March 2015 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates

Reminder: Process to Change Office Administrator is Online

As of January 4, 2015, updates to the Office Administrator on a provider record are accomplished by completing an online Change Office Administrator Application. The online application is available on a new NCTracks Office Administrator Change Process web page at https://www.nctracks.nc.gov/content/public/providers/Office-Admin.html. The web page is also accessible from the navigation menu on the left side of the NCTracks public Provider Portal home page.

A step-by-step "Change Office Administrator Application Guide" is posted under Quick Links on the new Office Administrator Change Process web page.

This automated process replaces the previous paper form(s) used to change an Office Administrator.

Inactive NCID accounts removed from NCID after 18 months

Providers and trading partners should be aware that North Carolina Identity Management (NCID) accounts, both business and individual, are removed from NCID after 18 months of inactivity. This will not impact those who enter claims, prior approval requests, or otherwise access the NCTracks Provider portal regularly.

However, trading partners who use secure File Transfer Protocol (FTP) to submit transactions to NCTracks and do not log on to the Provider portal will have no activity registered on their NCID. **Trading partners who use secure FTP are encouraged to log on to the NCTracks portal at least once a quarter to maintain their NCID account.**

Note: Accessing the NCID portal at https://ncid.nc.gov also counts toward NCID activity.

Once an NCID account is removed, the user must obtain a new NCID and be reprovisioned for access to NCTracks.

For more information, see the state NCID website at https://www.ncid.its.state.nc.us.

Increase in NCTracks Recredentialing Period

Effective February 18, 2015, DMA has changed the length of time required before a provider must recredential in NCTracks from 3 years to 5 years.

NCTracks is adding 2 years to the due dates for recredentialing of existing providers. For

example, if a provider's current due date for recredentialing is October 1, 2015, his new due date will be October 1, 2017. For new providers who enroll in NCTracks, the due date for recredentialing will automatically be set to 5 years.

Providers who are currently recredentialing will complete the process already underway. The due date for their next recredentialing will be set to 5 years from the approval date.

Providers who have received a letter notifying them that recredentialing is due soon, but have not yet started the recredentialing process, should disregard the letter. Their recredentialing due date will be extended by two years.

Update on 2014 IRS 1099 Tax Forms

The 2014 IRS 1099 tax forms were printed and mailed on Tuesday, January 27, 2015. Providers receive one 1099 per Tax ID per payment source (e.g., Division of Medical Assistance (DMA), Division of Public Health (DPH), etc.).

- If a provider has multiple NPIs associated with the same Tax ID and only serves DMA recipients, they will receive only one 1099.
- If they serve DMA and DPH recipients, they will receive two 1099s, etc.

The 1099s were sent to the "Pay To" location currently on file. The "Pay To" address is found in location 001 on the provider record.

Note: If there are multiple NPIs using the same Tax ID, the 1099 will be sent to the address associated with the most recently updated provider record.

An updated list of Frequently Asked Questions (FAQ) regarding 1099s can be found on the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-1099s.html. Consult this FAQ before contacting the Call Center with questions regarding a 1099.

Providers who did not receive a 1099 can notify NCTracks by using the "Contact Us" link found in the footer of every NCTracks web page. Instructions for submitting the notification are included in the FAQ page.

Ensuring accurate EINs in provider records

A change was implemented on January 4, 2015, that will help ensure accurate Employer Identification Numbers (EINs) on provider records. Due to this change, providers will receive an error message if they attempt to enter an EIN into their provider record that is already in the NCTracks system.

Previously, individual providers may have placed the EIN of the group they work for on their application.

- Individual providers should never report the EIN of an organization on their individual provider record.
- The record of an individual provider must reflect their own EIN or Social Security Number (SSN).

NCTracks has already sent notification requesting that individual providers correct the information on their personal records if they are using an organization's EIN instead of their own EIN or SSN. Letters will be sent at the end of each quarter to individual providers who continue to maintain the EIN of an organization on their provider record.

For more information, see the Provider Enrollment Frequently Asked Questions (FAQ) on the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-providerenrollment.html.

Reminder - Default Effective Dates When Updating Provider Record

When updating a provider record in NCTracks, the Manage Change Request (MCR) will assign a default effective date of the current date to most changes. The same is true of initial enrollment applications.

The system will edit subsequent transactions against the effective dates in the provider record. For example, claims are edited against the effective date of the taxonomy codes on the provider record. The claim will deny, if a provider bills for a service rendered prior to the effective date of the relevant taxonomy code on the provider record. Some effective dates can be changed from the default date, such as the effective date a health plan is added or reinstated and changes to service locations or taxonomy codes. **However, the effective date must be changed before the initial enrollment application or MCR is submitted.**

The effective date also **cannot** precede the enrollment date, the date associated with the relevant credential or license, or be older than 365 days.

Other effective dates cannot be changed from the default date. For example, the effective date for affiliation of an individual provider to a group or hospital will default to the current date and it cannot be changed. Therefore, it is important that affiliations be designated on the provider record prior to rendering the service. [Note: the affiliation edit is currently set to pay and report.]

Note: Providers are not guaranteed a retroactive effective date and are **strongly** encouraged to provide services only after they are enrolled as N.C. Medicaid or N.C. Health Choice (NCHC) providers. However, DMA will consider specific requests for retroactive effective dates if a beneficiary has been granted retroactive eligibility; an emergency service was provided; or medically necessary services were rendered and the

provider's credentials, licensure, certifications, etc. were active and in good standing for the earliest effective date of service.

If an initial enrollment application or MCR is submitted with the wrong effective date(s), the provider will need to contact the NCTracks Call Center at 1-800-688-6696 and request a ticket be entered to change the effective date.

- This process may take several weeks to complete because it requires multiple levels of approval.
- Consequently, providers are encouraged to verify the effective dates of any additions or changes to the provider record prior to submitting the initial enrollment application or MCR.

"Share Your ICD-10 Story"

The Centers for Medicare & Medicaid Services (CMS) is seeking providers, vendors, clearinghouses, and others to share their ICD-10 stories with the health care community regarding how they are preparing their organization for the transition. Sharing stories can help others across the country prepare for October 1, 2015.

Areas of interest include:

- Training and educating staff about the transition
- Clinical documentation improvement
- Coordinating with vendors to update software
- Testing systems within the practice and with clearinghouses and health plans
- Collaborating with other health care organizations on ICD-10

Visit www.roadto10.org/physician-stories/ to view others' stories or share one of your own.

New User Guide – How to Access Online Training Sessions

A new User Guide, "How to Access Online Training Sessions," has been posted under the heading **NCTracks Training Tool Kits** on the Provider Training page of the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/provider-training.html .

The guide provides step-by-step instructions for attending online training sessions, also referred to as "Remote via WebEx." Providers who are planning to attend an online training session are encouraged to read the guide in advance.

CSC, 1-800-688-6696

Attention: All Providers

Non-Emergent Medical Transportation (NEMT) by Nursing Facilities and Adult Care Homes – UPDATE

Note: This updates an article titled *Non-emergency Transportation by Nursing Facilities and Adult Care Homes* which was published in March 2001.

This article clarifies the responsibility of nursing facilities and Adult Care Homes (ACHs) have when Medicaid beneficiaries requires non-emergent medical transportation (NEMT).

According to 42 CFR 431.53 (c)(1) *Assurance of Transportation*, provisions must be made for assuring necessary transportation of beneficiaries to and from their providers. Methods used to assure such transportation are described in 42 CFR 431. 53 (c)(1) Attachment 3.1D. Examples of NEMT include transporting Medicaid beneficiaries to a physician's office or from an emergency department back to their residence.

Since October 1, 1994, nursing facilities have been responsible for the NEMT of their residents – unless ambulance transport is required. The cost of NEMT service is reimbursed under the facility's direct rate.

However, ACHs have not been reimbursed for NEMT as part of the facility's direct rate since January 1, 2013. Rather, county Department of Social Services (DSS) offices are responsible for providing NEMT to ACH residents who receive Medicaid. ACHs may contact their county DSS office to request NEMT assistance, or may sign a contract with the county DSS office to provide the service directly. Such contracts must be mutually agreed upon by the county DSS and ACH.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Procedure Code Update to Add Nurse Practitioner and Physician Assistant Taxonomies

Note: This article was previously published in the February 2015 Medicaid Bulletin.

The N.C. Division of Medical Assistance (DMA) continues to identify procedure codes for which Nurse Practitioners (NP) and Physician Assistants (PA) have been unable to receive reimbursement. Some of the CPT codes that have been identified are listed below. System changes have been made and NPs and PAs should resubmit claims that were filed in a timely manner for dates of service on or after July 1, 2013.

As other procedure codes are identified, system changes will be made and providers will be notified in future Medicaid Bulletins.

10080	11100	11752	11981	17106	17111	20500	20552
20610	22632	23600	24530	24560	24576	27501	27560
27810	27824	32655	33405	33430	33464	33472	36558
36571	36581	36582	36589	36561	36590	36870	38220
43644	47525	49422	51705	51741	51798	54056	56501
58300	58301	59025	63030	63047	67700	70450	72069
72070	72110	72120	72202	73000	73080	73550	75820
75978	75984	76645	76700	80048	80061	80069	80154
80299	81002	81003	81025	82043	82075	82145	82205
82486	82520	83540	83735	83789	83805	83840	83925
83992	84153	84460	84479	85018	85610	85652	86376
86756	87184	87480	87510	87660	87880	88164	99202
99203	99204	99205	99212	99213	99214	99215	99219
99243	99251	99252	99253	99254	99255	99285	99354
99385	99395	G0202	G0434	J3420	J3480	J7030	J7321
J7323	J7325	Q0111					

CSC, 1-800-688-6696

All Providers

Viekira Pak to be the Preferred Hepatitis-C Agent

Effective March 20, 2015, Viekira Pak will be the preferred agent for treatment of Hepatitis-C. A PA form is required for all Hepatitis-C products. Prior Authorization (PA) forms will be available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

Note: PA forms will be denied if they are not accompanied by a "Patient Readiness to Treat" form signed by the patient, and supporting lab results.

Additional criteria for the treatment of Hepatitis-C criteria are posted at https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Behavioral Health Service Providers

Behavioral Health Unmanaged Visits to Restart on State Fiscal versus Calendar Year

Starting July 1, 2015, limitations on unmanaged visits to behavioral health providers will begin resetting according to the state fiscal year (July 1 – June 30), rather than the calendar year. **Therefore, unmanaged visits will reset every July 1, rather than every January 1.**

Behavioral health outpatient services and selected behavioral health enhanced services have a specified number of unmanaged visits that do not require Prior Authorization (PA). For example, children are allowed 16 unmanaged outpatient visits before PA is required.

The number of unmanaged visits for beneficiaries managed by the LME-MCO is determined by the LME-MCO. Historically, these unmanaged visits for N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries reset every January 1. Beneficiaries will receive their unmanaged visits effective January 1, 2015. **Effective July 1, 2015, the count of behavioral health services with unmanaged visits will restart and new unmanaged visits will be available every July 1.** This applies to Medicaid beneficiaries, NCHC beneficiaries, legal aliens, and children ages 0 to 3.

It is recommended that approved vendors providing PA to the above populations end-date their authorizations effective June 30, 2015 to ensure that beneficiaries receive new unmanaged benefits effective July 1, 2015.

Contacts for questions about:

- **Medicaid and NCHC:**
  Bert Bennett at 336-946-1003 (Bert.Bennett@dhhs.nc.gov)

- **Other State-Funded Behavioral Health Programs:**
  Mabel McGlothlen at 919-218-1953(Mabel.McGlothen@dhhs.nc.gov)

- **General Inquiries:**
  Kathy Nichols at 919-855-4289 (Katherine.Nichols@dhhs.nc.gov)
  Bert Bennett at 336-946-1003 (Bert.Bennett@dhhs.nc.gov).

Behavioral Health Policy Section
DMA, 919-855-4290

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

Terminating Service Locations in NCTracks

Providers are advised to contact their regional consultant prior to terminating a service location that is currently active with Community Care of North Carolina/Carolina ACCESS (CCNC/CA). Such changes may affect the patient population in unexpected ways.

Consultants can provide assistance with:

- Completing the NCTracks Managed Change Request (MCR).
- Discussion of options when closure of service location is due to name change, NPI change or change of ownership.
- Coordination with the CCNC network, if applicable.
- Information regarding patient notification and record retention.

A current list of consultants is on the 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: Hospital Providers

NC Medicaid Recovery Audit Contract II (RACII)

As described in an article titled *NC Medicaid Recovery Audit Contractors (RAC)* in the October, 2012 Medicaid Bulletin, the N.C. Division of Medical Assistance (DMA) has selected HMS to become the second Recovery Audit Contactor (RAC) vendor for the State of North Carolina.

HMS initiated RAC activities by performing post-pay audits on inpatient hospital claims. Inpatient hospital reviews for medical necessity are being discontinued and HMS will begin reviewing alternate scenarios and provider types.

As posted on the HMS website in January 2015, HMS is identifying outpatient hospital services rendered by the same provider within 24 hours of admission for an inpatient hospital stay. Per Subsection 3.4 of DMA Clinical Coverage Policy 2A-1: *Acute Inpatient Hospital Services*, reimbursement for these services represents an overpayment. When overpayments are identified, providers will receive a Tentative Notice of Overpayment (TNO) letter specifying each claim overpayment and a description of the findings.

Clinical coverage policies can be found on DMA's website at www.ncdhhs.gov/dma/mp/.

The next HMS RAC review is scheduled to begin March, 2015. This review will focus on claims for which the DRG assignment for **newborn care** appears inconsistent with the claim attributes. This review will entail validating the accuracy of the hospital's ICD-9-CM coding of all diagnoses and procedures that affect the MS-DRG by review of the medical record.

For more information, visit the HMS RAC website at www.medicaid-rac.com/ncproviders/ or contact:

- **DMA:** Linda Marsh at Linda.Marsh@dhhs.nc.gov or 919-814-0000
- **HMS:** NCRACII@HMS.com or 1-855-438-6415

Program Integrity
DMA, 919-814-0000

Attention: Physicians, Physician Assistants and Nurse Practitioners

Testosterone undecanoate (Aveed™) HCPCS code J3145: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid program covers testosterone undecanoate (Aveed™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3145 Injection, testosterone undecanoate, 1 mg. Aveed™ is currently commercially available in 750 mg/3 mL vials.

Testosterone undecanoate (Aveed™) is indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). Aveed™ is restricted to males only, and safety has not been established in pediatric patients less than 18 years old.

The recommended dosage for testosterone undecanoate (Aveed™) is 3 mL (750 mg) injected intramuscularly at initiation, at 4 weeks, and every 10 weeks thereafter.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing testosterone undecanoate (Aveed™) is 257.2, Other testicular hypofunction.
- Providers must bill Aveed™ with HCPCS code J3145 Injection, testosterone undecanoate, 1 mg.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Aveed™ is 1 mg .The maximum reimbursement rate per 1 mg is $1.1880. One 750 mg/3 mL vial contains 750 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Aveed™ 750 mg/3 mL vial is 67979-0511-43.
- The NDC units for testosterone undecanoate (Aveed™) should be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers must bill their usual and customary charge for non-340-B drugs.

- The PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (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 amount 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, Physician Assistant and Nurse Practitioners

Blinatumomab (Blincyto™) HCPCS code J9999: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover blinatumomab (Blincyto™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 Not otherwise classified, antineoplastic drugs. Blincyto™ is currently commercially available in 35 mcg vials.

Blinatumomab (Blincyto™) is indicated for the treatment of Philadelphia chromosome-negative relapsed or refractory B-cell precursor acute lymphoblastic leukemia.

The recommended dosage for blinatumomab (Blincyto™), in Cycle 1, is 9 mcg/day on Days 1–7 and 28 mcg/day on Days 8–28. For subsequent cycles, administer blinatumomab at 28 mcg/day on Days 1–28. This dosage is for patients at least 45 kg in weight.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing blinatumomab (Blincyto™) is 204.0, Acute lymphoid leukemia.
- Providers must bill Blincyto™ with HCPCS code J9999 not otherwise classified, antineoplastic drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid/NCHC unit of coverage for Blincyto™ is 1 mcg .The maximum reimbursement rate per 1 mcg is $98.0815. One 35 mcg vial contains 35 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Blincyto™ 35 mcg vials is 55513-0160-01.
- The NDC units for blinatumomab (Blincyto™) should be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update,* 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 amount 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, Physician Assistants and Nurse Practitioners

Hyaluronan (Monovisc™) HCPCS code J7327: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid program covers hyaluronan (Monovisc™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7327 Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose. Monovisc™ is currently commercially available in 88 mg/4 mL syringes.

Hyaluronan (Monovisc™) is indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy or simple analgesics. The safety and efficacy of Monovisc™ has not been established in children.

The recommended dosage for hyaluronan (Monovisc™) is 88 mg (4 mL) intra-articularly, once.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing hyaluronan (Monovisc™) are ICD-9 codes that support medical necessity for FDA approved indications. This includes 715.16, 715.26, 715.36, 715.96, Osteoarthrosis of lower leg.

- Providers must bill Monovisc™ with HCPCS code J7327 Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose.

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Monovisc™ is 1 dose (4 mL) .The maximum reimbursement rate per 1 dose is $1,053.00. One 88 mg/4 mL syringe contains 1 billable unit.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Monovisc™ 88 mg/4 mL syringe is 59676-0820-01.

- The NDC units for hyaluronan (Monovisc™) should be reported as "UN1".

- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, 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 N.C. Health Choice (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 amount 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 www.ncdhhs.gov/dma/fee.

CSC, 1-800-688-6696

Attention: Physicians, Physician Assistants and Nurse Practitioners

Nivolumab (Opdivo®) HCPCS code J9999: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover nivolumab (Opdivo®), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 Not otherwise classified, antineoplastic drugs. Opdivo® is currently commercially available in 40 mg/4 ml and 100 mg/10 ml vials.

Nivolumab (Opdivo®) is a human programmed death receptor-1 (PD-1) blocking antibody indicated to treat unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 is mutation positive, a BRAF inhibitor.

The recommended dosage for nivolumab (Opdivo®) is 3 mg/kg as an intravenous infusion over 60 minutes every 2 weeks.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code for the FDA indication for nivolumab (Opdivo®) is172.0, Malignant melanoma of skin.
- Providers must bill Opdivo® with HCPCS code J9999 not otherwise classified, antineoplastic drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid/NHC unit of coverage for Opdivo® is 1 mg. The maximum reimbursement rate per 1 mg is $25.8984. One 100 mg/10 mL syringe contains 100 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Opdivo® 40mg/4ml is 00003-3772-11. The NDC for Opdivo® 100mg/10ml is 00003-3774-12.
- The NDC units for nivolumab (Opdivo®) should be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, 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 amount 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 www.ncdhhs.gov/dma/fee.

CSC, 1-800-688-6696

Attention: Physicians, Nurse Practitioners and Physician Assistants

Updated NDCs for billing of Oritavancin diphosphate (Orbactiv™), HCPCS code J3490

Note: This article corrects the NDC code of an article titled *Oritavancin diphosphate (Orbactiv™), HCPCS code J3490: Billing Guidelines* which was published December 2014.

Effective with date of service September 1, 2014, the N.C. Medicaid program covers oritavancin diphosphate (Orbactiv™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 unclassified drugs. Orbactiv™ will be commercially available in 400 mg vials in October 2014.

Oritavancin diphosphate (Orbactiv™) is indicated for acute bacterial skin and skin structure infections (ABSSSI).

The recommended dosage for oritavancin diphosphate (Orbactiv™) is a 1,200 mg single dose administered by intravenous infusion over 3 hours.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing oritavancin diphosphate (Orbactiv™) are 680 - 686 Infections of Skin and Subcutaneous Tissue.
- Providers must bill Orbactiv™ with HCPCS code J3490 unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Orbactiv™ is 1 mg .The maximum reimbursement rate per mg is $2.6100. One 400 mg vial contains 400 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Orbactiv™ 400 mg vials are **65293-015-01** and **NDC 65293-015-03**.
- The NDC units for oritavancin diphosphate (Orbactiv™) should be reported as "UN1".
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.

- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.

- Providers shall bill their usual and customary charge.

- 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, Physician Assistants and Nurse Practitioners

Peramivir (Rapivab™) HCPCS code J3490: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover peramivir (Rapivab™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 Unclassified drugs. Rapivab™ is currently commercially available in 200 mg/20 mL vials.

Peramivir (Rapivab™) is an inhibitor of influenza virus neuraminidase and is indicated for the treatment of acute, uncomplicated influenza in patients 18 years and older who have been symptomatic for no more than two days.

The recommended dosage for peramivir (Rapivab™) is 600 mg, administered by intravenous infusion for a minimum of 15 minutes.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing peramivir (Rapivab™) are 488 Influenza due to certain identified influenza viruses and 487 Influenza.
- Providers must bill Rapivab™ with HCPCS code J3490 Unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid/NCHC unit of coverage for Rapivab™ is 1 mg. The maximum reimbursement rate per 1 mg is $1.7100. One 200 mg/20 mL syringe contains 200 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Rapivab™ 200 mg/20 mL vial are 61364-0181-01 and 61364-0181-03.
- The NDC units for peramivir (Rapivab™) should be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, 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 amount 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, Physician Assistants and Nurse Practitioners

Ceftolozane/Tazobactam (Zerbaxa™), HCPCS code J3490: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ceftolozane/tazobactam (Zerbaxa™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 Unclassified drugs. Zerbaxa™ is currently commercially available in 1 gm - 0.5 gm vials.

Zerbaxa™ is indicated for complicated intra-abdominal infections, used in combination with metronidazole, and complicated urinary tract infections, including pyelonephritis.

The recommended dosages for ceftolozane/tazobactam (Zerbaxa™) are:

- Estimated creatinine clearance (ml/min) >50: 1.5 g (1 g/0.5 g) every 8 hours by intravenous infusion administered over 1 hour for patients 18 years or older.
- Estimated creatinine clearance (ml/min) 30 to 50: 750 mg (500 mg/250 mg) intravenously every 8 hours.
- Estimated creatinine clearance (ml/min) 15 to 29: 375 mg (250 mg/125 mg) intravenously every 8 hours.
- End-stage renal disease (ESRD) on hemodialysis (HD): A single loading dose of 750 mg (500 mg/250 mg) followed by a 150 mg (100 mg/50 mg) maintenance dose administered intravenously every 8 hours for the remainder of the treatment period (on hemodialysis days, administer the dose at the earliest possible time following completion of dialysis).

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing ceftolozane/tazobactam (Zerbaxa™) should describe the patient's condition with the highest level of specificity. All codes must be supported with adequate documentation in the medical record.
- Providers must bill Zerbaxa™ with HCPCS code J3490 Unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid/NCHC unit of coverage for Zerbaxa™ is 1 mg. The maximum reimbursement rate per 1 mg is $0.05976. One 1-0.5 gm vial contains 1500 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Zerbaxa™ 1-0.5 gm vial is 67919-0030-01.

- The NDC units for Zerbaxa™ should be reported as "UN1".

- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update,* 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 amount 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, Physician Assistants and Nurse Practitioners

Radium Ra 223 dichloride (Xofigo®), HCPCS code A9606: Billing Guidelines

Effective with date of service January 1, 2015, the N.C. Medicaid program covers radium Ra 223 dichloride (Xofigo®), for use in the Physician's Drug Program (PDP) when billed with HCPCS code A9606 (radium RA 223 dichloride, therapeutic, per microcurie). Xofigo® is available as a single use vial at a concentration of 1,000 kBq/mL (27 microcurie/mL) with a total radioactivity of 6,000 kBq/vial (162 microcurie/vial).

This product is an indicated alpha particle-emitting radioactive therapeutic agent indicated for the treatment of patients with castration-resistant prostate cancer, symptomatic bone metastases and no known visceral metastatic disease.

The dose regimen of Xofigo® is 50 kBq (1.35 microcurie) per kg body weight, given at 4 week intervals for 6 injections.

For Medicaid Billing

- Providers must bill the product with HCPCS code A9606 (radium RA 223 dichloride, therapeutic, per microcurie), 1 microcurie.

- The following procedural terminology codes are required when billing for Xofigo®:
  - 79101 Radiopharmaceutical therapy, by intravenous administration.

- Providers must indicate the number of HCPCS units (assumption: 1 unit = 1 microcurie).

- One Medicaid unit of coverage for Xofigo® is 1 microcurie. The maximum rate of reimbursement rate per 1 microcurie is $113.82.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Xofigo® is 50419020801.

- The NDC units for Radium Ra 223 dichloride (Xofigo®), should be reported as "UN1".

- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update,* 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 N.C. Health Choice (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 amount 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, Physician Assistants and Nurse Practitioners

Ado-trastuzumab emtansine intravenous injection (Kadcyla™), HCPCS code J9999: Billing Guidelines

Effective with date of service April 1, 2013 through December 31, 2013, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ado-trastuzumab emtansine intravenous injection (Kadcyla™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 (not otherwise classified antineoplastic drugs). Kadcyla™ is currently commercially available in 100 mg and 160 mg single use vials.

Ado-trastuzumab emtansine intravenous injection (Kadcyla™) is indicated for the treatment of HER2-positive, metastatic breast cancer in patients who previously received trastuzumab and a taxane, separately or in combination, and have either received prior therapy for metastatic disease or developed disease recurrence during or within six months of completing adjuvant therapy.

Ado-trastuzumab emtansine is an HER2-antibody drug conjugate which incorporates the HER2 targeted actions of trastuzumab with the microtubule inhibitor DM1 (a maytansine derivative). The conjugate, which is linked via a stable thioether linker, allows for selective delivery into HER2 over expressing cells, resulting in cell cycle arrest and apoptosis.

The recommended dose of ado-trastuzumab emtansine intravenous injection (Kadcyla™) is 3.6 mg per kg of patient body weight, administered as an intravenous infusion every three weeks until disease progression or unacceptable toxicity.

For Medicaid Billing and NCHC

- The ICD-9-CM diagnosis code required for billing ado-trastuzumab emtansine (Kadcyla™) is:
  - 174.0 – 175.9 (Malignant neoplasms of the breast)

- Providers must bill ado-trastuzumab emtansine (Kadcyla™) with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).

- Providers must indicate the number of HCPCS units.

- One Medicaid/NCHC unit of coverage for Kadcyla™ is 10 mg. The maximum reimbursement rate per unit is $299.55. One 100 mg single use vial contains 10 billable units. One 160 mg single use vial contains 16 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Kadcyla™ are 50242-0088-01 for the 100 mg vial and

50242-0087-01 for the 160 mg vial (manufacturer rebateable). To bill for the entire 100 mg vial of Kadcyla™, report the NDC units as "UN10". To bill for the entire 160 mg vial of Kadcyla™, report the NDC units as "UN16".

- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update,* at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.

- Providers must bill their usual and customary charge for non-340-B drugs.

- The PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (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 amount 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, Physician Assistants and Nurse Practitioners

Updated Billing Guidelines for Ado-trastuzumab emtansine intravenous injection (Kadcyla™), HCPCS code J9354

Effective with date of service January 1, 2014, the N.C. Medicaid program covers ado-trastuzumab emtansine intravenous injection (Kadcyla™) for use in the Physician's Drug Program when billed with HCPCS code J9354 (Ado-trastuzumab emtansine).

CSC, 1-800-688-6696

Attention: Physicians

3% Physician Rate Reduction

Note: This was published as a Special Bulletin in February 2015
Note: This applies only to physicians and providers who bill for physician services

The 3% fee reduction in accordance with North Carolina Session Law 2013-360, Section 12H.18 (b) **will be implemented on March 2, 2015**. The reduction was announced in the January, 2014 Medicaid Bulletin article titled *3 Percent Rate Reduction.*

3% rate reduction for primary care physician who attested for Affordable Care Act (ACA) enhanced payments.

- Subject to the 3% fee reduction enacted under Session Law 2013 – 360
  - The reduction was effective Jan. 1, 2015 and will be implemented March 2, 2015.
  - NCTracks will reprocess claims from Jan. 1, 2015 through March 1, 2015 at a later date.

3% rate reduction for physician services (physicians, midwives, nurse practitioners, physician assistants and certified registered nurse assistants)

- Subject to the 3% fee reduction enacted under Session Law 2013 – 360
  - The reduction was effective Jan. 1, 2014 and will be implemented March 2, 2015.
  - NCTracks will reprocess claims from Jan. 1, 2014 through March 1, 2015 at a later date.

Frequently Asked Questions (FAQ)

Q - Are physicians in North Carolina still receiving ACA enhanced payments?

No, enhanced payments ended for all services provided on or after January 1, 2015.

Q - Why did the 3% fee reduction not apply to ACA primary care physicians until Jan. 1, 2015, when it applied to all other services effective Jan. 1, 2014?

North Carolina Session Law 2013 – 360 instructed that ACA primary care physicians were to be exempt from the 3% rate reduction until Jan. 1, 2015.

Current fee schedules have been adjusted to reflect the 3% fee reduction and have been posted to the DMA website. DMA will alert providers through Medicaid bulletins,

NCTracks email blasts and in the NCTracks provider portal as more information is available.

Note: Pending Centers for Medicare & Medicaid Services (CMS) approval, all providers will be subject to a 1% fee schedule reduction effective January 1, 2015 as enacted by Session Law 2014 – 100.

Provider Reimbursement
DMA, 919-814-0060

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
March	3/05/15	3/10/15	3/11/15
	3/12/15	3/17/15	3/18/15
	3/19/15	3/24/15	3/25/15
	3/26/15	3/31/15	4/01/15
April	4/02/15	4/07/15	4/08/15
	4/09/15	4/14/15	4/15/15
	4/16/15	4/21/15	4/22/15
	4/23/15	4/28/15	4/29/15
	4/30/15	5/05/15	5/06/15

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