



# NC Medicaid Bulletin

## September 2019

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**ATTENTION: ALL PROVIDERS****DHHS Provider Resources for Transition to Medicaid Managed Care**

The Department of Health and Human Services (DHHS) recently launched an online “[Provider Playbook](#)” as part of its commitment to ensure providers have resources to help Medicaid beneficiaries transition smoothly to Medicaid Managed Care. This new Provider Playbook is a collection of information and tools specifically tailored to providers.

The first resources include:

- [Fact Sheet #1. Medicaid Transformation: Overview](#). What will change for Medicaid beneficiaries, what providers can expect with Medicaid Managed Care, and how providers can partner with the Department to support beneficiaries during the transition.
- [Fact Sheet #2. Medicaid Transformation: Beneficiary Enrollment & Timelines](#). How health plans are either selected or assigned to beneficiaries and when enrollment opportunities occur.
- [Overview of the Beneficiary Enrollment Experience in NC Medicaid Managed Care for Medicaid Providers](#). A detailed look at what beneficiaries will experience over the next few months as they transition to Medicaid Managed Care. In addition to details on Fact Sheet topics, it includes information on recertification, appeals and grievances, Behavioral Health I/DD Tailored Plans and transition of care.

New resources will be added to the Provider Playbook as they become available.

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**ATTENTION: ALL PROVIDERS****NC’s Transition to Medicaid Managed Care: The Crossover Communication Series**

Supporting beneficiaries in their transition between the current fee-for-service delivery system and NC Medicaid Managed Care is called transition of care. The transitional period surrounding the launch of Medicaid Managed Care is referenced as crossover.

As part of its broader efforts to prepare providers for NC Medicaid Managed Care, in [August 2019 NC Medicaid launched](#) a time-limited, time-sensitive informational series, *NC’s Transition to Medicaid Managed Care: The Crossover Communication Series*. Through this series, NC Medicaid provides guidance and resources to assist providers in ensuring beneficiary service continuity during the crossover period.

This crossover communication series will supplement current education activity and direct readers to existing resources, as appropriate.

**Featured this Month: Online Resources to Assist through Crossover**

In September 2019, NC Medicaid will launch Crossover guidance on the NC Medicaid Transformation Provider Resource Page: <https://medicaid.ncdhhs.gov/providers>

Resources to be provided:

- Guidance for identifying members’ managed care status
- Guidance for submitting a prior authorization during crossover
- Overview of additional member safeguards during crossover
- Contacting the PHPs
- Reporting issues
- Additional information

**Upcoming Opportunities to Learn About Crossover-Related Activities and Processes**

<b>Webinar</b>	<b>Date</b>	<b>Notes</b>
<i>NC’s Transition to Managed Care: The Crossover Series</i>	Thursday, Sept. 5, 2019 1-2 p.m.	This session will provide general crossover guidance, with a focus on identifying beneficiary managed care detail and guidance on submitting prior authorization requests during the crossover period.
<i>NC’s Transition to Managed Care: The Crossover Series</i>	Thursday, Sept. 19, 2019 1-2 p.m.	This session will be a continuation of the session on Sept. 5, 2019, providing a brief review of topics previously covered and additional guidance for supporting beneficiaries through the transition to NC Medicaid Managed Care.

For more information about upcoming and previous webinars, visit: <https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses>

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**ATTENTION: ALL PROVIDERS**

**Procedure for 340B Drug Claim Submissions**

The North Carolina Division of Health Benefits (DHB) would like to reiterate the 340B provider and claim submission requirements for both the outpatient pharmacy and Physician’s Drug Program (PDP). Providers are required to comply with all aspects of their respective clinical coverage policy to submit 340B claims for reimbursement.

Please note that Clinical Coverage Policy No. 9 was updated on July 15, 2019. Prior to this update the policy allowed for submission of POS claims with an ‘8’ in the basis of cost determination field (NCPDP D.0 field 423-DN) **OR** a ‘20’ in the submission clarification field (NCPDP D.0 field 420-DK). **The updated policy requires use of both indicators.** In addition, providers were instructed to submit both the actual purchased drug price **AND** the dispensing fee in the usual and customary charge field. Per the updated policy, **only the actual purchased drug price should be submitted** in the usual and customary charge field.

#### Physician’s Drug Program (PDP) – Clinical Coverage Policy No. 1B

- The PDP reimburses for drugs billed to Medicaid and NCHC by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA) found at <http://opanet.hrsa.gov/opa/CE/CEMedicaidextract.aspx>.
- Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the ‘UD’ modifier on the drug detail.
- Providers billing for a 340B drug shall bill the cost that is reflective of their acquisition cost.

#### Outpatient Pharmacy – Clinical Coverage Policy No. 9 (*Updated July 15, 2019*)

- 340B providers must be listed on the HRSA website found at <http://www.hrsa.gov/opa/>.
- 340B providers must submit POS claims with an ‘8’ in the basis of cost determination field (NCPDP D.0 field 423-DN) **AND** a ‘20’ in the submission clarification field (NCPDP D.0 field 420-DK) to indicate they are dispensing a 340B product. This will eliminate duplicate discounts as the claims will be pulled from rebate collections.
- 340B providers must submit the actual purchased drug price in the *usual and customary charge* field.
- Providers who maintain two separate inventories – one for eligible 340B prescriptions and a purchased inventory for non-340B prescriptions – may not dispense a 340B program purchased drug and bill Medicaid or NC Health Choice the calculated Medicaid price for non-qualified 340B prescriptions.
- Hemophilia drugs
  - 340B providers may submit the state upper limit established for a 340B purchased hemophilia drug.

The referenced clinical coverage policies can be found at:

Clinical Coverage Policy 1B: [https://files.nc.gov/ncdma/documents/files/1B\\_1.pdf](https://files.nc.gov/ncdma/documents/files/1B_1.pdf)

Clinical Coverage Policy 9: [https://files.nc.gov/ncdma/documents/files/9\\_4.pdf](https://files.nc.gov/ncdma/documents/files/9_4.pdf)

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

**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.

The Center for Medicare and Medicaid Services (CMS) has updated its Promoting Interoperability Program website with Program Year 2019 information and details including the [2019 Medicaid EP specification sheets](#).

**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 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 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](mailto:NCMedicaid.HIT@dhhs.nc.gov).

## **Recent Updates from CMS**

The [Program Year 2019 Medicaid EP Specification Sheets](#) were updated July 31, 2019 to clarify the requirements for meeting objectives six and seven. The language now reads, “An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.”

On Aug. 2, 2019, CMS issued the Fiscal Year 2020 Inpatient Prospective Payment System (IPPS) and the Long-Term Acute Care Hospital (LTCH) Prospective Payment System (PPS) [final rule](#). This rule changes the minimum MU reporting period for returning meaningful users from a full calendar year to any continuous 90-day period in Program Year 2021.

## **Reminder on MU Stage 3 Objective 8 Measure 1 (Public Health and Clinical Data Registry Reporting: Immunization Registry Reporting)**

To meet [Objective 8 Measure 1](#) (Public Health and Clinical Data Registry Reporting: Immunization Registry Reporting), EPs who administer vaccinations must be in active engagement with the North Carolina Immunization Registry (NCIR). NCIR is capable of accepting the specific standards required to meet the 2015 CEHRT definition and has declared readiness to receive immunization data, so EPs can take an exclusion for this measure only if they do not administer vaccinations.

EPs who wish to participate in Program Year 2019 of the NC Medicaid EHR Incentive Program but who are not yet in active engagement with NCIR, must complete registration with NCIR within 60 days after the start of their MU reporting period. In Program Year 2019, an EP’s MU reporting period must begin no later than Oct. 3, 2019 to get 90 days of MU data in calendar year 2019. This means the last day an EP may complete registration with NCIR to meet MU in Program Year 2019 is Dec. 1, 2019, with the 90-day MU reporting period being Oct. 3, 2019 through Dec. 31, 2019.

To begin registering with NCIR, EPs should contact the NCIR Help Desk by phone at (877) 873-6247 or by email at [ncirhelp@dhhs.nc.gov](mailto:ncirhelp@dhhs.nc.gov). EPs who are not already in active engagement with NCIR should begin this process now if they wish to apply for Program Year 2019 of the NC Medicaid EHR Incentive Program.

## **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](mailto: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](mailto: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](mailto:NCMedicaid.HIT@dhhs.nc.gov)**

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## **ATTENTION: ALL PROVIDERS**

### **Recent Changes to State Health Information Exchange, NC HealthConnex**

North Carolina's state-designated health information exchange, NC HealthConnex, was created in 2015 by the North Carolina General Assembly to help bridge the gap between distinct electronic health record systems and health care networks to support whole patient care. With over seven million unique patient records and growing, NC HealthConnex is working to connect the state's health care providers to deliver a holistic view of a patient's record. The North Carolina Health Information Exchange Authority (NC HIEA) is the agency managing NC HealthConnex.

#### **How has the law changed?**

Previously, we notified you that state law (N.C.G.S. § 90-414.4) requires that all health care providers who receive any state funds for the provision of health care services (e.g. Medicaid, NC Health Choice, State Health Plan, etc.) connect and submit patient demographic and clinical data to NC HealthConnex by certain dates in 2018 and 2019 in order to continue to receive payment for services.

On June 6, 2019, Governor Cooper signed into law Session Law 2019-23 which revised portions of N.C.G.S. § 90-414.4. The legislation extends the June 1, 2019 deadline until **June 1, 2020**. Additionally, licensed physicians whose primary area of practice is psychiatry, and the State Laboratory of Public Health and State healthcare facilities operated by the North Carolina Department of Health and Human Services now have until **June 1, 2021** to connect.

Further, Session Law 2019-23 now exempts certain provider types from the mandatory requirement to connect and submit data to the Health Information Exchange network, NC HealthConnex. The following provider types have the option to connect on a **voluntary basis**, however, they are **no longer required to connect**:

- Community-based long-term services and supports providers, including personal care services, private duty nursing, home health, and hospice care providers.

- Intellectual and developmental disability services and supports providers, such as day supports and supported living providers.
- Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.
- Eye and vision services providers.
- Speech, language, and hearing services providers.
- Occupational and physical therapy providers.
- Durable medical equipment providers.
- Nonemergency medical transportation service providers.
- Ambulance (emergency medical transportation service) providers.
- Local education agencies and school-based health providers.

See N.C.G.S. § 90-414.4(e).

**If I am no longer required to connect, may I still choose to participate with NC HealthConnex?**

Yes! Providers covered by N.C.G.S. § 90-414.4(e) may voluntarily choose to submit data to NC HealthConnex or they can access patient data in the clinical portal and utilize the NC HealthConnex value-added features. Voluntary providers **must** sign a [Full Participation Agreement](#) if they want to participate. Submission Only Agreements do not include a Business Associate Agreement and therefore can only be signed by providers who are required to connect and submit data to NC HealthConnex.

**What if my organization has signed a participation agreement with the NC HIEA, but we are now no longer required to connect per changes in HB70?**

Provider types listed under N.C.G.S. § 90-414.4(e) who are no longer required to connect have several choices. Voluntary providers can still connect to NC HealthConnex, but they must sign a Full Participation Agreement. Submission Only agreements will not be processed for providers not required to connect.

**If you are no longer required to connect, but have already submitted a full participation agreement:**

1. You have the option to continue your relationship as an NC HealthConnex participant. You may choose to still submit data to NC HealthConnex, or you may simply receive access to the clinical portal and other value-added services. Having access to the clinical portal will allow you to view a more complete health record for patients with whom you have treatment relationship. No action is necessary at this time if you plan to become a full participant of NC HealthConnex.
2. If you do not want to submit data to NC HealthConnex or access patient data, you can terminate your agreement. If your agreement has not been signed by the NC



HIEA yet, you can request that the agreement not be finalized. Please send an email to [HIEA@nc.gov](mailto:HIEA@nc.gov) if you do not want the NC HIEA to process your participation agreement or you would like to terminate it. This will end your relationship with the NC HIEA and NC HealthConnex.

If you are no longer required to connect but submitted a Submission Only Agreement, the NC HIEA will reach out to you about terminating or replacing your agreement soon. If your organization would like to voluntarily participate in NC HealthConnex in order to view patient records or utilize the NC HealthConnex value-added features, your organization can complete a Full Participation Agreement, which is available at <https://nchealthconnex.gov>.

For more information about the benefits of participating in NC HealthConnex visit our website at <https://hiea.nc.gov/nc-healthconnex-suite-services> or sign up for the next [How to Connect Call](#) that is hosted the last Monday of each month at noon.

NC HIEA, (919) 754-6912 or [hiea@nc.gov](mailto:hiea@nc.gov)

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#### **ATTENTION: ALL PROVIDERS**

### **Influenza Vaccine and Reimbursement Guidelines for 2019-2020 for North Carolina Medicaid and NC Health Choice**

A fully detailed outline of the influenza vaccine and reimbursement guidelines for 2019-2020 for North Carolina Medicaid and NC Health Choice was distributed in a [Medicaid Special Bulletin on Aug. 27, 2019](#).

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#### **ATTENTION: ALL PROVIDERS**

### **Update to Clinical Policy 15 Ambulance Services**

Session Law 2018-5 Sec.11H.4 (see Appendix A) instructed the NC Department of Health and Human Services (DHHS) to submit to Centers for Medicare and Medicaid Services (CMS) for the necessary authority to establish Medicaid reimbursement for ambulance transports of Medicaid beneficiaries in behavioral health crisis to behavioral health clinics or other alternative locations effective July 1, 2019.

The policy has been updated to include reimbursement for ambulance transport to alternative location and will be posted on the NC Medicaid website for 30-day comment.

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**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/>:

- 8F, Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder) \*EDIT\* Aug. 15, 2019
- 1A-8, Hyperbaric Oxygenation Therapy- Aug. 15, 2019
- 1A-12, Breast Surgeries - Aug. 15, 2019
- 1N-2, Allergy Immunotherapy- Aug. 15, 2019
- 15, Ambulance Services – Aug. 15, 2019
- 1A-12, Breast Surgeries – Sept. 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.

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**ATTENTION: ALL PROVIDERS****Revisions to Hematopoietic Stem Cell Transplantation Clinical Coverage Policies**

The following Hematopoietic Stem Cell Transplantation (HSCT) clinical coverage policies have been revised. The revisions, which will become effective Oct. 1, 2019 are outlined below:

**11A-1 Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia (ALL)**

- Coverage added for allogeneic HSCT to treat relapsing ALL after a prior autologous HSCT for both children and adults.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).

**11A-2 Hematopoietic Stem Cell Transplantation for Acute Myeloid Leukemia (AML)**

- AML description, classifications, and prognostic factors updated in accordance with the new 2016 World Health Organization (WHO) classifications.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).

- Clarified coverage criteria to specify situations in which AML relapses or is refractory to induction chemotherapy but can be brought into remission with intensified induction chemotherapy.

### **11A-3 Hematopoietic Stem Cell Transplantation for Chronic Myeloid Leukemia (AML)**

- Terminology changed from chronic *myelogenous* leukemia to chronic *myeloid* leukemia throughout policy.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).

### **11A-5 Allogeneic Hematopoietic Stem Cell Transplantation for Genetic Diseases and Acquired Anemias**

- Title of policy edited from “*Allogeneic Hematopoietic Stem Cell & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias*” to above.

### **11A-6 Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors**

- Definitions added for *salvage therapy* and *tandem transplants*.

### **11A-7 Hematopoietic Stem Cell Transplantation for Hodgkin Lymphoma**

- Definitions added for *induction therapy* and *tandem transplants*.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).

### **11A-8 Hematopoietic Stem Cell Transplantation for Multiple Myeloma, POEMS Syndrome, and Primary Amyloidosis**

- POEMS syndrome added to policy title and coverage criteria. Autologous HSCT is indicated to treat disseminated POEMS syndrome.
- Definitions added for *M protein*, *salvage therapy*, and *tandem transplants*.
- Policy Guidelines revised to define levels of response to treatment for multiple myeloma.

### **11A-9 Hematopoietic Stem Cell Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms**

- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).
- Policy Guidelines updated to reflect new 2016 WHO classifications.

### **11A-11 Hematopoietic Stem Cell Transplantation for Non-Hodgkin Lymphomas**

- Updated to the new 2016 WHO classifications for lymphoid neoplasms.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).

### **11A-14 Placental and Umbilical Cord Blood as a Source of Stem Cells**

- Updated criteria to allow the use of cord blood in any case where allogeneic transplant would be indicated.

### **11A-16 Hematopoietic Stem Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)**

- Provided highlights to changes in new 2016 WHO classification.
- Coverage criteria added and prior approval requirement removed from the donor lymphocyte infusion (DLI) procedure (CPT 38242).
- Revised text discussing adverse and favorable prognostic factors.

**GDIT 1-800-688-6696**

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### **ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS**

## **Dexamethasone ophthalmic insert 0.4 mg, for intracanalicular use (Dextenza®) HCPCS code J3490: Billing Guidelines**

Effective with date of service June 20, 2019, the North Carolina Medicaid and NC Health Choice programs cover dexamethasone ophthalmic insert 0.4 mg, for intracanalicular use (Dextenza) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J3490 - Unclassified drugs.

Strength/Package Size(s): Ophthalmic intracanalicular insert containing a 0.4 mg dose of dexamethasone.

Indicated for the treatment of ocular inflammation and pain following ophthalmic surgery.

Recommended Dose: A single Dextenza insert releases a 0.4 mg dose of dexamethasone for up to 30 days following insertion.

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: 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; H57.10 - Ocular pain, unspecified eye; H57.11 - Ocular pain, right eye; H57.12 - Ocular pain, left eye; H57.13 - Ocular pain, bilateral
- Providers must bill with HCPCS code: J3490 - Unclassified drugs
- One Medicaid and NC Health Choice unit of coverage is: 0.4 mg (1 insert)
- The maximum reimbursement rate per unit is: \$581.94

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 70382-0204-01, 70382-0204-10
- 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](#).

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## **ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS**

### **Polatuzumab vedotin-piiq for Injection, for Intravenous Use (Polivy™) HCPCS code J9999: Billing Guidelines**

Effective with date of service June 11, 2019, the North Carolina Medicaid and NC Health Choice programs cover polatuzumab vedotin-piiq for injection, for intravenous use (Polivy) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs.

Strength/package size(s): For injection: 140 mg of polatuzumab vedotin-piiq as a lyophilized powder in a single-dose vial.

Indicated in combination with bendamustine and a rituximab product for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified, after at least two prior therapies.

Recommended Dose: 1.8 mg/kg as an intravenous infusion over 90 minutes every 21 days for six cycles in combination with bendamustine and a rituximab product. Subsequent infusions may be administered over 30 minutes if the previous infusion is tolerated.

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: C83.30 - Diffuse large B-cell lymphoma, unspecified site; C83.31 - Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck; C83.32 - Diffuse large B-cell lymphoma, intrathoracic lymph nodes; C83.33 - Diffuse large B-cell lymphoma, intra-abdominal lymph nodes; C83.34 - Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb; C83.35 - Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb; C83.36 - Diffuse large B-cell lymphoma, intrapelvic lymph nodes; C83.37 - Diffuse large B-cell lymphoma, spleen; C83.38 - Diffuse large B-cell lymphoma, lymph nodes of multiple sites; C83.39 - Diffuse large B-cell lymphoma, extranodal and solid organ sites
- 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: \$115.71
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 50242-0105-01
- 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](#).

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**ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS****Infliximab-abda for Injection, for Intravenous Use (Renflexis® ) HCPCS code Q5104: Billing Guidelines**

Effective with date of service Aug. 1, 2019, the North Carolina Medicaid and NC Health Choice programs cover infliximab-abda for injection, for intravenous use (Renflexis) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code Q5104 - Injection, infliximab-abda, biosimilar, (renflexis), 10 mg.

Strength/package size(s): For injection: 100 mg of lyophilized infliximab-abda in a 20 mL vial for intravenous infusion

Indicated for:

*Crohn's Disease:*

- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.
- Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing disease.

*Pediatric Crohn's Disease:*

Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

*Ulcerative Colitis:*

Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

*Pediatric Ulcerative Colitis:*

Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

*Rheumatoid Arthritis in combination with methotrexate:*

Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active disease.

*Ankylosing Spondylitis:*

Reducing signs and symptoms in patients with active disease.

*Psoriatic Arthritis:*

Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function.

*Plaque Psoriasis:*

Treatment of adult patients with chronic severe (i.e., extensive and/or disabling) plaque

psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

**Recommended Dose:** Renflexis is administered by intravenous infusion over a period of not less than 2 hours.

*Crohn's Disease:* 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response.

*Pediatric Crohn's Disease:* 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

*Ulcerative Colitis:* 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

*Pediatric Ulcerative Colitis:* 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

*Rheumatoid Arthritis:* In conjunction with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks.

*Ankylosing Spondylitis:* 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks.

*Psoriatic Arthritis and Plaque Psoriasis:* 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

See full prescribing information for further detail.

### **For North Carolina Medicaid and NC Health Choice Billing**

- The ICD-10-CM diagnosis code(s) required for billing are:

*Crohn's Disease:*

K50.00 Crohn's disease of small intestine without complications; K50.011 Crohn's disease of small intestine with rectal bleeding; K50.012 Crohn's disease of small intestine with intestinal obstruction; K50.013 Crohn's disease of small intestine with fistula; K50.014 Crohn's disease of small intestine with abscess; K50.018 Crohn's disease of small intestine with other complication; K50.019 Crohn's disease of small intestine with unspecified complications; K50.10 Crohn's disease of large intestine without complications; K50.111 Crohn's disease of large intestine with rectal bleeding; K50.112 Crohn's disease of large intestine with intestinal obstruction; K50.113 Crohn's disease of large intestine with fistula; K50.114 Crohn's disease of large intestine with abscess; K50.118 Crohn's disease of large intestine with other complication; K50.119 Crohn's disease of large intestine with unspecified complications; K50.80 Crohn's disease of both small and large intestine without complications; K50.811 Crohn's disease of both small and large intestine with rectal bleeding; K50.812 Crohn's disease of both small and large intestine with intestinal obstruction; K50.813 Crohn's disease of both small and large intestine with fistula; K50.814 Crohn's disease of both small and large intestine with abscess; K50.818 Crohn's disease of both small and large intestine with other complication; K50.819 Crohn's disease of both small and large intestine with unspecified complications; K50.90 Crohn's disease,



unspecified without complications; K50.911 Crohn's disease, unspecified, with rectal bleeding; K50.912 Crohn's disease, unspecified, with intestinal obstruction; K50.913 Crohn's disease, unspecified, with fistula; K50.914 Crohn's disease, unspecified, with abscess; K50.918 Crohn's disease, unspecified, with other complication; K50.919 Crohn's disease, unspecified, with unspecified complications

*Ulcerative Colitis:*

K51.00 - Ulcerative Colitis Ulcerative (chronic) pancolitis without complications; K51.011 Ulcerative (chronic) pancolitis with rectal bleeding; K51.012 Ulcerative (chronic) pancolitis with intestinal obstruction; K51.013 Ulcerative (chronic) pancolitis with fistula; K51.014 Ulcerative (chronic) pancolitis with abscess; K51.018 Ulcerative (chronic) pancolitis with other complication; K51.019 Ulcerative (chronic) pancolitis with unspecified complications; K51.20 Ulcerative (chronic) proctitis without complications; K51.211 Ulcerative (chronic) proctitis with rectal bleeding; K51.212 Ulcerative (chronic) proctitis with intestinal obstruction; K51.213 Ulcerative (chronic) proctitis with fistula; K51.214 Ulcerative (chronic) proctitis with abscess; K51.218 Ulcerative (chronic) proctitis with other complication; K51.219 Ulcerative (chronic) proctitis with unspecified complications; K51.30 Ulcerative (chronic) rectosigmoiditis without complications; K51.311 Ulcerative (chronic) rectosigmoiditis with rectal bleeding; K51.312 Ulcerative (chronic) rectosigmoiditis with intestinal obstruction; K51.313 Ulcerative (chronic) rectosigmoiditis with fistula; K51.314 Ulcerative (chronic) rectosigmoiditis with abscess; K51.318 Ulcerative (chronic) rectosigmoiditis with other complication; K51.319 Ulcerative (chronic) rectosigmoiditis with unspecified complications; K51.50 Left sided colitis without complications; K51.511 Left sided colitis with rectal bleeding; K51.512 Left sided colitis with intestinal obstruction; K51.513 Left sided colitis with fistula; K51.514 Left sided colitis with abscess; K51.518 Left sided colitis with other complication; K51.519 Left sided colitis with unspecified complications; K51.80 Other ulcerative colitis without complications; K51.811 Other ulcerative colitis with rectal bleeding; K51.812 Other ulcerative colitis with intestinal obstruction; K51.813 Other ulcerative colitis with fistula; K51.814 Other ulcerative colitis with abscess; K51.818 Other ulcerative colitis with other complication; K51.819 Other ulcerative colitis with unspecified complications; K51.90 Ulcerative colitis, unspecified without complications; K51.911 Ulcerative colitis, unspecified with rectal bleeding; K51.912 Ulcerative colitis, unspecified with intestinal obstruction; K51.913 Ulcerative colitis, unspecified with fistula; K51.914 Ulcerative colitis, unspecified with abscess; K51.918 Ulcerative colitis, unspecified with other complication; K51.919 Ulcerative colitis, unspecified with unspecified complications

*Rheumatoid Arthritis:*

M05.00 Felty's syndrome, unspecified site; M05.011 Felty's syndrome, right shoulder; M05.012 Felty's syndrome, left shoulder; M05.019 Felty's syndrome, unspecified shoulder; M05.021 Felty's syndrome, right elbow; M05.022 Felty's syndrome, left elbow; M05.029 Felty's syndrome, unspecified elbow; M05.031 Felty's syndrome, right wrist; M05.032 Felty's syndrome, left wrist; M05.039

Felty's syndrome, unspecified wrist; M05.041 Felty's syndrome, right hand; M05.042 Felty's syndrome, left hand; M05.049 Felty's syndrome, unspecified hand; M05.051 Felty's syndrome, right hip; M05.052 Felty's syndrome, left hip; M05.059 Felty's syndrome, unspecified hip; M05.061 Felty's syndrome, right knee; M05.062 Felty's syndrome, left knee; M05.069 Felty's syndrome, unspecified knee; M05.071 Felty's syndrome, right ankle and foot; M05.072 Felty's syndrome, left ankle and foot; M05.079 Felty's syndrome, unspecified ankle and foot; M05.09 Felty's syndrome, multiple sites; M05.60 Rheumatoid arthritis of unspecified site with involvement of other organs and systems; M05.611 Rheumatoid arthritis of right shoulder with involvement of other organs and systems; M05.612 Rheumatoid arthritis of left shoulder with involvement of other organs and systems; M05.619 Rheumatoid arthritis of unspecified shoulder with involvement of other organs/systems; M05.621 Rheumatoid arthritis of right elbow with involvement of other organs and systems; M05.622 Rheumatoid arthritis of left elbow with involvement of other organs and systems; M05.629 Rheumatoid arthritis of unspecified elbow with involvement of other organs/systems; M05.631 Rheumatoid arthritis of right wrist with involvement of other organs and systems; M05.632 Rheumatoid arthritis of left wrist with involvement of other organs and systems; M05.639 Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems; M05.641 Rheumatoid arthritis of right hand with involvement of other organs and systems; M05.642 Rheumatoid arthritis of left hand with involvement of other organs and systems; M05.649 Rheumatoid arthritis of unspecified hand with involvement of other organs and systems; M05.651 Rheumatoid arthritis of right hip with involvement of other organs and systems; M05.652 Rheumatoid arthritis of left hip with involvement of other organs and systems; M05.659 Rheumatoid arthritis of unspecified hip with involvement of other organs and systems; M05.661 Rheumatoid arthritis of right knee with involvement of other organs and systems; M05.662 Rheumatoid arthritis of left knee with involvement of other organs and systems; M05.669 Rheumatoid arthritis of unspecified knee with involvement of other organs and systems; M05.671 Rheumatoid arthritis of right ankle and foot with involvement of other organs/systems; M05.672 Rheumatoid arthritis of left ankle and foot with involvement of other organs/systems; M05.679 Rheumatoid arthritis of unspecified ankle/foot with involvement of other organs/systems; M05.69 Rheumatoid arthritis of multiple sites with involvement of other organs and systems; M05.70 Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement; M05.711 Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement; M05.712 Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement; M05.719 Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement; M05.721 Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement; M05.722 Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement; M05.729 Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement; M05.731 Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement; M05.732 Rheumatoid arthritis with

rheumatoid factor of left wrist without organ or systems involvement; M05.739 Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement; M05.741 Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement; M05.742 Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement; M05.749 Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement; M05.751 Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement; M05.752 Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement; M05.759 Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement; M05.761 Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement; M05.762 Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement; M05.769 Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement; M05.771 Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement; M05.772 Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement; M05.779 Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement; M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement; M05.80 Other rheumatoid arthritis with rheumatoid factor of unspecified site; M05.811 Other rheumatoid arthritis with rheumatoid factor of right shoulder; M05.812 Other rheumatoid arthritis with rheumatoid factor of left shoulder; M05.819 Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder; M05.821 Other rheumatoid arthritis with rheumatoid factor of right elbow; M05.822 Other rheumatoid arthritis with rheumatoid factor of left elbow; M05.829 Other rheumatoid arthritis with rheumatoid factor of unspecified elbow; M05.831 Other rheumatoid arthritis with rheumatoid factor of right wrist; M05.832 Other rheumatoid arthritis with rheumatoid factor of left wrist; M05.839 Other rheumatoid arthritis with rheumatoid factor of unspecified wrist; M05.841 Other rheumatoid arthritis with rheumatoid factor of right hand; M05.842 Other rheumatoid arthritis with rheumatoid factor of left hand; M05.849 Other rheumatoid arthritis with rheumatoid factor of unspecified hand; M05.851 Other rheumatoid arthritis with rheumatoid factor of right hip; M05.852 Other rheumatoid arthritis with rheumatoid factor of left hip; M05.859 Other rheumatoid arthritis with rheumatoid factor of unspecified hip; M05.861 Other rheumatoid arthritis with rheumatoid factor of right knee; M05.862 Other rheumatoid arthritis with rheumatoid factor of left knee; M05.869 Other rheumatoid arthritis with rheumatoid factor of unspecified knee; M05.871 Other rheumatoid arthritis with rheumatoid factor of right ankle and foot; M05.872 Other rheumatoid arthritis with rheumatoid factor of left ankle and foot; M05.879 Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot; M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites; M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified; M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site; M06.011 Rheumatoid arthritis without rheumatoid factor, right shoulder; M06.012 Rheumatoid arthritis without rheumatoid factor, left

shoulder; M06.019 Rheumatoid arthritis without rheumatoid factor, unspecified shoulder; M06.021 Rheumatoid arthritis without rheumatoid factor, right elbow; M06.022 Rheumatoid arthritis without rheumatoid factor, left elbow; M06.029 Rheumatoid arthritis without rheumatoid factor, unspecified elbow; M06.031 Rheumatoid arthritis without rheumatoid factor, right wrist; M06.032 Rheumatoid arthritis without rheumatoid factor, left wrist; M06.039 Rheumatoid arthritis without rheumatoid factor, unspecified wrist; M06.041 Rheumatoid arthritis without rheumatoid factor, right hand; M06.042 Rheumatoid arthritis without rheumatoid factor, left hand; M06.049 Rheumatoid arthritis without rheumatoid factor, unspecified hand; M06.051 Rheumatoid arthritis without rheumatoid factor, right hip; M06.052 Rheumatoid arthritis without rheumatoid factor, left hip; M06.059 Rheumatoid arthritis without rheumatoid factor, unspecified hip; M06.061 Rheumatoid arthritis without rheumatoid factor, right knee; M06.062 Rheumatoid arthritis without rheumatoid factor, left knee; M06.069 Rheumatoid arthritis without rheumatoid factor, unspecified knee; M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot; M06.072 Rheumatoid arthritis without rheumatoid factor, left ankle and foot; M06.079 Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot; M06.08 Rheumatoid arthritis without rheumatoid factor, vertebrae; M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites; M06.80 Other specified rheumatoid arthritis unspecified site; M06.811 Other specified rheumatoid arthritis, right shoulder; M06.812 Other specified rheumatoid arthritis, left shoulder; M06.819 Other specified rheumatoid arthritis, unspecified shoulder; M06.821 Other specified rheumatoid arthritis, right elbow; M06.822 Other specified rheumatoid arthritis, left elbow; M06.829 Other specified rheumatoid arthritis, unspecified elbow; M06.831 Other specified rheumatoid arthritis, right wrist; M06.832 Other specified rheumatoid arthritis, left wrist; M06.839 Other specified rheumatoid arthritis, unspecified wrist; M06.841 Other specified rheumatoid arthritis, right hand; M06.842 Other specified rheumatoid arthritis, left hand; M06.849 Other specified rheumatoid arthritis, unspecified hand; M06.851 Other specified rheumatoid arthritis, right hip; M06.852 Other specified rheumatoid arthritis, left hip; M06.859 Other specified rheumatoid arthritis, unspecified hip; M06.861 Other specified rheumatoid arthritis, right knee; M06.862 Other specified rheumatoid arthritis, left knee; M06.869 Other specified rheumatoid arthritis, unspecified knee; M06.871 Other specified rheumatoid arthritis, right ankle and foot; M06.872 Other specified rheumatoid arthritis, left ankle and foot; M06.879 Other specified rheumatoid arthritis, unspecified ankle and foot; M06.88 Other specified rheumatoid arthritis, vertebrae; M06.89 Other specified rheumatoid arthritis, multiple sites; M06.9 Rheumatoid arthritis, unspecified

*Ankylosing Spondylitis:*

M45.0 - Ankylosing spondylitis of multiple sites in spine; M45.1 - Ankylosing spondylitis of occipito-atlanto-axial region; M45.2 - Ankylosing spondylitis of cervical region; M45.3 - Ankylosing spondylitis of cervicothoracic region; M45.4 - Ankylosing spondylitis of thoracic region; M45.5 - Ankylosing spondylitis of thoracolumbar region; M45.6 - Ankylosing spondylitis lumbar region; M45.7 -

Ankylosing spondylitis of lumbosacral region; M45.8 - Ankylosing spondylitis sacral and sacrococcygeal region; M45.9 - Ankylosing spondylitis of unspecified sites in spine

*Plaque Psoriasis:*

L40.50 - Arthropathic psoriasis, unspecified; L40.51 - Distal interphalangeal psoriatic arthropathy; L40.52 - Psoriatic arthritis mutilans; L40.53 - Psoriatic spondylitis; L40.59 - Other psoriatic arthropathy; L40.0 - Psoriasis vulgaris

- Providers must bill with HCPCS code: Q5104 - Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
- One Medicaid and NC Health Choice unit of coverage is: 10 mg
- The maximum reimbursement rate per unit is: \$54.65
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is: 00006-4305-02
- 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**

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## **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).

NC 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:

21931 (A)	26587 (A)	27230	27230 (B)
27265	27265 (B)	27514 (A)	27524 (A)
27690 (A)	27758 (A)	33257 (A)	33391 (A)
33670 (A)	33730 (A)	33736 (A)	33870 (A)
33945 (A)	33980 (A)	35600 (A)	44120 (A)
44121 (A)	64708 (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 NPs, PAs and Certified Nurse Midwives](#).

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

(MP 19.190, MP 19.218, MP 19.222 and MP 20.012)

**GDIT, (800) 688-6696**

**ATTENTION: NURSING HOME PROVIDERS**

**NCMUST Audit**

In accordance with our approved annual plan, the NCMUST PASRR team will be performing an audit of all current organizations, administrators and users of the system. This audit will be performed in more than one phase.

The objectives of this audit are to:

- Identify active organizations
- Identify and confirm organization administrators
- Ensure only active users have access to the system

The scope of the audit will include identifying and taking steps to ensure only active organizations are listed within the system and ensure any inactive user or administrator is removed from the system for the time period of (identify time frame).

Should you have any questions please contact [uspquestions@dhhs.nc.gov](mailto:uspquestions@dhhs.nc.gov).

**PASRR Level 1 Submissions and Supporting Documentation:**

The NC Medicaid Long-Term Care FL2 form should be signed by a physician and dated within 30 days to be considered current. Nurse practitioner (NP) and physician assistant (PA) signatures are only acceptable when counter-signed by a physician. Electronic signatures are acceptable when they clearly identify the physician responsible for the signature.

The history and physical (H & P) and progress notes should contain information related to the most recent hospitalization.

Adult Care Home FL2 forms are no longer authorized for SNF Admissions. The NC Medicaid Long-Term Care FL2 Form can be accessed at:

<https://www.nctracks.nc.gov/content/public/providers/prior-approval.html>

### **NCMUST Tracking Portlet**

42CFR 483.130 (p) requires the State to maintain a tracking system for all individuals with MI or IID in NFs. North Carolina's tracking system is the tracking portlet contained within the NCMUST web application. Nursing home providers should use the tracking portlet when admitting or discharging an individual or when an individual transfers in or out of a facility. The tracking portlet should also be used when a resident with MI or IID has expired. Instructions on using the tracking portlet can be accessed in Chapter 10, page 88 of the PASRR user manual:

<https://ncmust.com/about/User%20Documentation%20ver9.pdf>

### **Help Desk Number**

The Help Desk number has changed. The new number is (919) 813-5603 (direct). The toll-free number continues to be (888) 245-0179. Support staff are available Monday – Friday from 8 a.m. – 5 p.m. except observed State holidays.

**GDIT, (800) 688-6696**

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