



NC Medicaid Bulletin

May 2019

All Providers

Medicare Advantage Plan Pricing Rules	2
Recovery Audit Contractor (RAC)	2
Credit Balance Audits (CBA)	3
Coverage for Psychiatric Collaborative Care Management Reminder.....	4
Clinical Coverage Policy 1K-2, Bone Mass Measurement.....	5
Clinical Coverage Policy Update.....	6
Updates to the NC Medicaid Electronic Health Record (EHR) Incentive Program.....	6

Physicians, Physician Assistants and Nurse Practitioners

Caplacizumab-yhdp for injection, for intravenous or subcutaneous use (Cabliivi ®) HCPCS code J3590: Billing Guidelines.....	8
Dexamethasone intraocular suspension 9%, for intraocular administration (Dexycu™) HCPCS code J1095 – injection, dexamethasone 9%, intraocular, 1 microgram: Billing Guidelines.....	9
Mifepristone tablets, for oral use (Mifeprex®) HCPCS code S0190 and Misoprostol tablets, for oral use (Cytotec®) HCPCS code S0191: Billing Guidelines.....	11

Physician Assistants and Nurse Practitioners

Billing Code Update for Nurse Practitioners and Physician Assistants.....	13
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RB-BHT Providers

CPT Transition Code Information.....	14
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ATTENTION: ALL PROVIDERS**Medicare Advantage Plan Pricing Rules**

This communication serves as an advisory notice for all Providers. The intent is to increase awareness of the Medicare Advantage Plan. The statement below should be used to gain further clarification regarding claims denied for Medicare Part C coverage.

A Medicare Advantage Plan (also known as Medicare Part C or Medicare HMO) is a type of Medicare health plan offered by a private/commercial health insurance company that contracts with Medicare. The Medicare Advantage Plans covers the same services as the Medicare part A or B plan and is subject to the NCTracks Medicare crossover pricing rules. The difference is the Medicare Advantage Plan claims are edited as private/commercial health insurance secondary claims which may differ from the secondary Medicare part A and B claims editing.

NC Medicaid Third-Party Recovery, (919) 527-7690

ATTENTION: ALL PROVIDERS**Recovery Audit Contractor (RAC)**

Health Management System (HMS) is under contract with North Carolina Medicaid as NC Medicaid's Recovery Audit II Contractor (RAC II), pursuant to Section 6411 of the **Patient Protection and Affordable Care Act of 2010**. HMS is authorized to audit provider payments and financial records for claims to identify underpayments and overpayments, and to recover any overpayment made to providers. HMS will support DHB in its efforts to combat abusive, fraudulent or overutilization activities through the provision of a comprehensive RAC program. HMS will ensure that Medicaid dollars are spent appropriately by performing identification, validation, recovery, and cost avoidance services that are in accordance with State restricted reviewed time period limitations.

HMS activities will include but not be limited to the following service types:

- Inpatient hospital
- Outpatient hospital
- Long-term care
 - Skilled nursing facilities
 - Intermediate Care Facilities for persons with Mental Retardation (ICF/MRs)
 - Adult Care Homes
- Laboratory and X-Ray
 - Hospital and free standing
- Specialized outpatient therapies
 - Physical therapy
 - Occupational therapy
 - Respiratory therapy
 - Audiology and speech/language pathology services for all ages

The look-back period for reviewing claims will be no greater than three (3) years from the date of the onset of the review. HMS will use generally accepted and valid auditing, accounting, analytical, statistical and peer-review methods.

Pursuant to 42 CFR 433 Subpart F, the Division of Health Benefits (DHB) must recover or attempt to recover any overpayments made to Medicaid providers to receive full federal financial participation for the NC Medicaid Program. Within thirty (30) days from the date an overpayment becomes final pursuant to N.C.G.S. §108C-2(5), money owed to Medicaid will automatically be recovered from future payment(s).

Any communication about a RAC audit matter should be with HMS or the Division of Health Benefits. Do not, under any circumstances, request the fiscal agent GDIT (NC Tracks) to adjust for the amount or items identified during an audit, as this could result in duplicate recoupment.

If you have questions about this notice, please contact the RAC team at HMS Provider Services toll free at (855) 438- 6415, fax to (855) 278-3489 or email at NCRACII@hms.com. You may also call the Division of Health Benefits Office of Compliance and Program Integrity at (919) 527-7700.

ATTENTION: ALL PROVIDERS

Credit Balance Audits (CBA)

North Carolina's Department of Health and Human Services, Division of Health Benefits (DHB) has contracted with Health Management Systems (HMS) to conduct Overpayment Recovery Reviews for Medicaid/Health Choice recipients.

Pursuant to SEC. 1866 [42 U.S.C. 1395cc] providers are required to make adequate provision for return of any moneys incorrectly collected from such individual or other person.

DHB's objective is to identify and recover overpayments determined to be refundable to the Medicaid/Health Choice programs.

Definition of a Medicaid Overpayment

A Medicaid overpayment is a payment you receive in excess of the amounts properly payable under Medicaid statutes and regulations. Once Medicaid, the recovery vendor or the provider identifies an overpayment, the overpayment amount becomes a debt you owe to the N.C. Medicaid program. Federal law requires states timely attempt recovery of all identified overpayments.

In Medicaid, overpayments commonly occur due to:

- Duplicate submission of the same service or claim;
- Furnishing and billing for excessive or non-covered services; or
- Payment to the incorrect payee.

Overpayment Collection Process

When Medicaid discovers an overpayment, the Medicaid Administrative Contractor, Health Management Systems (HMS) initiates the overpayment recovery process by sending notification to the provider via the HMS Provider Portal. The provider has 30 days to dispute or issue payment for the overpayment. If payment or dispute is not received in 30 days, then the Contractor will adjust the claim(s) to recover the overpayment on the provider's account.

We prefer that a provider submit adjusted claims to return the overpayment to the State; however, if an adjusted or voided claim cannot be submitted electronically we will accept payment via a physical check.

Please follow the NCTracks Provider refund form instructions found at the following website:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

If you have questions, please contact the Credit Balance Audit team, Michael Flynn at 919-909-5339 or by email at Michael.flynn@hms.com.

NC Medicaid Third Party Recovery, (919) 527-7690

ATTENTION: ALL PROVIDERS

Coverage for Psychiatric Collaborative Care Management Reminder

Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting. These services are rendered when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning and provision of brief interventions. These beneficiaries may require assistance engaging in treatment or further assessment prior to being referred to a psychiatric care setting.

The following psychiatric collaborative care management codes may only be billed by the primary care provider directing the service; they may not be billed by the behavioral health care manager or the psychiatric consultant:

- **99492** – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- **99493** – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
- **99494** – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Additional Billing Guidelines

- Evaluation and management (E/M) and other services may be reported separately by the same physician or NPP during the same calendar month.

- If the treating physician or NPP personally performs behavioral health care manager activities and those activities are not used to meet criteria for a separately reported service, his or her time may be counted toward the required behavioral health care manager time to meet the elements of 99492, 99493, or 99494.
- The behavioral health care manager may report separate services such as therapy, psychiatric evaluation, tobacco cessation, or substance use services during the same calendar month. Activities for separately reported services are not included in the time applied to psychiatric collaborative care management.
- Behavioral health care manager time spent coordinating care with the emergency department may be reported using 99492, 99493, or 99494, but time while the beneficiary is inpatient or admitted to observation status may not be reported using psychiatric collaborative care management codes.
- The psychiatric consultant may provide services such as E/M services and psychiatric evaluations and these services may be separately reported. Activities for services separately reported are not included in the reporting of psychiatric collaborative care management.
- Behavioral health care managers and psychiatric consultants who prescribe medication or make direct referrals for Medicaid beneficiaries must be actively enrolled in NC Medicaid. If they bill for separately reimbursable services, they must be enrolled with a behavioral health Local Management Entity /Managed Care Organization for billing.

Refer to the 2018 Current Procedural Terminology (CPT) manual, published by The American Medical Association (AMA) for more information regarding psychiatric collaborative care management codes and requirements.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS

Clinical Coverage Policy 1K-2, Bone Mass Measurement

Bone Mass Measurement policy has been updated to reflect the addition of anorexia nervosa as an approved diagnosis for beneficiaries with other conditions or currently receiving medical therapies known to cause low bone mass.

NC Medicaid has added the following ICD 10 diagnosis codes to the policy for procedures on bone mass measurement for dates of service on or after May 1, 2019.

- F50.0 – Anorexia nervosa
- F50.01 – Anorexia nervosa, restricting type
- F50.02 – Anorexia nervosa, binge eating/purging type

Refer to policy Section 5.1 for prior approval requirements.

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

ATTENTION: ALL PROVIDERS

Clinical Coverage Policy Update

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

- 1H, Telemedicine and Telepsychiatry – 04-15-2019
- 10A, Outpatient Specialized Therapies – 04-15-2019
- 1K-2, Bone Mass Measurement – 05-01-2019

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 and Programs, (919) 813-5550 / (888) 245-0179

ATTENTION: ALL PROVIDERS

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

Program Year 2018 is now closed

The NC Medicaid EHR Incentive Program is no longer accepting Program Year 2018 attestations.

Program Year 2018 attestations are being processed in the order they were received.

Attestations received in April may take up to eight weeks to be processed from the date the signed attestation was received.

Eligible professionals (EP) may check the status of their attestation at any time on the Status Page on the NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)).

NC-MIPS is Open for Program Year 2019

[NC-MIPS](#) is currently accepting Program Year 2019 Stage 3 Meaningful Use (MU) attestations.

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

In Program Year 2019, EPs may continue to use a 90-day MU reporting period. The MU reporting period must be from calendar year 2019 and will be any continuous 90-day period in which an EP successfully demonstrates MU of certified EHR technology.

EPs who were paid for Program Year 2018 using a 90-day patient volume reporting period from calendar year 2018, have the option to use the same patient volume reporting period to attest for Program Year 2019.

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

The Two-Part Attestation Process

All EPs who have 90 days of MU objective data that meets CMS' requirements may submit their demographic, license, patient volume and MU objective data in NC-MIPS beginning **May 1, 2019**.

In Program Year 2019, EPs who have successfully attested to MU in a previous program year will be required to use a full calendar year clinical quality measure (CQM) reporting period. Returning meaningful users who would like an early review of requirements, excluding CQMs, may submit their attestation in two parts. Part 1 of the attestation may be submitted **now** through Dec. 31, 2019.

The two-part attestation 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. Submitting in two parts also allows ample time for EPs to address any attestation discrepancies. These EPs will return to NC-MIPS after Jan. 1, 2020 to submit their CQM data.

EPs who have only attested to adopt, implement, upgrade (AIU), may use a 90-day CQM reporting period and may submit a complete attestation in NC-MIPS beginning May 1, 2019.

EPs who attested in NC-MIPS in a previous year will be automatically directed to the appropriate page in NC-MIPS.

For more information on the two-part attestation process, please email NCMedicaid.HIT@dhhs.nc.gov.

Program Year 2019 Clinical Quality Measures

EPs are required to report on **six** of 50 CQMs. New in Program Year 2019, CMS is encouraging EPs to report at least one outcome measure and one high priority measure. If any outcome or high priority CQMs are relevant to the EP's scope of practice, those should be reported first. If there are no outcome and/or high priority CQMs that are relevant to the EP's scope of practice, the EP may choose to report on any other six CQMs.

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

General Reminders

EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting with North Carolina for Program Year 2019.

For those practices unsure if a new provider may participate in the NC Medicaid EHR Incentive Program in Program Year 2019, please email the EP's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the provider previously attested with another practice.

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

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Caplacizumab-yhdp for injection, for intravenous or subcutaneous use (Cablivi®) HCPCS code J3590: Billing Guidelines

Effective Feb. 25, 2019, the North Carolina Medicaid and NC Health Choice programs cover caplacizumab-yhdp for injection, for intravenous or subcutaneous use (Cablivi) for use in the Physician Administered Drug Program when billed with HCPCS code J3590 - Unclassified biologics.

Cablivi is available as 11 mg of lyophilized powder in a single-dose vial kit for injection. It is indicated for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.

Cablivi should be administered upon the initiation of plasma exchange therapy. The recommended dose of Cablivi is as follows:

- First day of treatment: 11 mg bolus intravenous injection at least 15 minutes prior to plasma exchange followed by an 11 mg subcutaneous injection after completion of plasma exchange on day 1.
- Subsequent treatment during daily plasma exchange: 11 mg subcutaneous injection once daily following plasma exchange.
- Treatment after the plasma exchange period: 11 mg subcutaneous injection once daily for 30 days beyond the last plasma exchange.
- If after initial treatment course, sign(s) of persistent underlying disease such as suppressed ADAMTS13 activity levels remain present, treatment may be extended for a maximum of 28 days.
- Discontinue Cablivi if the patient experiences more than 2 recurrences of aTTP, while on Cablivi.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

- The ICD-10-CM diagnosis code required for billing is: M31.1 - Thrombotic microangiopathy
- Providers must bill with HCPCS code: J3590 - Unclassified biologics
- One Medicaid and NC Health Choice unit of coverage is: 11 mg (1 kit)
- The maximum reimbursement rate per unit is: \$7,884.00
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 58468-0225-01
- 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 9B](#), Attachment A, H.7 on the DHB 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 the DHB [PADP web page](#).

GDIT, (800) 688-6696

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS**Dexamethasone intraocular suspension 9%, for intraocular administration (Dexycu™) HCPCS code J1095 - injection, dexamethasone 9%, intraocular, 1 microgram: Billing Guidelines**

Effective March 1, 2019, the North Carolina Medicaid and NC Health Choice programs cover dexamethasone intraocular suspension 9%, for intraocular administration (Dexycu) for use in the Physician Administered Drug Program when billed with HCPCS code J1095 - Injection, dexamethasone 9%, intraocular, 1 microgram.

Dexycu is available as an intraocular suspension: 9% equivalent to dexamethasone 103.4 mg/mL in a single-dose vial provided in a kit. It is indicated for the treatment of postoperative inflammation.

Administer 0.005 mL of Dexycu into the posterior chamber inferiorly behind the iris at the end of ocular surgery.

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: H20.041 - Secondary noninfectious iridocyclitis, right eye; H20.042 - Secondary noninfectious iridocyclitis, left eye; H20.043 - Secondary noninfectious iridocyclitis, bilateral; H20.049 - Secondary noninfectious iridocyclitis, unspecified eye; H44.001 - Unspecified purulent endophthalmitis, right eye; H44.002 - Unspecified purulent endophthalmitis, left eye; H44.003 - Unspecified purulent endophthalmitis, bilateral; H44.009 - Unspecified purulent endophthalmitis, unspecified eye; H44.131 - Sympathetic uveitis, right eye; H44.132 - Sympathetic uveitis, left eye; H44.133 - Sympathetic uveitis, bilateral; H44.139 - Sympathetic uveitis, unspecified eye; H44.19 - Other endophthalmitis; H59.091 - Other disorders of the right eye following cataract surgery; H59.092 - Other disorders of the left eye following cataract surgery; H59.093 - Other disorders of the eye following cataract surgery, bilateral; H59.099 - Other disorders of unspecified eye following cataract surgery
- Providers must bill with HCPCS code: J1095 - Injection, dexamethasone 9%, intraocular, 1 microgram
- One Medicaid and NC Health Choice unit of coverage is: 1 microgram
- The maximum reimbursement rate per unit is: \$1.24
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 71879-0001-01
- 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 1B](#), Attachment A, H.7 on DHB'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 DHB's [PADP web page](#).

GDIT, (800) 688-6696

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Mifepristone tablets, for oral use (Mifeprex®) HCPCS code S0190 and Misoprostol tablets, for oral use (Cytotec®) HCPCS code S0191: Billing Guidelines

The Food and Drug Administration (FDA) previously approved a Risk Evaluation and Mitigation Strategies (REMS) for Mifeprex (mifepristone) to mitigate the risk of serious adverse events. After reviewing the supplemental application, the FDA determined that a [REMS](#) is necessary to ensure the safe use of Mifeprex. Under the REMS:

- Mifeprex must be ordered, prescribed and dispensed by or under the supervision of a healthcare provider who prescribes and who meets certain qualifications;
- Healthcare providers who wish to prescribe Mifeprex must complete a Prescriber Agreement Form prior to ordering and dispensing Mifeprex;
- Mifeprex may only be dispensed in clinics, medical offices, and hospitals by or under the supervision of a certified healthcare provider;
- The healthcare provider must obtain a signed Patient Agreement Form before dispensing Mifeprex.

Healthcare providers who prescribe Mifeprex are required under FDA regulations to provide the patient with a copy of the Mifeprex Medication Guide (FDA-approved information for patients).

Providers must follow the guidelines in Clinical Policy 1E-2.

Since the FDA requires Mifeprex to only be dispensed in clinics, medical offices, and hospitals, the North Carolina Medicaid and NC Health Choice programs will add coverage of mifepristone tablets, for oral use (Mifeprex) in the Physician Administered Drug Program effective Feb. 1, 2019 when billed with HCPCS code S0190 - Mifepristone, oral, 200 mg.

Additionally, since Cytotec (misoprostol) 200 mcg is indicated, in a regimen with mifepristone, the Medicaid and NC Health Choice programs will also add coverage of misoprostol tablets, for oral use (Cytotec) for use in the Physician Administered Drug Program when billed with HCPCS code S0191 - Misoprostol, oral, 200 mcg.

Mifeprex is available as tablets containing 200 mg of mifepristone each, supplied as 1 tablet on one blister card. It is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.

Recommended Dose:

- Day 1: Mifeprex 200 mg orally in a single dose
- Day 2 or 3: Misoprostol 800 mcg (four 200 mcg tablets) buccally
- Minimum interval between Mifeprex and misoprostol is 24 hours.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing of Mifepristone

- The ICD-10-CM diagnosis code required for billing is: Z33.1 Pregnant State, incidental
- Providers must bill HCPCS code: S0190 - Mifepristone, oral, 200 mg as the primary code in conjunction with HCPCS code: S0191 - Misoprostol, oral, 200 mcg as secondary. S0190 and S0191 should be billed on the same claim form in the order in which they are administered.
- One Medicaid and NC Health Choice unit of coverage is: 200 mg
- The maximum reimbursement rate per unit is: \$73.80
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 64875-0001-01
- 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 on the DHBs 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 the DHB [PADP web page](#).

Misoprostol is available as a 200 mcg tablet and is indicated, in a regimen with mifepristone, for the medical termination of intrauterine pregnancy through 70 days gestation.

Recommended Dose:

- Day 1: Mifeprex (mifepristone) 200 mg orally in a single dose
- Day 2 or 3: Misoprostol 800 mcg (four 200 mcg tablets) buccally
- Minimum interval between Mifeprex and misoprostol is 24 hours.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing of Misoprostol

- The ICD-10-CM diagnosis code required for billing is: Z33.1 Pregnant State, incidental
- Providers must bill HCPCS code S0191 Misoprostol, oral, 200 mcg as the secondary code in conjunction with HCPCS code: S0190 - Mifepristone, oral, 200 mg as primary. S0190 and S0191 must be billed on the same claim form in the order in which they are administered.
- One Medicaid and NC Health Choice unit of coverage is: 200 mcg
- The maximum reimbursement rate per unit is: \$0.98
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 00025-1461-31, 00025-1461-34, 00025-1461-60, 63704-0008-01, 59762-5008-01, 59762-5008-02, 43386-0161-01, 43386-0161-06, 68084-0041-01, 68084-0041-11, 00172-4431-49, 00172-4431-60
- 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 on the DHB 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 the DHB [PADP web page](#).

GDIT, (800) 688-6696

**ATTENTION: NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS
Billing Code Update for Nurse Practitioners and Physician Assistants**

NC Medicaid has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

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

32220 (A)	32854 (A)	33411 (A)	33416 (A)
33426 (A)	33476 (A)	33606 (A)	33619 (A)
33690 (A)	33694 (A)	33724 (A)	33767 (A)
33802 (A)	33920 (A)	33979 (A)	34201 (A)
34203 (A)	35570 (A)	38381 (A)	50435
50435 (B)	60240 (A)	60500 (A)	60512 (A)
60520 (A)			

* Codes marked with an (A) were updated for modifiers 80 and 82

* Codes marked with a (B) were updated for modifier 59

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

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

(MP 19.162, MP 19.167, MP 19.170, MP 19.176)

GDIT, (800) 688-6696

ATTENTION: RB-BHT Providers

CPT Transition Code Information

NC Medicaid has adopted the American Medical Association's new Current Procedural Terminology® (CPT) Category I codes for Research Based Behavioral Health Treatment, effective for dates of service on or after Jan. 1, 2019.

Category III to Category I CPT Code Transition Information

Authorizations

Providers will not need a new authorization from NC Medicaid or their LME/MCO as a result of the transition from Category III CPT codes to Category I codes. Existing (current) authorizations issued by Medicaid or the LME/MCOs remain valid. Please do not submit requests to NC Medicaid or the LME/MCOs asking for existing authorizations to be converted to Category I codes.

Updates to Existing Authorizations

Effective April 1, 2019, NC Medicaid is converting existing authorizations from Category III to Category I codes. If the care started prior to Jan. 1, 2019, authorized Category III codes will be end dated Dec. 31, 2018. The new Category I codes will start Jan.1, 2019, and remain valid through the current authorization period.

- NC Medicaid will include the additional 16 units per month of 97155 through the end of the current authorization period on all applicable authorizations.

All requests for services (initial and ongoing) submitted on or after April 1, 2019 must specify Category I codes/units. NC Medicaid will only authorize to what is documented in the treatment plan. Please update any treatment plan templates to ensure all recommendations are listed in units, not hours. RB-BHT treatment plans submitted after April 1, 2019, without Category I codes/units will not be approved and an updated treatment plan will be requested.

To convert approved Category III codes/units to Category I codes/units for dates of service on or after Jan. 1, 2019, please use the following conversions. Additional information on descriptions, billing increments, medically unlikely edits (daily limits), restrictions, and exclusions can be found below.

Category III Code	Units Approved	Category I Code	Units Converted	Notes
0359T	1 unit	97151	8 units	untimed to timed
0360T/0361T	1 unit	97152	2 units	
0364T/0365T	1 unit	97153	2 units	
0366T/0367T	1 unit	97154	2 units	
0368T/0369T	1 unit	97155	2 units + 16 units	4 hours/16 units per month added for program modification (for current authorizations issued prior to Jan. 1, 2019)*
0370T	1 unit	97156	4 units	untimed to timed**
0371T	1 unit	97157	4 units	untimed to timed

*RB-BHT providers must complete an individualized clinical evaluation in order to determine the number of units needed for program modification for each beneficiary. For current authorizations issued prior to Jan. 1, 2019, NC Medicaid has determined RB-BHT providers should receive an additional four hours (16 units) per month of 97155 program modification hours in addition to what is currently approved under 0368T/0369T, through the end of the current authorization period.

The additional 16 units per month will allow RB-BHT providers to evaluate the tasks permitted under 97155 and the needs of the beneficiary prior to the next authorization

period. At the next authorization period, RB-BHT providers who want to modify their recommended number of units for 97155 should update the treatment plan and include the clinical justification for the modification. The recommended number of units for program modification should be based on an evaluation of a variety of factors including, but not limited to, the intensity of the program, presence of behavior excesses and management of behavior intervention plans, the acquisition rate, frequency and rate of modifications to maintain progress, and the level of modeling to the behavior technician and/or parents.

****RB-BHT providers who need to adjust the number of units approved for 97156 and 97157 to align with parent training hours can submit a new request for ongoing services. Please include an updated treatment plan with the modified quantities of units for 97156 and 97157 along with an explanation of the change with the request.**

Claims

All claims for RB-BHT services rendered on or after April 1, 2019, must include Category I CPT codes. Claims will be processed based on the conversion table above.

Continue to bill using Category III codes for ABA services rendered prior to Jan. 1, 2019.

RB-BHT Billing Codes

Weekly units: The weekly units authorized for 97153 cannot be rolled over to other weeks. The week is defined as Sunday to Saturday.

Monthly units: The monthly units authorized for 97155 and 97156 cannot be rolled over to other months. The month is from the first day of the approved authorization through the end date of that initial month. Then each month afterward is based on the calendar month. For example, if the authorization starts Feb. 10, 2019, then the first month is Feb. 10–Feb. 28, 2019 and the second month is March 1–March 31, 2019.

Category I CPT Code Billing Reminders

Concurrent billing: Concurrent billing is excluded for all RB-BHT Category I CPT codes except when the family and the beneficiary are receiving separate services and the beneficiary is not present in the family session. The correct rendering provider must be identified in Box 24J on the claim form. Medical documentation should clearly identify who was present during the session, including all providers, the beneficiary and parents/caregivers, when applicable.

- *97153 and 97155:* Concurrent billing is not permitted. Only one code should be billed when concurrent care services are performed.
- *97153 and 97156:* Concurrent billing is permitted if the behavior health technician is working with the beneficiary (97153) and the Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) is conducting parent training (97156) and the beneficiary is not present.

- *97155 and 97156*: Concurrent billing is permitted if the Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) is working with the beneficiary (97155) with or without the behavior health technician present and a different Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) is conducting parent training (97156), and the beneficiary is not present.
- *97151 and 91753, 97155, 97156*: Concurrent billing is permitted if the Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) is completing an element of the assessment (for example, direct time, report writing) under 97151 and a different Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) or behavioral health technician is rendering 97153, 97155 or 97156. The beneficiary can only be present for one code.

Team Meetings: Team meetings are not reimbursable. Please note, that 97155 is not reimbursable for team meetings conducted with school personnel, including attendance at IEPs. This applies to all beneficiaries including those who are approved to receive services in the school setting.

Program Modification vs. Supervision: 97155 covers adaptive behavior treatment with protocol modification where the Licensed Qualified Autism Professional (LQASP) or Certified Autism Professional (C-QP) resolves one or more problems with the protocol (for example, evaluating progress, progressing programs, modeling modifications, probing skills). As of Jan. 1, 2019, supervision of the assistant behavior analyst and behavior technician, such as treatment fidelity checks and feedback, is not covered. The oversight and supervision of behavior technicians and is required as clinically appropriate and in accordance with the Behavior Analyst Certification Board guidelines and ethics but are not billable.

Reimbursement Rates

CPT CODE	Units	Rates
97151	15 Minutes	53.13
97152	15 Minutes	107.29
97153	15 Minutes	36.17
97154	15 Minutes	19.75
97155	15 Minutes	56.00
97156	15 Minutes	41.20
97157	15 Minutes	20.00

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