



NC Medicaid Bulletin

July 2019

All Providers

Approved PHP Provider Contract Templates as of June 21, 2019	2
Updates to NC Medicaid Electronic Health Record (EHR) Incentive Program	4
Clinical Coverage Policy Update	5
NCTracks Provider Training Available in July 2019	6

Physicians, Physician Assistants and Nurse Practitioners

North Carolina Medicaid and NC Health Choice Preferred Drug List (PDL) Changes	8
Coagulation factor Xa (recombinant), inactivated-zhzo lyophilized powder for solution for intravenous injection (Andexxa®) HCPCS code J3590: Billing Guidelines	14
Romosozumab-aqqg injection, for subcutaneous use (Evenity™) HCPCS code J3590: Billing Guidelines	15
Trastuzumab and hyaluronidase-oysk injection, for subcutaneous use (Herceptin Hylecta™) HCPCS code J9999: Billing Guidelines	17

Specialized Therapies Providers

Updates to Clinical Coverage Policy 10B: Independent Practitioners	19
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Hospice Providers

Reminders on Hospice Policy	22
Hospice Payment Reform Update	23

ATTENTION: ALL PROVIDERS
Approved PHP Provider Contract Templates as of June 21, 2019

The Contract for Prepaid Health Plan Services (the State Contract) between the Department of Health and Human Services (the Department) and the selected Medicaid Managed Care plans (i.e., Prepaid Health Plans or PHPs) indicates that contracts between PHPs and providers shall comply with the terms of the State Contract and must be approved by the Department.

The Department announces the approval of the following provider contract templates:

PHP Name	Contract/Document Name	Date of Approval
United HealthCare of North Carolina, Inc.	Ancillary Provider Participation Agreement	6/21/19
United HealthCare of North Carolina, Inc.	Facility Participation Agreement	6/21/19
United HealthCare of North Carolina, Inc.	[FQHC]/[RHC]/[IHCP] Participation Agreement	6/21/19
United HealthCare of North Carolina, Inc.	Medical Group Participation Agreement - Medicaid Only Option	6/21/19
United HealthCare of North Carolina, Inc.	Facility Participation Agreement - Medicaid Only Option	6/21/19
United HealthCare of North Carolina, Inc.	Single Practitioner Participation Agreement - Medicaid Only Option	6/21/19
United HealthCare of North Carolina, Inc.	Small Medical Group Participation Agreement	6/20/19
United HealthCare of North Carolina, Inc.	Provider Organization Participation Opt In Agreement	6/20/19
United HealthCare of North Carolina, Inc.	Provider Organization Participation Agreement	6/20/19
United HealthCare of North Carolina, Inc.	Single Physician/Practitioner Participation Agreement	6/20/19
United HealthCare of North Carolina, Inc.	Practitioner Group Participation Agreement	6/20/19
United HealthCare of North Carolina, Inc.	Medical Group Participation Agreement	6/20/19
AmeriHealth Caritas North Carolina, Inc.	Health System Provider Agreement	6/19/19
Carolina Complete Health, Inc.	Participating Provider Agreement for Individual Practitioner	6/17/19
WellCare of North Carolina, Inc.	Participating Provider Agreement - IHCP	6/14/19

PHP Name	Contract/Document Name	Date of Approval
AmeriHealth Caritas North Carolina, Inc.	Ancillary Services Agreement	6/10/19
WellCare of North Carolina, Inc.	Participating Provider Agreement – AMH	6/10/19
WellCare of North Carolina, Inc.	Participating Provider Agreement – LHD	6/10/19
AmeriHealth Caritas North Carolina, Inc.	Hospital Services Agreement	6/4/19
AmeriHealth Caritas North Carolina, Inc.	Physician Provider Agreement	6/4/19
AmeriHealth Caritas North Carolina, Inc.	Provider Agreement Addendum - Tier 3 AMH	6/4/19
AmeriHealth Caritas North Carolina, Inc.	Provider Agreement Addendum - LHD CM for At-Risk Children	6/4/19
AmeriHealth Caritas North Carolina, Inc.	Provider Agreement Addendum - LHD CM for High-Risk Pregnancy	6/4/19
WellCare of North Carolina, Inc.	Participating Provider Agreement for Facility Providers	6/4/19
WellCare of North Carolina, Inc.	Services Agreement - Home and Community Based Services	6/4/19
WellCare of North Carolina, Inc.	Participating Provider Agreement - Provider System	6/4/19
WellCare of North Carolina, Inc.	Participating Provider Agreement - Hospital	6/4/19
WellCare of North Carolina, Inc.	Participating Provider Agreement - Professional	6/4/19
Blue Cross Blue Shield of North Carolina/Healthy Blue	Medicaid Provider Agreement for all provider types	5/29/19
Carolina Complete Health, Inc.	Participating Provider Agreement for Facility Providers	5/29/19

The Department is continuing to review other Provider contracts for PHPs. As the Department approves other provider contract templates, the Department will update this list and issue updated notices.

PHPs are permitted to utilize draft Provider contract templates until the Department approves the templates. Providers who are considering contracting with a PHP or who are in contract negotiations with a PHP should discuss with the PHP how to access the approved contract templates.

Providers wishing to discuss contracting with a PHP or obtain a copy of an approved contract template will find contact information for the PHPs here:

<https://medicaid.ncdhhs.gov/health-plan-contact-information>

In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the State Contract, a PHP shall not exclude eligible providers from its

network except when a provider fails to meet the PHP's Objective Quality Standards or refuses to accept network rates (which shall not be lower than any applicable rate floors).

Medicaid.Transformation@dhhs.nc.gov

ATTENTION: ALL PROVIDERS

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

NC-MIPS is Open for Program Year 2019

The NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)) is only accepting Program Year 2019 Stage 3 Meaningful Use (MU) attestations.

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

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 CEHRT.

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 EP specification sheets](#).

Program Year 2019 Webinar Series

The NC Medicaid EHR Incentive Program's webinar series has been updated to reflect the rules and regulations for Program Year 2019.

The webinars are designed with the busy provider in mind, so most of them are less than five minutes long. Each short webinar explains a different piece of the attestation process such as updating a CEHRT number, updating a username in NC-MIPS, and submitting an attestation.

Other webinar topics include patient volume, auditing, MU, clinical quality measures (CQM) in Program Year 2019 and more. These webinars can be found on the Resources and Webinars tab of the [program website](#).

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 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 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 will not be required to sign or email any documentation for Part 1. The signed attestation packet will be emailed only once – after submission of CQMs in Jan. 2020.

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 CQMs

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 CQMs 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: 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/>:

- 8A, Enhanced Mental Health and Substance Abuse Services (Multisystemic Therapy) – 06/15/2019
- 8A-6 Community support Team – 07/1/2019
- 9A, Over-The-Counter Products – 07/1/2019
- 1C-1, Podiatry Services – 07/1/2019
- 8A, Enhanced Mental Health and Substance Abuse Services (Diagnostic Assessment) – 07/1/2019
- 1A-39, Clinical Trial Services for Life Threatening Conditions – 07/1/2019

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 and Programs, (919) 527-7660

ATTENTION: ALL PROVIDERS

NCTracks Provider Training Available in July

Registration is open for the July 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 GDIT/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)

July 8, 2019 1 - 4 p.m.

July 16, 2019 1 - 4 p.m.

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

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal
- 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.

Submitting Institutional Prior Approvals (On-site)

July 9, 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 includes hands-on training.

Submitting Institutional Claims (On-site)

July 9, 2019 1 – 4 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.

Submitting Professional Claims (On-site)

July 10, 2019 1 – 4 p.m.

This course will focus on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to enter a professional claim, save a draft claim, use the Claims Draft Search tool, submit a claim, and view the results of a claim submission. The course includes hands-on training.

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

July 18, 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 Professional Claims – NEMT (WebEx)

July 22, 2019 9 a.m. – noon

This course will review the process of submitting Non-Emergency Medical Transportation (NEMT) claims through NCTracks. At the end of training, users will be able to:

- Understand Claims Terminology
- Create a Professional Claim via NCTracks
- Save a Draft
- Use Claims Draft Search
- Submit a Claim
- View Results of a Claim Submission
- Claim Status and Claim Copy

- Resubmit a Claim
- Void Prior Claim or Replacement Prior Claims
- Understand How to Read a Remittance Advice
- Prior Authorization Inquiry

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.

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

North Carolina Medicaid and NC Health Choice Preferred Drug List (PDL) Changes

Effective July 1, 2019, NC Medicaid will make changes to the [North Carolina Medicaid and NC Health Choice Preferred Drug List](#).

Below is a quick summary (not a complete exhaustive list) of the changes.

ANALGESICS (OPIOID ANALGESIC, LONG ACTING)

- Move tramadol ER tablet to Long Acting Opioid analgesic category (from short acting)
- Move tramadol ER tablet to Preferred status from Non-Preferred

ANALGESICS (SHORT ACTING SCHEDULE II OPIOIDS)

- Add Apadaz™ tablet to Non-Preferred status

- Add Oxaydo[®] tablet to Non-Preferred status

ANALGESICS (SHORT ACTING SCHEDULE III-IV OPIOIDS / ANALGESIC COMBINATIONS)

- Move tramadol ER tablet to Long Acting opioid analgesic category and move to Preferred status
- Move Conzip[®] capsule to Long Acting opioid analgesic category and leave it as a Non-Preferred product

ANALGESICS (NEUROPATHIC PAIN)

- Add ZTLido[™] to Non-Preferred status with clinical criteria

ANTICONVULSANTS (SECOND GENERATION)

- Add clobazam suspension / tablet to Non-Preferred status
- Add Epidiolex[®] solution to Non-Preferred status with an exception made for children ≥ 2 years old with Lennox-Gastaut Syndrome or Dravet Syndrome

ANTI-INFECTIVES (NITROMIDAZOLES)

- Add Firvanq[™] to Non-Preferred status

ANTI-INFECTIVES (TETRACYCLINE DERIVATIVES)

- Add Minocin[®] to Non-Preferred status
- Add Nuzyra[™] to Non-Preferred status

ANTI-INFECTIVES (ANTIFUNGALS)

- Add Tolsura[™] capsule to Non-Preferred status

ANTI-INFECTIVES - ANTIVIRALS (HEPATITIS B AGENTS)

- Move Epivir[®] HBV Tablet / Solution to Non-Preferred status from Preferred status
- Move lamivudine HBV tablet (generic for Epivir[®] HBV) to Preferred status from Non-Preferred status

ANTI-INFECTIVES - ANTIVIRALS (HEPATITIS C AGENTS)

- Add sofosbuvir-velpatasvir tablet (generic of Epclusa[®] tablet) to Preferred status for recipients with Hepatitis C, all genotypes with decompensated cirrhosis. Note that the same clinical criteria as branded Epclusa[®] tablet will apply to this product.
- Move Epclusa[®] tablet to Non-Preferred status from Preferred status
- Add ledipasvir-sofosbuvir (generic for Harvoni Epclusa[®] tablet tablet) to Non-Preferred status. The same clinical criteria as branded Harvoni apply to this generic version.

ANTI-INFECTIVES - ANTIVIRALS (INFLUENZA)

- Remove amantadine capsule / solution (generic for Symmetrel[®]) from this PDL category
- Add Xofluza[™] to Non-Preferred status

ANTI-INFECTIVES (INHALED ANTIBIOTICS)

- Add Arikayce[®] to Non-Preferred status

BEHAVIORAL HEALTH (ANTIHYPERKINESIS/ADHD)

- Move clonidine ER tablet to Preferred status from Non-Preferred status. This move was made on 1/28/2019 due to recipient access issues from Kapvay[®] becoming a CMS non-rebateable product.
- Move Dyanavel[®] XR suspension to Preferred status from Non-Preferred status

BEHAVIORAL HEALTH (ATYPICAL ANTIPSYCHOTICS- INJECTABLE LONG ACTING)

- Add Aristada[®] Initio[™] syringe to Preferred status
- Move Perseris[®] syringe to Preferred status from Non-Preferred status

BEHAVIORAL HEALTH (ATYPICAL ANTIPSYCHOTICS – ORAL)

- Add Abilify[®] MyCite[®] to Non-Preferred status

CARDIOVASCULAR (ANGIOTENSIN II RECEPTOR BLOCKER COMBINATIONS)

- Move Exforge[®] HCT to Non-Preferred status from Preferred status
- Move amlodipine/valsartan/HCTZ tablet (generic for Exforge[®] HCT) to Preferred status from Non-Preferred status
- Move Exforge[®] to Non-Preferred status from Preferred status

CARDIOVASCULAR (ANTI-ARRHYTHMICS)

- Move dofetilide capsule (generic for Tikosyn[®] capsule) to Preferred status from Non-Preferred status

CARDIOVASCULAR (BETA BLOCKERS)

- Add Tenormin[®] to Non-Preferred status
- Add Kapsargo[™] Sprinkle to Non-Preferred status, with an exemption for children < 12 years of age

CARDIOVASCULAR (BILE ACID SEQUESTRANTS)

- Add colestevlam packet / tablet (generic for Welchol[®]) to Non-Preferred status

CARDIOVASCULAR (DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS)

- Move nifedipine ER tablet (generic for Adalat CC[®] / Procardia XL[®]) to Preferred status from Non-Preferred status. This move was made 12/14/2018 due to product discontinuation of Afeditab CR[®] and Nifedical XL[®].

CENTRAL NERVOUS SYSTEM (ANTIMIGRAINE AGENTS - CGRP BLOCKERS/MODULATORS)

- Add CGRP Blockers/Modulators as a new PDL subcategory under Antimigraine Agents. All drugs in this category have clinical criteria for coverage.
- Add Aimovig[™] and Emgality[®] to Preferred status
- Add Ajovy[™] to Non-Preferred status

CENTRAL NERVOUS SYSTEM (ANTIPARKINSON AND RESTLESS LEG SYNDROME AGENTS)

- Add Osmolex™ ER tablet to Non-Preferred status with clinical criteria for coverage

CENTRAL NERVOUS SYSTEM (MULTIPLE SCLEROSIS)

- Add dalfampridine ER tablet (generic of Ampyra® tablet) to Preferred status

ENDOCRINOLOGY (HYPOGLYCEMICS- INJECTABLE, RAPID ACTING INSULIN)

- Add Humalog® U-100 KwikPen® / vial to Preferred status. This is a clarification / FYI only; as this has been processing this way.
- Add Humalog® U-100 cartridge / U-100 Junior KwikPen® to Non-Preferred status. This is a clarification / FYI only; as this has been processing this way.
- Add Humalog® U-200 KwikPen® to Non-Preferred status. This is a clarification / FYI only; as this has been processing this way.

ENDOCRINOLOGY - HYPOGLYCEMICS (INJECTABLE, SHORT ACTING INSULIN)

- Add Humulin® R U500 vial to Preferred status. This is a clarification / FYI only; as this has been processing this way.

ENDOCRINOLOGY – HYPOGLYCEMICS (INJECTABLE, LONG ACTING INSULIN)

- Add Toujeo® Max SoloStar® to Non-Preferred status.

ENDOCRINOLOGY – HYPOGLYCEMICS (INJECTABLE, PREMIXED 70/30 COMBINATION INSULIN)

- Add Novolin® 70/30 FlexPen® to Non-Preferred status.
- Move Humulin® 70/30 KwikPen® to Preferred status from Non-Preferred status

GASTROINTESTINAL (ANTIEMETIC-ANTIVERTIGO AGENTS)

- Add Compro® rectal to Non-Preferred status
- Move promethazine ampule / vial (generic for Phenergan®) to Preferred status from Non-Preferred status

GASTROINTESTINAL (PROTON PUMP INHIBITORS)

- Move lansoprazole Rx capsule (generic for Prevacid® Rx capsule) to Preferred status from Non-Preferred status

GASTROINTESTINAL (ULCERATIVE COLITIS – ORAL)

- Add budesonide ER tablet (generic for Uceris®) to Non-Preferred status

GASTROINTESTINAL (ULCERATIVE COLITIS – RECTAL)

- Add mesalamine suppository (generic for Canasa®) to Non-Preferred status

GENITOURINARY / RENAL (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

- Add silodosin capsule (generic for Rapaflo®) to Non-Preferred status

- Add tadalafil tablet (generic for Cialis®) to Non-Preferred status. Clinical criteria apply for coverage.

HEMATOLOGIC (COLONY STIMULATING FACTORS)

- Add Udenyca™ Syringe to Non-Preferred status

HEMATOLOGIC (HEMATOPOIETIC AGENTS)

- Add Retacrit® vial to Non-Preferred status

HEMATOLOGIC (THROMBOPOIESIS STIMULATING AGENTS)

- Add Promacta® suspension to Preferred status
- Add Tavalisse™ tablet to Non-Preferred status

OPHTHALMIC (ANTIBIOTICS)

- Move Neo-Polycin® ophthalmic ointment (branded generic for Neosporin® Ophthalmic Ointment) to Non-Preferred status from Non-Preferred status

OPHTHALMIC (ANTI-INFLAMMATORY)

- Add Bromsite™ solution to Non-Preferred status
- Add Dexycu™ vial to Non-Preferred status
- Add Inveltys™ drops to Non-Preferred status
- Add Yutiq™ implant to Non-Preferred status

OPHTHALMIC (ANTI-INFLAMMATORY / IMMUNOMODULATOR)

- Add Cequa™ drops to Non-Preferred status

OPHTHALMIC (CARBONIC ANHYDRASE INHIBITORS / COMBINATIONS)

- Add dorzolamide/timolol PF drops (generic for Cosopt PF®) to Non-Preferred status

OPHTHALMIC (PROSTAGLANDIN AGONISTS)

- Add Xelpros® drops to Non-Preferred status

RESPIRATORY (BETA ADRENERGIC HANDHELD, SHORT ACTING)

- Add albuterol HFA inhaler (generic for Proair® HFA inhaler) to Non-Preferred status
- Add albuterol HFA inhaler (generic for Ventolin® HFA inhaler) to Non-Preferred status
- Add levalbuterol HFA inhaler (generic for Xopenex® HFA inhaler) to Non-Preferred status

RESPIRATORY (ORALLY INHALED ANTICHOLINERGICS / COPD AGENTS)

- Add Yulpelri™ solution to Non-Preferred status

RESPIRATORY (CORTICOSTEROID COMBINATIONS)

- Add fluticasone/salmeterol inhaler (generic for Advair® Diskus®) to Non-Preferred status
- Add Wixela™ Inhub™ to Non-Preferred status

RESPIRATORY (INTRANASAL RHINITIS AGENTS)

The panel approves the PDL proposal for INTRANASAL RHINITIS AGENTS with the following changes:

- Add Sinuva™ implant to Non-Preferred status

TOPICALS (ACNE AGENTS)

- Add adapalene solution to Non-Preferred status
- Add clindamycin/benzoyl peroxide with pump (generic for Acanya®) to non-Preferred status
- Add Plixda® swabs to Non-Preferred status

TOPICALS (NSAIDS)

The panel approves the PDL proposal for NSAIDS with the following changes:

- Add DermacinRx® Lexitral PharmaPak® to Non-Preferred status

TOPICALS (ANTIFUNGALS)

- Add miconazole/zinc oxide/petrolatum ointment (generic for Vusion®) to Non-Preferred status with clinical criteria to match the branded Vusion® product

TOPICALS (ANTIPARASITICS)

- Add Crotan™ lotion to Non-Preferred status

TOPICALS (IMMUNOMODULATORS - ATOPIC DERMATITIS)

- Add pimecrolimus cream (generic for Elidel®) to Non-Preferred status

TOPICALS (IMMUNOMODULATORS – IMIDAZOQUINOLINAMINES)

The panel approves the PDL proposal for TOPICAL IMMUNOMODULATORS, IMIDAZOQUINOLINAMINES with the following changes:

- Add Veregen® ointment to Non-Preferred status

TOPICALS (ROSACEA AGENTS)

- Add azelaic acid gel (generic for Finacea® gel) to Non-Preferred status

TOPICALS (STEROIDS - HIGH POTENCY)

- Add desoximetasone spray (generic for Topicort®) to Non-Preferred status

TOPICALS (STEROIDS - VERY HIGH POTENCY)

- Add Bryhali™ lotion to Non-Preferred status
- Add halobetasol propionate foam (generic for Lexette®) to Non-Preferred status
- Add Lexette® foam to Non-Preferred status

MISCELLANEOUS (EPINEPHRINE - SELF INJECTED)

- Clarifying that all self-injected epinephrine products have quantity limits that apply. This has been the case, but it has not been listed on the PDL document.
- Add Symjepi™ to Non-Preferred status

MISCELLANEOUS (PROGESTATIONAL AGENTS)

- Move hydroxyprogesterone caproate injection single dose vial to Preferred status from Non-Preferred status
- Move Makena auto injector to Preferred status from Non-Preferred status
- Both of these PDL updates were made for access reasons on 12/27/2018 due to Makena vials being on manufacturer backorder.

MISCELLANEOUS (IMMUNOMODULATORS – SYSTEMIC)

- Add Ilumya[®] injection to Non-Preferred status
- Add Olumiant[®] tablet to Non-Preferred status

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS**Coagulation factor Xa (recombinant), inactivated-zhzo lyophilized powder for solution for intravenous injection (Andexxa[®]) HCPCS code J3590: Billing Guidelines**

Effective with date of service April 4, 2019, the North Carolina Medicaid and NC Health Choice programs cover coagulation factor Xa (recombinant), inactivated-zhzo lyophilized powder for solution for intravenous injection (Andexxa) for use in the Physician Administered Drug Program when billed with HCPCS code J3590 - Unclassified biologics.

Strength/Package Size: Lyophilized powder in single-use vials of 100 mg or 200 mg

Indicated for patients treated with rivaroxaban and apixaban, when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding.

Recommended Dose: The recommended dosing of Andexxa is based on the specific FXa inhibitor, dose of FXa inhibitor, and time since the patient's last dose of FXa inhibitor.

Low Dose:

Initial IV Bolus - 400 mg at a target rate of 30 mg/min

Follow-On IV Infusion - 4 mg/min for up to 120 minutes

High Dose:

Initial IV Bolus - 800 mg at a target rate of 30 mg/min

Follow-On IV Infusion - 8 mg/min for up to 120 minutes

The safety and effectiveness of more than one dose have not been evaluated. See package insert for full dosage and administration guidelines and further detail.

For Medicaid and NC Health Choice Billing:

- The ICD-10-CM diagnosis codes required for billing are: D68.4 - Acquired coagulation factor deficiency; T45.511A - Poisoning by anticoagulants, accidental (unintentional), initial encounter; T45.511D - Poisoning by anticoagulants, accidental (unintentional), subsequent encounter; T45.511S - Poisoning by anticoagulants, accidental (unintentional), sequela; T45.512A - Poisoning by anticoagulants, intentional self-harm, initial encounter; T45.512D - Poisoning by anticoagulants, intentional self-harm, subsequent encounter; T45.512S - Poisoning by anticoagulants, intentional self-harm, sequela; T45.513A - Poisoning by anticoagulants, assault, initial encounter; T45.513D - Poisoning by anticoagulants, assault, subsequent encounter; T45.513S - Poisoning by anticoagulants, assault, sequela; T45.514A - Poisoning by anticoagulants, undetermined, initial encounter; T45.514D - Poisoning by anticoagulants, undetermined, subsequent encounter; T45.514S - Poisoning by anticoagulants, undetermined, sequela; T45.515A - Adverse effect of anticoagulants, initial encounter; T45.515D - Adverse effect of anticoagulants, subsequent encounter; T45.515S - Adverse effect of anticoagulants, sequela
- Providers must bill with HCPCS code: J3590 - Unclassified biologics
- One Medicaid and NC Health Choice unit of coverage is: 1 mg
- The maximum reimbursement rate per unit is: \$29.70
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units: 69853-0101-01, 69853-0102-01
- 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

Romosozumab-aqqg injection, for subcutaneous use (Evenity™) HCPCS code J3590: Billing Guidelines

Effective with date of service April 11, the North Carolina Medicaid and NC Health Choice programs cover romosozumab-aqqg injection, for subcutaneous use (Evenity) for use in the Physician Administered Drug Program when billed with HCPCS code J3590 - Unclassified biologics.

Strength/Package Size: Injection: 105 mg/1.17 mL solution in a single-use prefilled syringe. A full dose of Evenity requires two single-use prefilled syringes.

Indicated for the treatment of osteoporosis in postmenopausal women at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy.

Limitations of Use: Limit duration of use to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered.

Recommended Dose:

- The recommended dose of Evenity is 210 mg administered subcutaneously in the abdomen, thigh or upper arm. Administer once every month.
- The treatment duration is 12 monthly doses.
- Patients should be adequately supplemented with calcium and vitamin D during treatment.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing:

- The ICD-10-CM diagnosis code(s) required for billing are: M80.00XA to M81.8 – osteoporosis related diagnosis
- Providers must bill with HCPCS code: J3590 - Unclassified biologics
- One Medicaid and NC Health Choice unit of coverage is: 105 mg (1 prefilled syringe)
- The maximum reimbursement rate per unit is: \$985.50
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 55513-0880-01, 55513-0880-02
- 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 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

Trastuzumab and hyaluronidase-oysk injection, for subcutaneous use (Herceptin Hylecta™) HCPCS code J9999: Billing Guidelines

Effective with date of service April 5, 2019, the North Carolina Medicaid and NC Health Choice programs cover trastuzumab and hyaluronidase-oysk injection, for subcutaneous use (Herceptin Hylecta) for use in the Physician Administered Drug Program when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs.

Strength/Package Size: Injection: 600 mg trastuzumab and 10,000 units hyaluronidase per 5 mL (120 mg/2,000 units per mL) solution in a single-dose vial

Indicated in adults for the treatment of HER2-overexpressing breast cancer. Select patients for therapy based on an FDA-approved companion diagnostic for trastuzumab.

Recommended Dose: 600 mg/10,000 units (600 mg trastuzumab and 10,000 units hyaluronidase) administered subcutaneously over approximately 2-5 minutes once every three weeks.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing:

- The ICD-10-CM diagnosis code(s) required for billing are: C50.011 - Malignant neoplasm of nipple and areola, right female breast; C50.012 - Malignant neoplasm of nipple and areola, left female breast; C50.019 - Malignant neoplasm of nipple and areola, unspecified female breast; C50.021 - Malignant neoplasm of nipple and areola, right male breast; C50.022 - Malignant neoplasm of nipple and areola, left male breast; C50.029 - Malignant neoplasm of nipple and areola, unspecified male breast; C50.111 - Malignant neoplasm of central portion of right female breast; C50.112 - Malignant neoplasm of central portion of left female breast; C50.119 - Malignant neoplasm of central portion of unspecified female breast; C50.121 - Malignant neoplasm of central portion of right male breast; C50.122 - Malignant neoplasm of central portion of left male breast; C50.129 - Malignant neoplasm of central portion of unspecified male breast; C50.211 -

Malignant neoplasm of upper-inner quadrant of right female breast; C50.212 - Malignant neoplasm of upper-inner quadrant of left female breast; C50.219 - Malignant neoplasm of upper-inner quadrant of unspecified female breast; C50.221 - Malignant neoplasm of upper-inner quadrant of right male breast; C50.222 - Malignant neoplasm of upper-inner quadrant of left male breast; C50.229 - Malignant neoplasm of upper-inner quadrant of unspecified male breast; C50.311 - Malignant neoplasm of lower-inner quadrant of right female breast; C50.312 - Malignant neoplasm of lower-inner quadrant of left female breast; C50.319 - Malignant neoplasm of lower-inner quadrant of unspecified female breast; C50.321 - Malignant neoplasm of lower-inner quadrant of right male breast; C50.322 - Malignant neoplasm of lower-inner quadrant of left male breast; C50.329 - Malignant neoplasm of lower-inner quadrant of unspecified male breast; C50.411 - Malignant neoplasm of upper-outer quadrant of right female breast; C50.412 - Malignant neoplasm of upper-outer quadrant of left female breast; C50.419 - Malignant neoplasm of upper-outer quadrant of unspecified female breast; C50.421 - Malignant neoplasm of upper-outer quadrant of right male breast; C50.422 - Malignant neoplasm of upper-outer quadrant of left male breast; C50.429 - Malignant neoplasm of upper-outer quadrant of unspecified male breast; C50.511 - Malignant neoplasm of lower-outer quadrant of right female breast; C50.512 - Malignant neoplasm of lower-outer quadrant of left female breast; C50.519 - Malignant neoplasm of lower-outer quadrant of unspecified female breast; C50.521 - Malignant neoplasm of lower-outer quadrant of right male breast; C50.522 - Malignant neoplasm of lower-outer quadrant of left male breast; C50.529 - Malignant neoplasm of lower-outer quadrant of unspecified male breast; C50.611 - Malignant neoplasm of axillary tail of right female breast; C50.612 - Malignant neoplasm of axillary tail of left female breast; C50.619 - Malignant neoplasm of axillary tail of unspecified female breast; C50.621 - Malignant neoplasm of axillary tail of right male breast; C50.622 - Malignant neoplasm of axillary tail of left male breast; C50.629 - Malignant neoplasm of axillary tail of unspecified male breast; C50.811 - Malignant neoplasm of overlapping sites of right female breast; C50.812 - Malignant neoplasm of overlapping sites of left female breast; C50.819 - Malignant neoplasm of overlapping sites of unspecified female breast; C50.821 - Malignant neoplasm of overlapping sites of right male breast; C50.822 - Malignant neoplasm of overlapping sites of left male breast; C50.829 - Malignant neoplasm of overlapping sites of unspecified male breast; C50.911 - Malignant neoplasm of unspecified site of right female breast; C50.912 - Malignant neoplasm of unspecified site of left female breast; C50.919 - Malignant neoplasm of unspecified site of unspecified female breast; C50.921 - Malignant neoplasm of unspecified site of right male breast; C50.922 - Malignant neoplasm of unspecified site of left male breast; C50.929 - Malignant neoplasm of unspecified site of unspecified male breast

- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
- One Medicaid and NC Health Choice unit of coverage is: 1 mg
- The maximum reimbursement rate per unit is: \$8.42
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 50242-0077-01
- 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.

GCN 46111, V1W

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ATTENTION: SPECIALIZED THERAPIES PROVIDERS

Updates to Clinical Coverage Policy 10B: Independent Practitioners

On June 1, 2019, an amended version of Clinical Coverage Policy 10B, *Independent Practitioners*, was posted to the North Carolina Medicaid website. The following updates were made in accordance with State Plan Amendment (SPA) NC 18-0005 which allowed an expansion of the universe of documentation that a Local Education Agency (LEA) can use as a basis for providing school-based health services from beyond a student beneficiary's Individualized Education Program (IEP) to also include the Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP) or 504 Plan.

The following SPA-related updates became effective **October 1, 2018**:

In Subsection **3.2.1.7 Treatment Services, criterion e.**, was updated to **include** the following language, effective 10/01/2018:

For a Local Education Agency (LEA), the prior approval process is deemed met by the Individualized Education Program (IEP) Individual Family Service Plan

(IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP), or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with obtaining a dated physician order with signature.

In Subsection **5.2.2 Prior Approval Requirements, Specific** was updated to **include** the following language, effective 10/01/2018:

For an LEA, the prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes.

These additional updates, unrelated to the SPA, became effective **June 1, 2019**:

In Subsection **Related Clinical Coverage Policies**, the title of related policy 5A-1 was **updated** to *Physical Rehabilitation Equipment and Supplies*

In Subsection **1.0 Description of the Procedure, Product, or Service**, the following language was **moved** to section **2.1.2 Eligibility Requirements, Specific**:

The IPP provider may only render services to Medicaid beneficiaries under 21 years of age.

In Subsection **3.2.1.3(a)(1) Speech/ Language Therapy**, criterion I. was updated to read:

Neuromuscular degenerative disease likely to affect swallowing regardless of the presence of a communication difficulty

In Subsection **3.2.1.5 Evaluation Services**, the following language was **added** as the last sentence:

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

In Subsection **3.2.1.6 Treatment Plan (Plan of Care)**, criterion **h.** was **deleted**:

the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable; and

In Subsection **3.2.1.8 Re-evaluation Services**, the following language was **deleted**:

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

In Subsection **5.1 Prior Approval**, the following language was **added**:

To obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.

In Subsection **5.2.2 Prior Approval Requirements, Specific**, the following **updates** were made:

Deleted: For occupational therapy (OT) and physical therapy (PT) prior approval, a written report of an evaluation must occur within **six (6) months** of the requested beginning date of treatment.

Added: For prior approval, a written report of an evaluation must occur within **three months** of the requested beginning date of treatment.

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

Deleted: For audiology services (AUD) and speech/language services (ST) prior approval, a written report of an evaluation must occur within **six (6) months** of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report. The re-evaluation report must document include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.

In Subsection **6.1, Provider Qualifications and Occupational Licensing Entity Regulations**, updated references to Federal Register qualifications for OT, PT, SLP and audiology.

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

the combined frequency of services must be medically necessary to address the beneficiary's deficits.

The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program (that is, Head Start, early childhood intervention service or developmental day care program).

In **Attachment A: Claims-Related Information, Section C: Code(s)**, the following updates were made:

End-dated CPT code 97762 was removed and replaced with 97763.

In **Attachment A: Claims-Related Information, Section E: Billing Units**, the following **updates** were made:

Deleted: Evaluation services are the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service

providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires.

Added: Evaluation services: refer to Subsection 3.2.1.5.

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

Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid or NCHC beneficiary as a single visit, must not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.

Additional Resources

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

ATTENTION: HOSPICE PROVIDERS

Reminders on Hospice Policy

Clinical review is **not** required for North Carolina Medicaid and NC Health Choice hospice services until after the completion of the first and second 90-day benefit period.

- *First Benefit Period* - The Hospice provider must upload into the NCTracks Provider Portal the prior approval (PA) request and the election statement within six calendar days of the effective date for hospice election. This notifies NC Medicaid of the beneficiary's election of hospice services.
- *Second Benefit Period* - Only the PA request is entered in NCTracks.
- *Third and Subsequent Benefit Periods and Certification PA Requirements* - The Hospice provider shall upload the required documents into the NCTracks provider portal every 60-day benefit period. The third benefit period requires submission of a hospice face-to-face encounter which must occur no more than 30 calendar days prior to the third benefit period and each subsequent benefit period thereafter.

Hospice providers shall upload all required documents via the NCTracks provider portal for the third and subsequent benefit periods.

- NC Medicaid Hospice Prior Approval Authorization Form (NC DHB-3212);
- Hospice Recertification of Terminal Illness;
- Physician Plan of Treatment - Order for care and services;
- Face-To-Face Encounter; and,

- Supporting clinical documentation (e.g., medical history, nurses' notes, interdisciplinary group meeting notes [IDG notes], etc.)

The Hospice provider shall submit a PA request within:

- Six calendar days of the election of the Medicaid, Medicaid-pending or NC Health Choice Hospice benefit;
- Ten calendar days of the start of the second and each subsequent benefit period; and
- Six calendar days of the start of care, if Medicare is the primary payer and Medicaid is providing coverage for nursing home room and board.

Note: Effective Nov. 1, 2017, all prior approval (PA) requests, regardless of benefit period, require a one-time upload of the hospice service election statement. In addition, documents related to the current benefit period, per policy, will also be uploaded into the NCTracks provider portal at that time.

NC Medicaid Long Term Services and Supports, (919) 855-4380

ATTENTION: HOSPICE PROVIDERS

Hospice Payment Reform Update

Due to the implementation of Centers for Medicare and Medicaid Services (CMS) FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule, NC Medicaid made policy and system changes to allow for the use of two-tier hospice fee schedules effective Jan. 1, 2016. Hospice payment reform implemented the use of two Routine Home Care (RHC) rates based on days of hospice service and a Service Intensity Add-on (SIA) payment for services provided during the last seven days of life.

On Nov. 1, 2017, NCTracks system changes were implemented and all claims for hospice service began to be reimbursed in accordance with the requirements of hospice payment reform. NC Medicaid has since requested system updates to CSRA's previous implementation of the routine home care reform components.

NC Medicaid continues to work with hospice stakeholders to finalize the details of the phase-in approach that will be used to reprocess claims for services provided from Jan. 1, 2016 forward. Providers will not be required to take any action. The affected claims will be systematically reprocessed as adjustments to apply the revised rates. A claims reprocessing notice will be sent to the NCTracks message center inbox of affected providers before the reprocessing occurs.