January 2015 Medicaid Bulletin

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Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers

NCTracks Updates

EHDI Added to Benefit Plans for Prior Approval Requests

The Early Hearing, Detection and Intervention (EHDI) program (formerly known as Purchase of Medical Care Services, or POMCS) at the N.C. Division of Public Health (DPH) is now part of the NCTracks system. EHDI provides services for eligible children from birth to age 3 who have hearing loss.

Since NCTracks go-live, the EHDI program has been missing from the Benefit Plan drop down box on the Prior Approval (PA) tab of the secure Provider Portal. As a workaround, EHDI program staff have been entering the required information in NCTracks for their providers. This issue was fixed in November 2014 and now providers must complete PA requests before rendering services to EHDI eligible children.

Additional information regarding the EHDI option for PA requests:

- A PA Request form is located in the secure Provider Portal under the Prior Approval tab. For EHDI services, select Public Health as the payer and then select EHDI as the benefit plan.

  Note: The requested dates of service must be within the eligibility dates in NCTracks. No dollar amounts are needed when entering your billing codes (leave that blank).

- The program will pay the cost of the specific covered services if the recipient **does not have** Medicaid or any other form of insurance. The amount paid will not exceed the Medicaid rates.

  EHDI will pay for services when the recipient **has** insurance only if the recipient's insurance company denied the claim, or applies the claim to the deductible or co-pay. In these cases, EHDI will pay for the covered services up to Medicaid rates.

- EHDI covered services include: Initial first-time hearing aid dispensing and fitting fees, ear molds, batteries and accessory kit.

- The PA Request must be completed in its entirety. Once completed, EHDI managers at the DPH will review and approve or deny the request.

- Computer Based Training (CBT) is available regarding PA and NCTracks. Providers can access the training by following these steps:

- Providers can register for CBT courses in SkillPort, the NCTracks Learning Management System by logging onto the secure NCTracks Provider Portal and clicking on Provider Training.
- Open the folder labeled Provider Computer-Based Training (CBT) and Instructor Led Training (ILT). The courses can be found in the sub-folders under CBTs (sorted by topic).
- 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.
- Additional information can be found on the PA page of the NCTracks Provider Portal.

For more information about EHDI, contact Lizzie Guffey at 704-284-0642 or Charlotte Destino at 828-658-1739.

Reminder: 2015 Checkwrite Schedules Posted

The 2015 checkwrite schedules for DMA, DPH, Division of Mental Health/Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Office of Rural Health and Community Care (ORHCC) have been posted to the NCTracks website. They can be found under the Quick Links on the right side of the Provider Portal home page at https://www.nctracks.nc.gov/content/public/providers.html.

In addition, the 2015 checkwrite schedules for DMA, as well as the state holiday schedule, can be found on the DMA Calendar Web page at http://www.ncdhhs.gov/dma/provider/calendar.htm.

Modification to 834O transactions for Managed Care Organizations (MCOs)

Starting with the November 25, 2014 checkwrite, NCTracks began including the dates of service on the X12 834O Benefit Enrollment and Maintenance outbound transaction sent to Managed Care Organizations (MCOs). The dates of service will be returned in Loop 2300, DTP segment, Health Coverage Dates section of the X12. The following qualifiers will be sent to identify the dates of service:

- 2300, DTP01 will equal '343'
- 2300, DTP02 will equal 'RD8'
- 2300, DTP03 will equal the dates of service concatenated

For example, a qualifier might say "DTP*343*RD8*20141001-20141031~"

For additional information, refer to the 834O Benefit Enrollment and Maintenance Companion Guide on the Trading Partner Information page of the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html.

How to Request PA for State-to-State Ambulance Transportation

There are several important considerations when requesting prior approval (PA) for State-to-State Ambulance Transportation:

- Providers may either enter the PA Request via the secure NCTracks Provider Portal or fax/mail the request to NCTracks. Providers are encouraged to submit PA requests via the portal to expedite evaluation. If the request is submitted via the portal, it is preferable to upload supporting documentation as an attachment.

- If the supporting documentation is going to be faxed or mailed, the provider must indicate this when entering the PA request on the portal. The system will present a cover sheet. **The cover sheet should be printed and accompany the supporting documentation when it is faxed or mailed.** The cover sheet has a bar code that will link the supporting documentation to the PA request.

- Providers who fax or mail information with Protected Health Information (PHI) must follow HIPAA guidelines. HIPAA regulations regarding transmitting documents with PHI can be found on DMA's HIPAA Web page at www.ncdhhs.gov/dma/hipaa/ (click on "Submitting Patient Information") and in an article titled *HIPAA Fax and Mail Protections/DMA Addresses* in the September 2014 Medicaid Bulletin at www.ncdhhs.gov/dma/bulletin/0914bulletin.htm.

- If providers fax or mail the PA request, they must use the forms on the NCTracks Prior Approval page at www.nctracks.nc.gov/content/public/providers/prior-approval.html.

- If PA for State-to-State Ambulance Transportation is requested via fax or mail, the provider should submit the Medical Request for PA (DMA 372-118) form, as well as the State-to-State Ambulance Transportation Addendum (DMA 372-118A). Both of the forms must be submitted together.

- If the Medical Request for PA (DMA 372-118) is being submitted for State-to-State Ambulance Transportation, no other services should be included on the form. For example, PA requests for out-of-state surgery or medical services should be submitted on a separate Medical Request for PA (DMA 372-118) form.

- When entering the REQ. END DATE on the prior approval request, do **not** use 12/31/9999. Enter the expected end date, which can be no more than 365 days from the REQ. BEGIN DATE.

Updates Posted to Pharmacy PA Clinical Criteria and Forms

Pharmacy PA clinical criteria and forms for Juxtapid and Crinone 8% Gel have been added to the NCTracks Provider Portal under the Pharmacy Services Web page at www.nctracks.nc.gov/content/public/providers/pharmacy.html. Policy changes have also been posted for the following drug classes:

- Narcotic Analgesics
- Growth Hormones
- Triptans
- Hemanitics
- Sedative Hypnotics
- Buprenorphine
- A+KIDS
- Adult Safety with Antipsychotic Prescribing (ASAP) program.

Anticonvulsants no longer require PA, so PA clinical criteria and forms for such drugs have been removed from NCTracks. However, preferred drugs still must have failed before non-preferred can be prescribed.

Using Provider Portal to Inquire on Recipient Eligibility

Providers who seek information about recipient eligibility using the NCTracks website should use the secure Provider Portal. The Office Administrator for the provider's National Provider ID (NPI) can provision any staff members who need access to recipient eligibility information in NCTracks. Some providers have attempted to obtain recipient eligibility information using the secure Recipient Portal. **The Recipient Portal is for recipients and their families or guardians and should not be used by providers.**

The CBT course "RCP 131 Viewing Recipient Information Eligibility Providers" shows how to access recipient eligibility information using the secure Provider Portal. Providers can register for this course in SkillPort, the NCTracks Learning Management System, by following these steps:

- 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 course can be found under the topic "Recipient" in the sub-folder labeled CBTs.

- Refer to the Provider Training page of the public Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/provider-training.html 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.

CSC, 1-800-688-6696

Attention: All Providers

NC Health Information Exchange (HIE) Subsidy Program

North Carolina Health Information Exchange (NC HIE) and the N.C. Division of Medical Assistance (DMA) have partnered in offering a subsidy program to help cover the costs of connecting qualifying ambulatory practices to the NC HIE. This will enable ambulatory practices to access a wide array of NC HIE services and facilitate compliance with a number of Meaningful Use (MU) measures.

To be eligible, a practice must be a Community Care of North Carolina (CCNC), Carolina Access II medical practice or be a paid participant of the N.C. Medicaid Electronic Health Record (EHR) Incentive program. In addition, the practice must agree to contribute patient data to NC HIE to allow for longitudinal patient studies, and in the case of Medicaid beneficiaries, agree to make data available to CCNC for the purposes of care management.

To learn more about the subsidy and how to get connected to NC HIE, contact Jayson Caracciolo at jcaracciolo@n3cn.org or 919-926-3901 or Kerry Kribbs at kkribbs@n3cn.org or 919-926-3979.

N.C. Medicaid Health Information Technology (HIT)
DMA, NCMedicaid.HIT@dhhs.nc.gov **(preferred contact method), 919-814-0180**

Attention: All Providers

Claims Override Submissions to Behavioral Health

Effective January 1, 2015, when requesting an override for claims not processed through the Local Management Entity-Managed Care Organization (LME-MCO), **original** copies of claims must be mailed to N.C. Division of Medical Assistance (DMA). Faxed or emailed claims can no longer be accepted, as they are frequently illegible.

Mail to:

N.C. Division of Medical Assistance
Attention: Monica Hamlin
2501 Mail Service Center
Raleigh, NC 27699

HIPAA regulations must be followed as medical claims contain Protected Health Information (PHI). HIPAA mailing regulations can be found on DMA's HIPAA web page at www.ncdhhs.gov/dma/hipaa/ (click on "Submitting Patient Information") and in an article titled *HIPAA Fax and Mail Protections/DMA Addresses* in the September 2014 Medicaid Bulletin at www.ncdhhs.gov/dma/bulletin/0914bulletin.htm.

Behavioral Health Services
DMA, 919-855-4290

Attention: All Providers

DMA to begin Institution of Mental Diseases (IMD) Review

The Centers for Medicare & Medicaid Services (CMS) requires the N.C. Division of Medical Assistance (DMA) to undertake ongoing reviews of facilities to determine whether they meet the federal definition of an Institution of Mental Diseases (IMD). Medicaid funding is **not** available to, or for the benefit of, Medicaid beneficiaries living in facilities that have been determined to be IMDs.

An IMD is defined as:

> "A hospital, nursing facility or other institution **of more than 16-beds** that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services."

Facilities identified as potentially being IMDs will receive a letter early in the first quarter of 2015 and will have an initial scheduled phone call. More information about IMD and the review process is available at www.ncdhhs.gov/dma/provider/what-is-an-imd_1214.pdf.

Program Integrity
DMA, 919-855-4317

Attention: All Providers

Prior Approval Requests for Outpatient Specialized Therapies

All prior authorization (PA) requests for outpatient specialized therapies for both Medicaid and N.C. Health Choice must be submitted to the N.C. Division of Medical Assistance's (DMA's) PA Review Contractor – Carolinas Center for Medical Excellence (CCME).

CCME's web portal for submitting PA requests can be found at https://www.medicaidprograms.org/NC/ChoicePA/Account/Login.aspx.

Outpatient Specialized Therapy
DMA, 919-855-4308

Attention: All Providers

National Correct Coding Initiative: New PTP-Associated Modifiers

In a December 2014 special bulletin titled Modifier 59 Guidance from Centers for Medicare and Medicaid Services (CMS), the N.C. Division of Medical Assistance (DMA) published CMS guidance introducing four new modifiers to be used in the place of modifier 59:

- XE Separate encounter: a service that is distinct because it occurred during a separate encounter
- XP Separate practitioner: a service that is distinct because it was performed by a different practitioner
- XS Separate structure: a service that is distinct because it was performed on a separate organ/structure
- XU Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service

The start date for these modifiers was indicated as January 1, 2015. However, the necessary changes have not yet been made in NCTracks to accommodate these modifiers.

Providers must continue to use modifier 59 when appropriate until notified that the new modifiers may be used in NCTracks.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

CPT Code Update: 2015

Effective with date of service January 1, 2015, the American Medical Association (AMA) has added new CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2015 edition of Current Procedural Terminology, published by the AMA.) **Providers should note the full descriptions as well as all associated parenthetical information published in this edition when selecting a code for billing services to the N.C. Division of Medical Assistance (DMA).**

Claims submitted with the new 2015 Codes will pend.

The State and CSC are in the process of completing system updates to align our policies with CPT code changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that claims billed with the new codes will process and pay correctly.

Until this process is completed, claims submitted with new codes will pend for "no fee on file". These pended claims will recycle and pay when the system work is completed. No additional action will be required by providers to ensure that claims process and pay correctly after the system work is completed. This process will also be applicable to the Medicare crossover claims.

To maintain cash flow, providers may wish to split claims and bill new codes on a separate claim. This will ensure that only claims billed with the new procedure codes are pended for processing.

New CPT codes that are covered by the N.C. Medicaid program are effective with date of service January 1, 2015. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2015. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

New Covered CPT Codes by Medicaid and NCHC (effective 01/01/2015)									
20604	20606	20611	20983	21812	21813	27279	33270	33271	33272
33273	33946	33947	33948	33949	33951	33952	33954	33956	33958
33962	33964	33966	33984	33986	33987	33988	33989	37218	43180
44381	44384	44401	44402	44403	44404	44405	44406	44407	44408
45346	45347	45349	45350	45388	45389	45390	45393	45398	45399
46601	46607	47383	62302	62303	62304	62305	66179	66184	76641
76642	77085	77086	77306	77307	77316	77317	77318	77385	77386
77387	80163	80165	80300	80301	80302	80303	80304	80320	80321
80322	80323	80324	80325	80326	80327	80328	80329	80330	80331
80332	80333	80334	80335	80336	80337	80338	80339	80340	80341
80342	80343	80344	80345	80346	80347	80348	80349	80350	80351
80352	80353	80354	80355	80356	80357	80358	80359	80360	80361

New Covered CPT Codes by Medicaid and NCHC (effective 01/01/2015)									
80362	80363	80364	80365	80366	80367	80368	80369	80370	80371
80372	80373	80374	80375	80376	80377	87505	87506	87507	87623
87624	87625	87806	88341	88344	88364	88366	88369	88373	88374
88377	91200	93260	93261	93355	93644	96127	99188		

New HCPCS Codes Covered by Medicaid and NCHC (effective 01/01/2015)									
A9606	J0153	J0887	J0888	J1071	J1322	J1439	J2274	J3121	J7181
J7182	J7200	J7201	J7327	J7336	J9267	J9301	L3981	L6026	J7259

New CPT Codes Not Covered by Medicaid and NCHC									
21811	22510	22511	22512	22513	22514	22515	22858	33418	33419
34839	52441	52442	64486	64487	64488	64489	77061	77062	77063
81246	81288	81313	81410	81411	81415	81416	81417	81420	81425
81426	81427	81430	81431	81435	81436	81440	81445	81450	81455
81460	81465	81470	81471	81519	83006	89337	90630	90651	92145
93702	93895	97607	97608	99184	99490	99497	99498		

New CPT Codes Covered by Medicaid but Not Covered by NCHC							
33953	33955	33957	33959	33963	33965	33969	33985

End-Dated CPT Codes (effective 12/31/2014)									
00452	00622	00634	21800	21810	22520	22521	22522	22523	22524
22525	29020	29025	29715	33332	33472	33960	33961	36469	36822
42508	43350	44383	44393	44397	45339	45345	45355	45383	45387
61334	61440	61470	61490	61542	61609	61875	62116	64752	64761
64870	66165	69400	69401	69405	72291	72292	74291	76645	76950
77082	77305	77310	77315	77326	77327	77328	77403	77404	77406
77408	77409	77411	77413	77414	77416	77418	77421	80100	80101
80102	80103	80104	80152	80154	80160	80166	80172	80174	80182
80196	80440	82000	82003	82055	82101	82145	82205	82520	82646
82649	82651	82654	82666	82690	82742	82953	82975	82980	83008
83055	83071	83634	83805	83840	83858	83866	83887	83925	84022
84127	87001	87620	87621	87622	88343	88349	99481	99482	99488

All Category II and III Codes are not covered.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Behavioral Health Providers, Pharmacists and Prescribers

N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes - UPDATE

Note: This article was previously published in the December 2014 Medicaid Bulletin, but the highlighted portion has been changed.

Effective with an estimated date of service of **January 1, 2015,** the N.C. Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL). Below are highlights of some of the changes that will occur.

- The prior authorization criteria will be removed from the leukotriene class
- New classes are being added:
  - Under TOPICAL, Imidazoquinolinamines
  - Under MISCELLANEOUS, Epinephrine, Self-Injected; Estrogen Agents, Vaginal Preparations; Glucocorticoid Steroids, Oral
- Some mental health pharmaceuticals will have non-preferred options for the first time. Below is what the PDL will look like January 1, 2015. Note that only trial and failure of one preferred is required for antipsychotic medications. This programing will not be in place on January 1, 2015. All oral antipsychotics will stay preferred until the programing to allow trial and failure of one preferred is completed in mid- to late-February.

ANTIDEPRESSANTS- Other	
Preferred	**Non-Preferred**
bupropion (generic for Wellbutrin®)	Aplenzin®
bupropion SR (generic for Wellbutrin SR®)	Brintellix®
bupropion XL (generic for Wellbutrin XL®)	desvenlafaxine ER (generic for Pristiq®)
Cymbalta®	duloxetine (generic for Cymbalta®)
maprotiline (generic for Ludiomil®)	Effexor XR® Capsules
mirtazapine (generic for Remeron®)	Emsam®
Nardil®	Fetzima®
Parnate®	Forfivo XL®
phenelzine (generic for Nardil®)	Khedezla®

ANTIDEPRESSANTS- Other (continued)	
Preferred	**Non-Preferred**
Savella®	nefazodone (generic for Serzone®)
tranylcypromine (generic for Parnate®)	Oleptro ER®
trazodone (generic for Desyrel®)	Pristiq®
venlafaxine (generic for Effexor®)	Remeron®
venlafaxine ER capsules (generic for Effexor XR Capsules®)	Remeron® ODT
	venlafaxine ER tablets (generic for Effexor XR Tablets®)
	Viibryd®
	Wellbutrin®
	Wellbutrin SR®
	Wellbutrin XL®

ANTIDEPRESSANTS -Selective Serotonin Reuptake Inhibitor (SSRI)	
Preferred	**Non-Preferred**
citalopram (generic for Celexa®)	Brisdell®
escitalopram tablet (generic for Lexapro® Tablet)	Celexa®
fluoxetine capsule (generic for Prozac® Capsule)	escitalopram solution (generic for Lexapro® Solution)
fluoxetine solution (generic for Prozac® Solution)	fluoxetine DR 90mg Caps (generic for Prozac Weekly®)
fluvoxamine (generic for Luvox®)	fluvoxamine ER (generic for Luvox CR®)
paroxetine (generic for Paxil®)	Lexapro®
sertraline (generic for Zoloft®)	Luvox CR®
	paroxetine CR (generic for Paxil CR®)
	Paxil®
	Paxil CR®
	Pexeva®
	Prozac®
	Prozac Weekly®
	Sarafem®
	Zoloft®

ANTIHYPERKINESIS	
Preferred	**Non-Preferred**
Adderall XR®	amphetamine salt combo XR capsules (generic for Adderall XR)
Adderall®	Concerta®
amphetamine salt combo tablets (generic for Adderall)	dexmethylphenidate (generic for Focalin®)
clonidine ER (Kapvay®)	dexmethylphenidate XR (generic for Focalin® XR)
Daytrana®	dextroamphetamine ER (generic for Dexedrine Spansules®)
Desoxyn®	dextroamphetamine solution (generic for ProCentra®)
Dexedrine Spansules®	Intuniv®
dextroamphetamine (generic for DextroStat®)	methamphetamine (generic for Desoxyn®)
Focalin®	Methylin Chewable Tablet®
Focalin XR®	methylphenidate CD capsules (generic for Metadate® CD)
Kapvay®	methylphenidate LA capsules (generic for Ritalin® LA)
Metadate CD®	methylphenidate solution (generic for Methylin® Solution)
Metadate ER®	ProCentra®
Methylin Solution®	Ritalin® SR
methylphenidate ER tablets (generic for Concerta®)	Zenzedi®
methylphenidate ER tablets (generic for Ritalin® SR)	
methylphenidate tablets (generic for Methylin®/Ritalin®)	
Quillivant XR®	
Ritalin®	
Ritalin® LA	
Strattera®	
Vyvanse®	

ATYPICAL ANTIPSYCHOTICS	
Injectable Long Acting	
(Trial and Failure of only 1 preferred required)	
Preferred	**Non-Preferred**
Abilify Maintena®	
fluphenazine decanoate (generic for Prolixin decanoate®)	
Haldol decanoate®	
haloperidol decanoate (generic for Haldol decanoate®)	
Invega Sustenna®	
Risperdal Consta®	
Zyprexa Relprevv®	

ATYPICAL ANTIPSYCHOTICS	
Oral	
(Trial and Failure of only 1 preferred required)	
Preferred	**Non-Preferred**
Abilify®	Clozaril®
clozapine (generic for Clozaril®)	Fanapt® Titration Pack
clozapine ODT (generic for FazaClo®)	FazaClo®
Fanapt®	Geodon®
Invega®	olanzapine/fluoxetine (generic for Symbyax®)
Latuda®	Risperdal®
olanzapine (generic for Zyprexa®)	Risperdal M®
olanzapine ODT (generic for Zyprexa® Zydis)	Seroquel®
quetiapine (generic for Seroquel®)	Versacloz®
risperidone (generic for Risperdal®)	Zyprexa®
risperidone ODT (generic for Risperdal M®)	Zyprexa Zydis®
Saphris®	
Seroquel® XR	
Symbyax®	
ziprasidone (generic for Geodon®)	

If you have a patient who is stable on a non-preferred product, and want them to continue on it, you may fill out a standard drug request prior authorization form found at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

These forms will be accepted beginning December 1, 2014. Forms must be submitted by December 30, 2014 to have approved prior authorizations active in the system by January 1, 2015.

1. Update on preferred brands with non-preferred generic equivalents

In addition to the changes above, preferred brands with non-preferred generic equivalents will be updated and are listed in the chart below:

Brand Name	Generic Name
Accolate	Zafirlukast
Adderall XR	Amphetamine Salt Combo ER
Aldara	Imiquimod
Alphagan P	Brimonidine
Astelin/Astepro	Azelastine Hydrochloride
Bactroban	Mupirocin
Benzaclin	Clindamycin/Benzoyl Peroxide
Cardizem LA	Matzim LA
Catapress-TTS	Clonidine Patches
Cedax	Ceftibuten
Cymbalta	Duloxetine
Derma-Smoothe-FS	Fluocinolone 0.01% Oil
Desoxyn	Methamphetamine
Dexedrine Spansules	Dextroamphetamine
Diastat/Diastat Accudial	Diazepam Rectal
Differin	Adapalene
Diovan	Valsartan
Diovan HCT	Valsartan / Hydrochlorothiazide
Duetact	Pioglitazone / Glimepiride
Epivir HBV	Lamivudine HBV
Entocort EC	Budesonide
Epi-Pen	Epinephrine
Exforge	Amlodipine / Valsartan
Exelon	Rivastigmine
Focalin / Focalin XR	Dexmethylphenidate
Gabitril	Tiagabine
Gris-Peg	Griseofulvin Ultramicrosize
Hepsera	Adefovir
Kadian ER	Morphine Sulfate ER

Brand Name	Generic Name
Lovenox	Enoxaparin
Metadate CD	Methylphenidate CD
Methylin Solution	Methylphenidate Solution
Metrogel Vaginal	Metronidazole Gel Vaginal
Natroba	Spinosad
Niaspan ER	Niacin ER
Opana ER	Oxymorphone ER
Prandin	Repaglinide
PrevPac	Lansoprazole / Amoxicillin / Clarithromycin
Provigil	Modafinil
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Budesonide 0.25mg/2ml, 0.5mg/2ml
Ritalin LA	Methylphenidate ER
Symbyax	Olanzapine / Fluoxetine
Tobradex Suspension	Tobramycin/Dexamethasone Susp
Toprol XL	Metoprolol Succinate
Travatan	Travoprost
Verelan PM	Verapamil ER PM
Zovirax Ointment	Acyclovir Ointment

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Submitting Managed Change Requests

Regional Care Consultants can help providers planning to submit managed change requests affecting their Community Care of North Carolina/Carolina ACCESS (CCNC/CA) beneficiaries. Consultants can provide guidance in situations such as:

- Changes in ownership;
- Adding or deleting service locations;
- Adding or deleting providers; and
- Restriction changes.

A current list of consultants is on N.C. Division of Medical Assistance (DMA) CCNC/CA web page at www.ncdhhs.gov/dma/ca/mcc_051214.pdf.

CCNC/CA Managed Care Section
DMA, 919-855-4780

Attention: Hospice Providers

Hospice Prior Approval (PA) Process: Update

Effective **January 1, 2015,** requests for hospice prior approval (PA) updates are to be submitted to the N.C. Division of Medical Assistance (DMA) for review and processing. Update requests are inclusive of, but not limited, to revocations, discharges or voids.

Providers must complete the N.C. Division of Medical Assistance (DMA) Hospice Reporting Form (DMA-0004) which can be found at www.ncdhhs.gov/dma/provider/forms.htm and in the NCTracks Provider Portal.

Note: Forms should be faxed to DMA at 919-715-9025. Requests should not be sent to CSC.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Physicians, Physician Assistants and Nurse Practitioners

Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase (HyQvia®), HCPCS code J3590: Billing Guidelines

Effective with date of service November 1, 2014, the N.C. Medicaid Program covers immune globulin infusion 10% (human) with recombinant human hyaluronidase (HyQvia®), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 Unclassified biologics. HyQvia® is currently commercially available in 2.5 gm/25 ml, 5 gm/50 ml, 10 gm/100 ml, 20 gm/200 ml, and 30 gm/300 ml vials.

Immune globulin infusion 10% (human) with recombinant human hyaluronidase (HyQvia®) is indicated for the treatment of Primary Immunodeficiency (PI) in adults.

The recommended dosage for immune globulin infusion 10% (human) with recombinant human hyaluronidase (HyQvia®) is 300 to 600 mg/kg at 3 to 4 week intervals, after initial ramp-up.

Ramp-up schedule: Week 1: 7.5 grams; Week 2: 15 grams; Week 4: 22.5 grams; Week 7 (if needed): 30 grams.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing immune globulin infusion 10% (human) with recombinant human hyaluronidase (HyQvia®) must not be restricted based on ICD-9 code. There are many approved and medically accepted indications. Providers must select the most appropriate ICD-9 diagnosis codes with the highest level of specificity to describe a patient's condition. All codes must be supported with adequate documentation in the medical record.

- Providers must bill HyQvia® with HCPCS code J3590 Unclassified biologics.

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for HyQvia® is 100 mg. The maximum reimbursement rate per 100 mg is $16.4574. One 2.5 gm/25 ml vial contains 25 billable units; 5 gm/50 ml vials contain 50 billable units; 10 gm/100 ml vials contain 100 billable units; 20 gm/200 ml vials contains 200 billable units and the 30 gm/300 ml vials contains 300 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for HyQvia® 50 mg vials are 00944-2510-02, 00944-2511-02, 00944-2512-02, 00944-2513-02, and 00944-2514-02.

- The NDC units for immune globulin infusion 10% (human) with recombinant human hyaluronidase (HyQvia®) should be reported as "UN1."

- For additional instructions, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on the N.C. Division of Medical Assistance (DMA) Medicaid Bulletin web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.

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

- The fee schedule for the PDP is available on DMA's fee schedule web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Physicians, Nurse Practitioners and Physician Assistants

Pembrolizumab (Keytruda®), HCPCS code J9999: Billing Guidelines

Effective with date of service October 1, 2014, the N.C. Medicaid Program covers pembrolizumab (Keytruda®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 Not otherwise classified, antineoplastic drugs. Keytruda® is currently commercially available in 50 mg vials.

Pembrolizumab (Keytruda®) is indicated for unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor.

The recommended dosage for pembrolizumab (Keytruda®) is 2 mg/kg as an intravenous infusion over 30 minutes every 3 weeks.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing pembrolizumab (Keytruda®) is 172 malignant melanoma of skin.
- Providers must bill Keytruda® with HCPCS code J9999 Not otherwise classified, antineoplastic drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Keytruda® is 1 mg. The maximum reimbursement rate per mg is $46.6200. One 50 mg vial contains 50 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Keytruda® 50 mg vials are 00006-3029-01 and 00006-3029-02.
- The NDC units for pembrolizumab (Keytruda®) should be reported as "UN1".
- For additional instructions, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on the N.C. Division of Medical Assistance (DMA) Medicaid Bulletin web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge for non-340-B drugs. The Physician's Drug Program reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the

Office of Pharmacy Affairs (OPA) at http://opanet.hrsa.gov/opa/Default.aspx. Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on DMA's fee schedule web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Physicians, Nurse Practitioners and Physician Assistants

Peginterferon beta-1a (Plegridy™), HCPCS code J3590: Billing Guidelines

Effective with date of service October 1, 2014, the N.C. Medicaid Program covers peginterferon beta-1a (Plegridy™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 Unclassified biologics. Plegridy™ is currently commercially available in 63 mcg/0.5 ml, 94 mcg/0.5 ml, and 125 mcg/0.5 ml injections.

Peginterferon beta-1a (Plegridy™) is indicated for relapsing forms of multiple sclerosis.

The recommended dosage for peginterferon beta-1a (Plegridy™) is 125 micrograms every 14 days. Dose should be titrated, starting with 63 micrograms on day 1, 94 micrograms on day 15, and 125 micrograms (full dose) on day 29.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing peginterferon beta-1a (Plegridy™) is 340 Multiple sclerosis.
- Providers must bill Plegridy™ with HCPCS code J3590 Unclassified biologics.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Plegridy™ is 0.5 ml. The maximum reimbursement rate per 0.5 ml is $2,576.88. One syringe contains 1 billable unit.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Plegridy™ 63 mcg/0.5 ml, 94 mcg/0.5 ml, and 125 mcg/0.5 ml injections are 64406-0011-01, 64406-0012-01, 64406-0015-01, and 64406-0016-01.
- The NDC units for peginterferon beta-1a (Plegridy™) should be reported as "UN1."
- For additional instructions, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on the N.C. Division of Medical Assistance (DMA) Medicaid Bulletin web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge for non-340-B drugs. The PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs

(OPA) at http://opanet.hrsa.gov/opa/Default.aspx. Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on DMA fee schedule web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to:

Richard K. Davis
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2015 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	**EFT Effective Date**
January	1/01/15	1/06/15	1/07/15
	1/08/15	1/13/15	1/14/15
	1/15/15	1/21/15	1/22/15
	1/22/15	1/27/15	1/28/15
	1/29/15	2/03/15	2/04/15
February	2/05/15	2/10/15	2/11/15
	2/12/15	2/18/15	2/19/15
	2/19/15	2/24/15	2/25/15
	2/26/15	3/03/15	3/04/15

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

Sandra Terrell, MS, RN
Director of Clinical
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
CSC