anesthesiologist Assistant (AA) providers. The files are used by NCTracks during the credentialing process and to update license renewals on provider records.

Providers do not need to update their license renewals in NCTracks. The expiration date will be updated by NCTracks automatically as long as the license number on the provider's record is correct and matches the license number issued by the Board.

When completing an initial enrollment application, providers will be required to enter a valid license number in order to proceed through the application and to allow the data to be automatically updated in the future.

Depending on your license issue date and the date you are completing an enrollment application, you may receive an error when entering your license number on the application if it has not been loaded into NCTracks. You may need to attempt another application at a later date.

NC Medicaid Provider Services, 919-527-7200

ATTENTION: ALL PROVIDERS**Summary of New or Amended Clinical Coverage Policies
Posted Since Jan. 1, 2019**

The following new or amended clinical coverage policies are available on NC Medicaid's website at <https://medicaid.ncdhhs.gov/>:

- 1E-7, Family Planning Services – Jan. 2, 2019
- 1A-26, Deep Brain Stimulation – Feb. 1, 2019
- 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures – Feb. 1, 2019
- 1K-1, Breast Imaging Procedures – Feb. 1, 2019
- 1K-7, Prior Approval for Imaging Services – Feb. 1, 2019
- 8J, Children's Developmental Service Agencies (CDSAs) – Feb. 1, 2019
- 9B, Hemophilia Specialty Pharmacy Program – Feb. 1, 2019

These policies supersede previously published policies and procedures.

NC Medicaid Clinical Policy and Programs, 919-813-5550 / 888-245-0179

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

There are only two months left to submit an attestation for Program Year 2018. The NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)) will close for Program Year 2018 at midnight on April 30, 2019. **After that, no changes can be made.** Eligible professionals (EP) are strongly advised to review their attestation and documentation for accuracy and completeness.

If we are unable to validate an EP's attestation with the information submitted on NC-MIPS as of midnight on April 30, 2019, the EP will be denied for Program Year 2018. Attestations submitted within 30 days of the deadline are not guaranteed to be reviewed before April 30, 2019.

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

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

When attesting in Program Year 2018, an EP's 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 an EP successfully demonstrates MU of certified EHR technology.

EPs 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 EPs 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 EP's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the EP 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.

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 Announcements

All EPs attesting in Program Year 2019 will be required to attest to Stage 3 MU and will be required to use a 2015 Edition of certified EHR technology.

CMS has updated its Promoting Interoperability Program website with Program Year 2019 information and details including the [2019 Medicaid Eligible Professional specification sheets](#).

For more information, visit <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicaid.html>.

Program Year 2019 clinical quality measures are available on the [eCQI website](#).

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

ATTENTION: ALL PROVIDERS

NCTracks Provider Training Available in March 2019

Registration is open for the March 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.

Submitting Pharmacy Prior Approval (Webex)

Monday, Mar. 4, 2019, 10 a.m. – Noon

This course will cover submitting Pharmacy Prior Approval (PA) requests, 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 Pharmacy PA request.

Submitting Medical Prior Approvals (On-Site)

Tuesday, Mar. 5, 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
- Conduct electronic inquiries about Prior Approvals.

Submitting Professional Claims (On-Site)

Tuesday, Mar. 5, 2019, 1 – 4:30 p.m.

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:

- Enter a professional claim
- Save a draft
- Use claims draft search
- Submit a Professional claim
- View results of a claim submission
- Void and replace paid claims

Provider Re-verification Refresher (Webex)

Thursday, Mar. 7, 2019, 1 – 2:30 p.m.

Wednesday, Mar. 20, 2019, 1 – 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)

Wednesday, Mar. 13, 2019, 9:30 a.m. – Noon

This course will cover submitting Prior Approval requests with a focus on nursing facilities, to help ensure compliance with Medicaid clinical coverage policy and medical necessity, inquiring about those requests to determine their status. After completing this course, authorized users will be able to:

- Submit Prior Approvals
- Inquire about Prior Approvals

Submitting Institutional Claims (On-Site)

Wednesday, Mar. 13, 2019, 1 – 4:30 p.m.

This course will focus on how to submit an institutional claim with emphasis on long-term care and secondary claims. At the end of training, as an authorized user, you will be able do the following:

- Enter an institutional claim
- Save a draft
- Use the claims draft search tool
- Submit a claim
- View results of a claim submission

Provider Web Portal Applications (Webex)

Wednesday, Mar. 20, 2019, 9 a.m. – Noon

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 a change request (MCR), re-enrollment, re-verification and maintain eligibility
- Track and submit applications using the status and management page

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 the URL
<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.

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 Call Center, (800) 688-6696

ATTENTION: ALL PROVIDERS

Proposed Clinical Policies for Public Comment

Proposed new or amended North Carolina 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.

Clinical Policy and Programs, 919-813-5550 / 888-245-0179

ATTENTION: ALL PROVIDERS
Reminder about Drugs Administered by Injection or Infusion

This is a reminder that not all drugs administered by injection or infusion are covered in the Physicians Drug Program (PDP) as a part of the medical benefit. Some of these drugs are only covered in the outpatient pharmacy benefit when requested by [prior authorization \(PA\)](#) and dispensed by a retail or specialty pharmacy. If the drug is not listed on the [PDP Fee Schedule](#), then the drug is not covered in the PDP and medical benefit, and medical claims submitted for these drugs will be denied.

Drugs listed on the PDP fee schedule will be paid only when submitted on a medical CMS 1500/UB-04 claim. The medical provider may bill for the drug product and the administration of the drug in such instances.

Drugs covered only in the pharmacy benefit will be paid only when submitted as a pharmacy point-of-sale claim and when applicable PA criteria has been met. In these cases, physicians’ offices should only bill Medicaid for the administration of the drug product.

Drugs administered by injection or infusion which are currently covered only in the outpatient pharmacy benefit include:

Benlysta	Kevzara
Dupixent	Nucala
Exondys 51	Ocrevus
Fasenra	Renflexis
Haegarda	Xolair

Neuromuscular blocking agents such as (Botox, Dysport, Myobloc and Xeomin) are covered under both the outpatient pharmacy benefit and the PDP. However, the outpatient pharmacy benefit requires PA for all FDA approved indications; the PDP covers these agents for all indications except migraine and urinary incontinence therapy.

GDIT Call Center, (800) 688-6696

ATTENTION: ALL PROVIDERS**Request for Proposal for Independent Assessment Entity for Long-Term Services and Supports**

NC Medicaid has approved the release of a Request for Proposal (RFP) for an independent assessment entity (IAE) that will streamline access to Medicaid Long-Term Services and Supports (LTSS) effective July 2019. The IAE will provide beneficiaries a much-needed single point of entry for accessing Medicaid LTSS services and streamline the processes between initial contact and service enrollment.

The RFP will seek a vendor to conduct intakes, assessments and other screenings to determine eligibility for the following LTSS programs:

- State Plan Personal Care Services (PCS)
- Community Alternatives Program for Children (CAP/C)
- Community Alternatives Program for Disabled Adults (CAP/DA)

In addition, the selected vendor will also provide management and oversight for the **Pre-admission Screening and Resident Review process (PASRR) Level II** and serve as North Carolina's local contact agency (LCA) for nursing home (NH) residents who have requested information about options for less restrictive care settings. The LCA will provide NH residents with options for transitioning from institutional care to community-based living.

NC Medicaid LTSS currently utilizes an IAE, case management entities (CMEs), county departments of social services (DSSs), local management entities/managed care organizations (LME/MCOs) and hospitals to refer and authorize services for the above-mentioned programs. Medicaid is expanding the scope of the current IAE model to create a comprehensive assessment entity as a "single and uniform access point" for potential Medicaid enrollees and their caregivers to determine what services may support them in maintaining independence and stability in their health condition in the least restrictive setting possible.

NC Medicaid plans to initiate the IAE in three phases for each program. The phases are 1) stakeholder/beneficiary training; 2) scheduling; and 3) assessments/interview completion. NC Medicaid is working on a tentative schedule to be released after the RFP posting.

Additional benefits of the implementation of a comprehensive independent assessment entity are improvements in timeliness and overall operational efficiency for all programs. The selected vendor will be required to have customer support service center capacity to direct the public to the appropriate service area and assist with all questions related to their LTSS needs and programs.

NC Medicaid anticipates posting the comprehensive assessment entity RFP in March 2019.

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

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS AND NURSE PRACTITIONERS**Levoleucovorin, for intravenous use (Khapzory™) HCPCS code J3490: Billing Guidelines**

Effective with date of service Dec. 17, 2018, the North Carolina Medicaid and NC Health Choice programs cover levoleucovorin for injection, for intravenous use (Khapzory) for use in the Physician Administered Drug Program when billed with HCPCS code J3490 - Unclassified drugs.

Khapzory is available as 175 mg and 300 mg of levoleucovorin lyophilized powder in a single-dose vial for reconstitution.

It is indicated for:

- Rescue after high-dose methotrexate therapy in patients with osteosarcoma.
- Diminishing the toxicity associated with overdosage of folic acid antagonists or impaired methotrexate elimination.
- Treatment of patients with metastatic colorectal cancer in combination with fluorouracil.

Khapzory is not indicated for the treatment of pernicious anemia and megaloblastic anemia secondary to lack of vitamin B12 because of the risk of progression of neurologic manifestations despite hematologic remission.

Recommended Dose:Rescue After High-Dose Methotrexate Therapy:

- 7.5 mg as an intravenous infusion every six hours
- Dose can be increased up to 75 mg by intravenous infusion every three hours until methotrexate level is less than one micromolar; then 7.5 mg by intravenous infusion every three hours until methotrexate level is less than 0.05 micromolar.
- See package insert for dosage adjustments and duration based on laboratory findings.

Overdosage of Folic Acid Antagonists or Impaired Methotrexate Elimination:

- Administer Khapzory as soon as possible after an overdosage of methotrexate or within 24 hours of methotrexate administration when methotrexate elimination is impaired.
- 7.5 mg as an intravenous infusion every six hours
- Dose can be increased to 50 mg/m² by intravenous infusion every three hours until the methotrexate level is less than 0.05 micromolar.
- See package insert for dosage adjustments and duration based on laboratory findings .

In Combination with Fluorouracil for Metastatic Colorectal Cancer:

- 100 mg/m² by intravenous injection over a minimum of three minutes, followed by fluorouracil at 370 mg/m², once daily for five consecutive days OR 10 mg/m² by intravenous injection, followed by fluorouracil at 425 mg/m² once daily for five consecutive days
- The five-day course may be repeated every four weeks for two courses, then every four to five weeks, if the patient has recovered from toxicity from prior course.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

- The ICD-10-CM diagnosis code(s) required for billing is/are:
 - C18.0 - Malignant neoplasm of cecum;
 - C18.1 - Malignant neoplasm of appendix;
 - C18.2 - Malignant neoplasm of ascending colon;
 - C18.3 - Malignant neoplasm of hepatic flexure;
 - C18.4 - Malignant neoplasm of transverse colon;
 - C18.5 - Malignant neoplasm of splenic flexure;
 - C18.6 - Malignant neoplasm of descending colon;
 - C18.7 - Malignant neoplasm of sigmoid colon;
 - C18.8 - Malignant neoplasm of overlapping sites of colon;
 - C18.9 - Malignant neoplasm of colon, unspecified;
 - C19 - Malignant neoplasm of rectosigmoid junction;
 - C20 - Malignant neoplasm of rectum;
 - T45.1X5 - Adverse effect of antineoplastic and immunosuppressive drugs;
 - T45.1X5A - Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter;
 - T45.1X5D - Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter
- Providers must bill with HCPCS code: J3490 - Unclassified drugs
- One Medicaid and NCHC unit of coverage is: one mg
- The maximum reimbursement rate per unit is: \$4.32
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 68152-0112-01, 68152-0114-01
- 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 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 Administered Drug Program is available on NC Medicaid's [PADP web page](#).

GDIT Call Center, (800) 688-6696

ATTENTION: PHYSICIANS, PHYSICIAN'S ASSISTANTS AND NURSE PRACTITIONERS**Ravulizumab-cwvz injection, for intravenous use (Ultomiris™) HCPCS code J3590: Billing Guidelines**

Effective with date of service Dec. 21, 2018, the North Carolina Medicaid and NC Health Choice programs cover ravulizumab-cwvz injection, for intravenous use (Ultomiris) for use in the Physician Administered Drug Program when billed with HCPCS code J3590 - Unclassified Biologics.

Ultomiris is available as 300 mg/30 mL (10 mg/mL) in a single-dose vial and is indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

Recommended Dose:

- Starting two weeks after the loading dose, begin maintenance doses once every eight weeks.

For patients with a body weight of ≥ 40 kg to < 60 kg:

- 2,400 mg loading dose
- 3,000 mg maintenance dose

For patients with a body weight of ≥ 60 kg to < 100 kg:

- 2,700 mg loading dose
- 3,300 mg maintenance dose

For patients with a body weight ≥ 100 kg:

- 3,000 mg loading dose
- 3,600 mg maintenance dose

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

- The ICD-10-CM diagnosis code required for billing is:
 - D59.5 - Paroxysmal nocturnal hemoglobinuria
- Providers must bill with HCPCS code: J3590 - Unclassified Biologics
- One Medicaid and NC Health Choice unit of coverage is: one mg
- The maximum reimbursement rate per unit is: \$23.06
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 25682-0022-01
- 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 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 Administered Drug Program is available on NC Medicaid's [PADP web page](#).

GDIT Call Center, (800) 688-6696

ATTENTION: COMMUNITY ALTERNATIVE PROGRAM FOR CHILDREN STAKEHOLDERS

NC Medicaid-Enrolled Durable Medical Equipment Providers and Community Alternatives Program for Children Case Management Entities

Revised Effective Jan. 31, 2019: Clinical Coverage Policy 3K-1, Specialized Medical Equipment and Supplies for Adaptive Car Seat and Vehicular Transport Vest

Effective Jan. 31, 2019, NC Medicaid's Community Alternatives Program for Children (CAP/C) approves specialized medical equipment and supplies for an adaptive car seat and a vehicular transport vest for participants in CAP/C when all qualifying conditions are met per the CAP/C Clinical Coverage Policy, 3K-1. The billing procedure code is E0700. This billing procedure code is also used by Durable Medical Equipment (DME) providers.

When a request is approved for an adaptive car seat or a vehicular transport vest through CAP/C, the following requirements must be met for the claim to adjudicate:

1. Have a Managed Change Request (MCR) approved to provide waiver supplies for CAP/C under non-endorsed services for taxonomy 332B00000X. If an MCR is not under your non-endorsed services, you must initiate this process in NCTracks.
2. Have a service authorization from a CAP/C case management entity approving the rendering of an adaptive car seat or a vehicular transport vest by your agency.
3. Have a Prior Approval segment on file in NCTracks authorizing the date of service and reimbursement amount for an adaptive car seat or a vehicular transport vest.
4. Submit the claim using billing procedure code E0700.

GDIT Call Center, (800) 688-6696

ATTENTION: DENTAL PROVIDERS

New American Dental Association Procedure Codes

Effective with date of service Jan. 1, 2019, the following dental procedure codes were added for the NC Medicaid and Health Choice Dental Programs. These additions are a result of the Current Dental Terminology (CDT) 2019 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, Dental Services will be updated to reflect these changes.

CDT 2018 Code	Description and Limitations	PA Indicator
D1516	Space maintainer – fixed – bilateral, maxillary <ul style="list-style-type: none"> • Limited to beneficiaries under age 21 • Limited to replacement of primary molars and canines and permanent first molars • Bill D6985 when appliance is to serve as a fixed pediatric partial denture to replace maxillary anterior teeth • Use the delivery date as date of service when requesting payment • Reimbursement rate – same as D1515 	N
D1517	Space maintainer – fixed – bilateral, mandibular <ul style="list-style-type: none"> • Limited to beneficiaries under age 21 • Limited to replacement of primary molars and canines and permanent first molars • Bill D6985 when appliance is to serve as a fixed pediatric partial denture to replace maxillary anterior teeth • Use the delivery date as date of service when requesting payment • Reimbursement rate – same as D1515 	N
D5876	Add metal substructure to acrylic full denture (per arch) <ul style="list-style-type: none"> • Requires an arch indicator (UP, LO) in the area of oral cavity field • Reimbursement rate – same as D5511 	N
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites <ul style="list-style-type: none"> • Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control • Not for local anesthesia purposes • Allowed once per date of service • Reimbursement rate (to be determined) 	Y

The following procedure code was end-dated effective with date of service December 31, 2018.

Procedure Code	Description
D1515	Space maintainer – fixed – bilateral

The following procedure codes descriptions were revised effective with date of service January 1, 2019.

Procedure Code	Description
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5630	Repair or replace broken retentive/clasping materials – per tooth

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, Dental Services on the NC Medicaid Division of Health Benefits website at <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

NC Medicaid Dental Program, 919-855-4280

ATTENTION: OPTICAL PROVIDERS
Centers for Medicare and Medicaid Services (CMS)
Approved the State Plan Amendment for Adult Optical Services

NC Medicaid received approval from CMS for the State Plan Amendment for Adult Optical Services. Effective Feb. 10, 2019, providers may bill for routine eye exams and visual aids for adult Medicaid beneficiaries with dates of service on or after Jan. 1, 2019.

Providers should refer to Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older for Medicaid guidelines regarding optical services for adult beneficiaries.

For more information, please refer to Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older, at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

GDIT Call Center, (800) 688-6696

ATTENTION: OPTICAL PROVIDERS**Optical Services are Non-Covered for Medicare Qualified Beneficiary (MQB), Family Planning Waiver (MAFD), and Program of All-inclusive Care for the Elderly (PACE)**

Under the MQB Medicare Eligibility Codes, Medicaid pays only for Medicare Part B premiums or premiums, deductibles, and coinsurance for charges covered by Medicare. Routine eye exams, refraction only and visual aids are not covered by Medicare for MQB beneficiaries. Therefore, MQB beneficiaries are not eligible for Medicaid optical services.

Under MAFD and PACE, program specific services are covered. However, optical services are non-covered. Therefore, MAFD and PACE beneficiaries are not eligible for Medicaid optical services.

For more information, please refer to Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older, at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

GDIT Call Center, (800) 688-6696
