



May 2015 Medicaid Bulletin

In this Issue.....Page

All Providers

NCTracks Update.....	2
Clinical Coverage Policies.....	4
NCTracks Update.....	5

AHC, FCH, Home Health, PCS & Supervised Living Providers

Personal Care Services (PCS) Program Highlights.....	7
--	---

Behavioral Health Service Providers

Nurse Practitioners Providing Behavioral Health Outpatient Services.....	9
--	---

CCNC/CA Providers

Process for Referring a CCNC/CA Beneficiary to Another Provider.....	10
Community Care of NC/Carolina ACCESS Overrides.....	11

Dental Providers & Health Department Dental Centers

Dental Services and Medicaid for Pregnant Women Eligibility.....	12
Dental Services and Presumptive Eligibility for Pregnancy.....	13

HIV Case Management Providers

HIV Case Management Training Notices.....	14
---	----

In this Issue.....Page

LME-MCO & Providers of Residential Treatment Services (Levels I – IV)

Billing Codes for Residential Treatment Services Are Being Updated.....	15
---	----

Nurse Practitioners & Physicians Assistants

Billing Code Update for Nurse Practitioners and physician assistants.....	17
Secukinumab injection (Cosentyx™) HCPCS code J3590: Billing Guidelines.....	18
Pasireotide suspension (Signifor® LAR) HCPCS code J3490: Billing Guidelines.....	19

Pharmacists & Prescribers

N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes.....	20
Off-Label Antipsychotic Safety Monitoring in Beneficiaries through Age 17 (A+KIDS) to be Re-Instated May 18.....	21

Physicians

Secukinumab injection (Cosentyx™) HCPCS code J3590: Billing Guidelines.....	18
Pasireotide suspension (Signifor® LAR) HCPCS code J3490: Billing Guidelines.....	19

Providers are responsible for informing their billing agency of information in this bulletin. CPT codes, descriptors, and other data only are copyright 2014 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Attention: All Providers

NCTracks Updates

Important Guidance When Submitting Paper CMS 1500 Claims

It is acceptable to submit paper CMS 1500 claims in some circumstances, such as time limit override requests. It is acceptable to mail multiple paper CMS 1500 claims in a single packet to NCTracks. However, when submitting paper CMS 1500 claims, it is essential that providers treat each claim as a separate entity. **NCTracks does not process multiple claims as one claim. Each CMS 1500 form is an individual claim and is processed separately.**

Providers need to state the total on each claim submitted and attach any applicable documentation to **each** claim, even if the applicable documentation is the same for multiple claims. Failure to include all applicable documentation for each claim submitted may result in claim denials or slower processing due to pending claims.

NCTracks Now Producing Detailed PS&R Reports for Hospital Providers

Provider Statistical and Reimbursement (PS&R) reports accumulate statistical and payment data for hospital providers. PS&R reports are used to complete the annual cost reporting for hospital providers participating in the Medicaid program.

NCTracks is now producing detailed PS&R reports. The reports can be requested for any 12-month period, including those prior to the implementation of NCTracks. Although the legacy system was substantially different than NCTracks, the new detailed PS&R reports are designed to provide accurate reporting of data accumulated from both systems.

To order a PS&R report, complete the CSC PS&R Report Request Form, which can be found under the heading “Provider Forms” on the Provider Policies, Manuals, Guidelines, and Forms page of the NCTracks Provider Portal at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

Mail the completed form with a certified check to NCTracks, as instructed on the form. The PS&R report will be generated in PDF format within one checkwrite of receiving the request, and will be delivered on a password protected CD via FedEx. A signature will be required to receive the package.

After receiving the report, the provider must call the NCTracks Call Center to request the password. The financial team will return the call within one business day. This approach guards against the report being accessed by anyone besides the provider who requested it.

There is no limit to the size of the report or the number of reports a provider can request. However, each request must be submitted on a separate form. Service dates must be limited to a 12-month time period. Payment dates can be for a longer period of time. Answers to frequently asked questions about requesting PS&R reports can be found at <https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-PSnR-Reports.html>.

Hepatitis C TEMPORARY Prior Authorization Fax Forms available on NCTracks

Fax forms are available on NCTracks to request Hepatitis C medications at <https://nctracks.nc.gov/content/public/providers/pharmacy/forms.html>. Use these temporary forms to obtain a prior authorization (PA) for Hepatitis C medications and fax them to CSC at 1-855-710-1969. **These forms are temporary.**

Once the NCTracks PA Portal is updated with the ability to request these through the NCTracks portal, the forms and the ability to fax will end. At that time, Hepatitis C PAs will only be accepted through the NCTracks portal or by calling CSC at 1-866-246-8505.

New Requirement for Border Providers

NCTracks is now required to verify eligibility for new border providers (this has been a standing requirement for out-of-state providers). Border providers are defined as providers who conduct business within 40 miles of the North Carolina border.

The N.C. Medicaid program now requires that border providers be enrolled and active with their home state's Medicaid program. If an enrollment application from a border provider has been submitted to NCTracks but the provider is not active in its home state's Medicaid program, NCTracks will request that the application be withdrawn and a refund of the application fee will be requested from finance. Once the provider meets the requirement, it will be required to submit a new application.

No action is required for border providers already enrolled in NCTracks; this requirement only applies to new border providers.

CSC Regional Provider Relations Representatives

CSC has regional provider relations representatives, serving all regions of North Carolina. Provider site visits can be requested online using the NCTracks Provider Portal.

To request a visit, click on the "Contact Us" link at <https://www.nctracks.nc.gov/content/public/contact.html> (found at the bottom of every NCTracks web page), complete the form, select the subject "Request a Site Visit" from the drop down box, and click on the "Send" button. A provider relations representative will be in contact to schedule a site visit.

How to Access ZixMail

At various times, the NCTracks team may need to email files with Protected Health Information (PHI) to providers. To comply with Health Insurance Portability and Accountability Act (HIPAA) regulations regarding privacy and security, those files must be encrypted. One of the applications used by NCTracks to encrypt files containing PHI is ZixMail, a third-party application maintained by ZixCorp.

Note: ZixMail messages are sent to email addresses, and are not posted to the NCTracks message center inbox. The inbox is a secure delivery mechanism for receiving files containing PHI.

For more information about how to access ZixMail, see the job aid at <https://www.nctracks.nc.gov/content/public/dms/public/pdf/Training/How-to-Access-ZixMail/How%20to%20Access%20ZixMail.pdf>.

CSC, 1-800-688-6696

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on DMA's website at www.ncdhhs.gov/dma/mp/:

- 1E-7, *Family Planning Services* (5/1/15)
- 9D, *Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17* (4/1/15)
- 9E, *Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older* (2/2/15)
- 12A, *Case Management Services for Adults and Children at Risk for Abuse, Neglect, or Exploitation* (Date of Termination 6/30/14)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NCTracks ICD-10 Updates

Rules for Splitting Claims and Prior Approvals for ICD-10

A frequent question at NCTracks is: How will claims and prior approvals (PA) be submitted when the date of service begins before the October 1, 2015 implementation of ICD-10 and ends afterwards?

The answer is for providers to split claims and PAs into two separate claims. For services before October 1, 2015, providers must submit claims using ICD-9 codes. Services for claims offered October 1, 2015 and later must be submitted with ICD-10 codes. In other words, where one claim or PA would normally suffice, providers will need to submit two claims or PAs.

There is an exception for hospital inpatient claims. Inpatient claims with Diagnosis-Related Group (DRG) pricing cannot be split. Instead, use the appropriate ICD code based on the discharge date. If the discharge date is September 30, 2015 or earlier, hospitals must submit claims with ICD-9 codes. If the discharge date is October 1, 2015 or later, claims must be submitted with ICD-10 codes.

Most private payers also are using this process. NCTracks will not accept ICD-9 codes with date of service starting October 1, 2015 and later, per policy from the Center for Medicare & Medicaid Services (CMS).

Payment Can Vary for Hospitals

Most hospitals preparing for ICD-10 have noticed that payment varies between ICD-9 Procedure Coding System (PCS) codes (*inpatient codes*) and ICD-10 PCS codes. These variances occur mainly due to the hospital DRG codes from CMS. The CPT codes on professional claims do not have the same discrepancies.

Dental Practices and ICD-10 Compliance

The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

ICD-10 compliance means that all Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis codes for dates of service on or after October 1, 2015. ICD-9 diagnosis codes can no longer be used for health care services provided on or after this date.

As a rule, most dental practices will not use ICD-10 diagnosis codes because they do not use ICD-9 diagnosis codes today. Dental PA and claims submitted using American Dental Association (ADA) codes do not require the use of diagnosis codes. Dental practices will continue their use of Dental Procedures and Nomenclature (CDT-2015) codes for reporting procedures on dental PA requests and dental claims for payment.

However, there are exceptions to this rule. For dually-eligible Medicare and Medicaid beneficiaries, dental services covered by Medicare must be billed to the beneficiary's Medicare Part B carrier on a CMS-1500 form. Currently, it is necessary to file such Medicare claims using Current Procedural Terminology (CPT) codes, published by the American Medical Association, and ICD-9 diagnosis codes. **Effective October 1, 2015**, claims requiring diagnosis codes must be billed using the ICD-10 codes, not the ICD-9 codes that are used today.

Dental practices using ICD-9 codes today can see how they convert to ICD-10 codes in the section of this article titled *New NCTracks ICD-10 Crosswalk*.

New NCTracks ICD-10 Crosswalk

The NCTracks ICD-10 Crosswalk is available at <http://ncmmis.ncdhhs.gov/icdxwalk.asp>.

Input ICD-9 codes and see how they convert to ICD-10 codes in NCTracks. Remember, there may not be an exact match between ICD-9 and ICD-10 codes, as many singular ICD-9 codes have been replaced by numerous ICD-10 codes to better match the diagnosis. The crosswalk only serves as a preliminary guide and will be updated frequently. The N.C. Division of Medical Assistance (DMA) will be adding ICD-10 codes to clinical policies just prior to ICD-10 implementation on October 1, 2015. Some existing codes may change. Therefore, providers will need to reference DMA's clinical policies before submitting claims.

Note: To use the crosswalk, remove the decimal from the ICD-9 code. To build the crosswalk as quickly and easily as possible, NCTracks eliminated the decimal. On October 1, 2015, the system will recognize correct ICD-10 codes with or without a decimal.

ICD-10 Questions and Answers

From now until ICD-10 implementation goes live in October, providers can send their ICD-10 questions and comments to NCTracks-Questioner@dhhs.nc.gov. Providers will receive personal answers, and NCTracks will receive feedback on information providers need. Frequently asked questions (FAQs) will be shared with everyone.

CSC, 1-800-688-6696

Attention: Adult Care Home, Family Care Home, Home Health and Personal Care Service Providers and Supervised Living Homes Billing PCS Services

Personal Care Services (PCS) Program Highlights

Personal Care Services (PCS) Clinical Coverage Policy 3L

Clinical Coverage Policy 3L, *Personal Care Services*, is being amended to provide guidance about new program requirements for PCS. The policy is posted for the 45-day comment period through May 17, 2015. Interested parties may review the proposed policy amendments and provide comments and suggestions through the N.C. Division of Medical Assistance (DMA) proposed clinical coverage policies web page at www.ncdhhs.gov/dma/mpproposed/.

PCS Provider Regional Training Sessions

PCS spring regional training sessions will be conducted May 5-18, 2015. Training topics and materials will be available to all registered participants prior to May 5, 2015. Providers with questions may contact DMA at 919-855-4360 or Liberty Healthcare Corporation-NC at 1-855-740-1400, or visit www.nc-pcs.com. **There is no cost to attend the training, but registration is required.**

Event Dates and Locations:

- **Tuesday, May 5, 2015 – Fayetteville**
Doubletree by Hilton, *Grand Ballroom*
- **Wednesday, May 6, 2015 – Raleigh**
Jane S. McKimmon Conference and Training Center – N.C. State University
- **Thursday, May 7, 2015 – Greenville**
City Hotel and Bistro - *Ballroom*
- **Wednesday, May 13, 2015 – Asheville**
Doubletree by Hilton – Biltmore, *Burghley Room*
- **Thursday, May 14, 2015 – Charlotte**
Great Wolf Lodge Convention Center, *White Pine 1 & 2 Room*
- **Monday, May 18, 2015 – Greensboro**
Embassy Suites Greensboro Airport, *Timberlake Room*

Coming June 2015: Required On-line PCS Service Plan for all Providers

Effective June 10, 2015, all PCS providers will be required to use the QiRePort System to submit PCS Service Plans for beneficiaries they accept as clients/residents. To create online service plans, providers must be registered users of QiRePort, the PCS Provider Interface. Through QiRePort,

providers will have electronic access to the Independent Assessments needed to inform the development of each beneficiary’s on-line services plan. **PCS prior approval will not be generated until a beneficiary’s service plan has been completed and verified via QiRePort.**

Separate webinar training sessions on the On-line Service Plan functionality are scheduled for in-home and licensed residential providers on the following dates:

In Home Providers	Licensed Residential Providers
May 27, 2015	May 27, 2015
June 1, 2015	May 28, 2015
June 4, 2015	June 1, 2015
June 8, 2015	June 3, 2015
	June 4, 2015
	June 8, 2015
	June 9, 2015

Webinar registration and times will be available on the QiRePort Provider Portal (<https://www.qireport.net/>), as well as the DMA PCS (www.ncdhhs.gov/dma/pcs/pas.html) and Liberty Healthcare Corporation-NC (www.nc-pcs.com) websites.

Questions and concerns regarding the implementation of the online services plans can be directed to the DMA PCS team at 919-855-4360 or PCS_Program_Questions@dhhs.nc.gov.

**Facility, Home, and Community Based Services
DMA, 919-855-4340**

Attention: Behavioral Health Service Providers**Nurse Practitioner's Providing Behavioral Health Outpatient Services**

Nurse Practitioners (NP) have been granted a two-year extension to obtain certification as Psychiatric Mental Health Nurse Practitioners.

By **June 30, 2017**, NPs certified in a specialty other than psychiatric mental health who plan to provide behavioral health outpatient services under the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Clinical Coverage Policy No. 8-C Provided by Direct-Enrolled Providers*, or through state funds managed by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) must have completed the Psychiatric Mental Health Nurse Practitioner (PMHNP) national certification and be approved to practice as a Psychiatric Mental Health Nurse Practitioner by a Joint Committee of the North Carolina Medical Board and the North Carolina Board of Nursing.

NPs who do not obtain this approval to practice by June 30, 2017, will no longer be able to provide behavioral health services under Clinical Coverage Policy 8C or through DMH/DD/SAS state funds.

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

For more information, contact Kathy Nichols at 919-855-4289 (Katherine.Nichols@dhhs.nc.gov) or Kelsi Knick at 919-855-4288 (Kelsi.Knick@dhhs.nc.gov).

**Behavioral Health Policy Section
DMA, 919-855-4290**

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

Process for Referring a CCNC/CA Beneficiary to Another Provider

Coordination of care is a required component of Community Care of North Carolina/Carolina ACCESS (CCNC/CA).

A CCNC/CA Referral Authorization must be considered for medically necessary or urgent services, even when a member has failed to establish a medical record with the Primary Care Provider (PCP) of record.

- Recommendations for referrals to specialists for follow-up care after discharge from urgent care centers must be made to CCNC/CA PCP for their assessment and authorization.
- Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. Inpatient physician services do require CCNC/CA Referral Authorization from the member's PCP of record for billing.
- Referrals for routine follow-up care after discharge from a hospital must be made to the assigned PCP. Referrals to a specialist for follow-up care after discharge from a hospital require CCNC/CA Referral Authorization and should be coordinated through the PCP's office.
- If surgery is recommended, CCNC/CA primary care providers are required to refer members for a second opinion if the member requests it.
- If members disagree with their PCP's decision regarding referrals for specialty services or other care, the member should be advised of their option to choose a different CCNC/CA PCP.

PCPs and specialists with questions regarding CCNC/CA Referral Authorizations may contact their regional consultant. 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
DMA, 919-855-4780**

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

Community Care of NC/Carolina ACCESS Overrides

Medical providers **must** obtain a Community Care of NC/Carolina ACCESS (CCNC/CA) Referral Authorization from the member's CCNC/CA Primary Care Physician (PCP) of record prior to rendering treatment, **unless** the specific service is exempt from CCNC/CA Referral Authorization. For a listing of exempt services, see "Section 6.4.4.3.2 Services Exempt from CCNC/CA Authorization" of the *Provider Claims and Billing Assistance Guide* at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

When services are rendered to a CCNC/CA member without first obtaining a CCNC/CA Referral Authorization from the CCNC/CA PCP of record and the PCP refuses to authorize retroactively, medical providers may request an override. **CCNC/CA overrides are authorizations issued by the NCTracks Customer Support Center for CCNC/CA members. CCNC/CA override confirmation numbers are not placed on the claim.**

- Override requests will only be considered if extenuating circumstances – beyond the control of the parties involved on the claim – affect the member's access to medical care.
- Overrides will **not** be considered for current, future, or past dates of service unless the CCNC/CA PCP of record has been contacted and refused to authorize treatment.
- **Medical providers needing a CCNA/CA override must submit N.C. Division of Medical Assistance (DMA) CA Override Request to the NCTracks Customer Support Center.**

The following are two preferred methods for submitting an Override Request:

- **Telephone** – The provider can call NCTracks at 1-800-688-6696 to request an override for future dates of service, or if the member is in the provider's office waiting for treatment.
- **Fax** – The provider can fax the Override Request Form to NCTracks at 1-855-710-1964. Providers may fax the override request form for past dates of service.

A copy of the DMA CA Override Request Form can be found on the NCTracks "Provider Policies, Manuals, Guidelines and Forms" page at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

Providers may contact NCTracks at 1-800-688-6696 to check on the status of a pending override request.

Regional consultants are also available to assist providers with outstanding override requests. A current list of consultants is on DMA's CCNC/CA web page at www.ncdhhs.gov/dma/ca/mcc_051214.pdf.

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

Attention: Dental Providers and Health Department Dental Centers**Dental Services and Medicaid for Pregnant Women (MPW) Eligibility - UPDATE**

Notice to Providers: This is an update to an article published in the [*October 2012 Medicaid Bulletin*](#).

The N.C. Division of Medical Assistance (DMA), Program Integrity Section has identified provider noncompliance when billing for dental services rendered while the beneficiary is covered under the Medicaid for Pregnant Women (MPW) program class.

According to Clinical Coverage Policy 4A, *Dental Services*:

“For pregnant Medicaid-eligible beneficiaries covered under the Medicaid for Pregnant Women program class ‘MPW,’ dental services as described in this policy are covered through the day of delivery.”

Therefore, claims for dental services rendered for beneficiaries under “MPW” eligibility after the date of delivery are outside the policy limitation and are subject to recoupment.

According to Clinical Coverage Policy 4B, *Orthodontic Services*:

“Pregnant Medicaid-eligible beneficiaries covered under the Medicaid for Pregnant Women program class ‘MPW’ are not eligible for orthodontic services as described in this policy.”

Therefore, claims for orthodontic records (D0150, D0330, D0340, and D0470) or orthodontic banding (D8070 or D8080) rendered for beneficiaries under “MPW” eligibility are outside of policy limitation and are subject to recoupment.

Periodic orthodontic treatment visits (D8670) and orthodontic retention (D8680) will continue to be reimbursed regardless of the beneficiary’s eligibility status at that visit as long as the beneficiary was eligible on the date of banding.

Medicaid providers are required to verify a Medicaid beneficiary’s eligibility each time a service is rendered. For eligibility verification methods, refer to the *Provider Claims and Billing Assistance Guide* at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

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

**Dental Program
DMA, 919-855-4280**

Attention: All Providers

Dental Services and Presumptive Eligibility for Pregnancy

Notice to Providers: This article was originally published in the *October 2011 Medicaid Bulletin*.

Clinical Coverage Policy IE-5, *Obstetrics*, located on Division of Medical Assistant (DMA) Clinical Coverage Policy web page at www.ncdhhs.gov/dma/mp/, states that:

“Section 1920 (b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility is being determined.”

Dental services are not covered during the presumptive eligibility period. For more information about services covered under presumptive eligibility, review section 2.1.4 of Clinical Coverage Policy 1E-5, *Obstetrics*.

Dental Program
DMA, 919-855-4280

Attention: HIV Case Management Providers

HIV Case Management Training Notices

Notice to Providers: This article was previously published in the [April 2015 Medicaid Bulletin](#), which also included training dates in April.

Two three-day training sessions for the HIV case management provider community (managers/supervisors, and the official agency/program administrator; i.e., the agency owner or director) have been scheduled as follows:

Date:

May 20, 21 and 22, 2015

Location:

Wake County Cooperative Extension
Agriculture Extension Service
4001 Carya Drive, Suite E
Raleigh, North Carolina 27610

Time:

9 a.m. to 4 p.m.

All HIV Case managers and supervisors must attend 20 hours of continuing education related to HIV case management. This annual requirement is mandated for all participating providers to certify/recertify their agencies. Providers will also be contacted about training opportunities by email and U.S. mail. An application packet will accompany each notification.

Those with questions can contact Betty Jones, N.C. Division of Medical Assistance (DMA) HIV Program Manager at 919-855-4279 (Betty.Jones@dhhs.nc.gov) or Tamara Derieux at 919-855-4364 (Tamara.Derieux@dhhs.nc.gov).

**Betty “BJ” Jones or Tamara Derieux
DMA, 919-855-4364**

Attention: LME-MCO and Providers of Residential Treatment Services (Levels I – IV)

Billing Codes for Residential Treatment Services Are Being Updated

Notice to Providers: This article was previously published in the [April 2015 Medicaid Bulletin](#)

Billing codes for residential treatment services – covered in Medicaid Clinical Coverage Policy 8D-2, *Residential Treatment Services* – are being updated in compliance with federal Medicaid regulations. (Clinical coverage policies can be found on DMA’s website at www.ncdhhs.gov/dma/mp/.) The Local Codes (Y-Codes), which have been used for prior authorization (PA) to differentiate services on the payment system, are being replaced with National HCPCS Codes.

Effective May 3, 2015, the National Codes – and modifiers where indicated – for residential treatment services will be implemented on the NCTracks system. These codes are as follows:

Code	Modifier	Description	Taxonomy	Local Code being End Dated
H0046	##	Level I Therapeutic Foster Care	251S00000X	Y2347
S5145	##	HRI Level II Therapeutic Foster Care	251S00000X	Y2362
S5145	HA	Intensive Alternative Family Treatment	251S00000X	Y2364
H2020	##	HRI Level II Group	320800000X 251S00000X	Y2363
H0019	HQ	HRI Level III Residential 4 Beds or Less	320800000X 251S00000X	Y2348
H0019	TJ	HRI Level III Residential 5 Beds or more	320800000X 251S00000X	Y2349
H0019	HK	HRI Level IV Residential 4 beds or less	320800000X 251S00000X	Y2360
H0019	UR	HRI Level IV Residential 5 beds or more	320800000X 251S00000X	Y2361

For reimbursement claims and PA requests submitted for dates of service beginning May 3, 2015, a national code, and modifier where indicated, will be required.

For N.C. Health Choice (NCHC) beneficiaries, ValueOptions must modify existing or new PA records so the effective end date is May 2, 2015, and create a new record beginning May 3, 2015 with the corresponding national code. For example, if an existing PA record has code Y2347 for effective dates March 1, 2015 thru June 30, 2015. The existing record would be modified with the new

effective end date of May 2, 2015 and new record submitted for May 3, 2015 through June 30, 2015 with national code of H0046/##.

Any PA submitted with a local code for a date of service equal to or later than May 3, 2015 will deny. The reject report for ValueOptions will indicate these rejections with the code of B6.

Those with question should contact Katherine Nichols by email at Katherine.Nichols@dhhs.nc.gov or by phone at 919-855-4290.

**Behavioral Health Policy Section
DMA, 919-855-4290**

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

Since the transition to the new Medicaid Management Information System (MMIS) – NCTracks – the N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by Nurse Practitioners (NPs) and Physician Assistants (PAs). DMA has provided instruction to NCTracks on updating the claims processing system. The following procedure code list has been updated to include NP and PA taxonomies. Any codes currently in process for system updates will be published once system modifications are completed. Additional codes will be addressed as they are received by DMA Clinical Policy.

10080	22632	36589	72070	82728	96415	99245
11100	22633	36590	72110	83540	96417	99251
11752	22634	36870	72120	83550	96523	99252
11981	22802*	38220	72202	83735	99170	99253
17106	22804*	43644	73000	83789	99202	99254
17111	22843*	47525	73080	83805	99203	99255
20500	22845	49422	73550	83840	99204	99285
20552	23600	51705	75820	83925	99205	99291
20610	24530	51741	85018	83992	99212	99292
22325*	24560	51798	75978	84153	99213	99304
22326*	24576	54056	75984	84460	99214	99305
22327*	27245	56501	76645	84479	99215	99306
22328*	27269*	58300	76700	85610	99217	99354
22532*	27501	58301	80048	85652	99218	99355
22533*	27560	59025	80061	86376	99219	99385
22534*	27810	61070	80069	86756	99220	99395
22548*	27824	61154	80154	87184	99222	G0202
22552*	32655	62252	80299	87480	99223	G0434
22554*	33405	63030	81002	87510	99234	J2270
22556*	33430	63045*	81003	87660	99235	J2469
22558*	33464	63047	81025	87880	99236	J3420
22590*	33472	63281	82043	88164	99238	J3480
22595*	36558	63709*	82075	96366	99239	J7030
22600*	36561	64721	82145	96367	99241	J7321
22610*	36571	67700	82205	96372	99242	J7323
22612*	36581	70450	82486	96374	99243	J7325
22630*	36582	72069	82520	96375	99244	Q0111

* Codes marked with an asterisk (*) were updated for modifiers 80 and 82 only.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians**Secukinumab injection (Cosentyx™) HCPCS code J3590: Billing Guidelines**

Effective with date of service April 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers secukinumab injection (Cosentyx™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590, unclassified biologics. Cosentyx™ is currently commercially available in 150 mg injections.

Secukinumab injection (Cosentyx™) is indicated for moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

The recommended dosage for secukinumab injection (Cosentyx™) is 300 mg by subcutaneous injection at Weeks zero, one, two, three and four, followed by 300 mg every four weeks. For some patients, a dose of 150 mg may be acceptable.

For Medicaid and NCHC Billing:

- The ICD-9-CM diagnosis code required for billing secukinumab injection (Cosentyx™) is 696.1 other psoriasis.
- Providers must bill Cosentyx™ with HCPCS code J3590, unclassified biologics.
- One Medicaid and NCHC unit of coverage for Cosentyx™ is one daily dose. The maximum reimbursement rate per one daily dose is \$3,693.60. One packaged product with a total daily dose of 150 mg or 300 mg contains one daily dose.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Cosentyx™ 150 mg injections are 00078-0639-98, 00078-0639-68, 00078-0639-41, and 00078-0639-97.
- The NDC units for secukinumab injection (Cosentyx™) 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 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: Nurse Practitioners, Physician Assistants and Physicians**Pasireotide suspension (Signifor® LAR) HCPCS code J3490: Billing Guidelines**

Effective with date of service April 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers pasireotide suspension (Signifor® LAR), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490, unclassified drugs. Signifor® LAR is currently commercially available in 20 mg, 40 mg, and 60 mg vials/kits.

Pasireotide suspension (Signifor® LAR) is indicated for acromegaly patients who have had an inadequate response to surgery or for whom surgery is not an option.

The recommended dosage for pasireotide suspension (Signifor® LAR) is a 40 mg initial dose by intramuscular injection once every four weeks (every 28 days). Adjust dose based on biochemical response and tolerability.

For Medicaid and NCHC Billing:

- The ICD-9-CM diagnosis code required for billing pasireotide suspension (Signifor® LAR) is 253.0 Acromegaly and gigantism.
- Providers must bill Signifor® LAR with HCPCS code J3490, unclassified drugs.
- Providers must indicate the number of HCPCS code units.
- One Medicaid and NCHC unit of coverage for Signifor® LAR is one vial/kit. The maximum reimbursement rate per one vial/kit is \$11,630.77. One vial/kit contains one unit.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Signifor® LAR 20 mg, 40 mg, and 60 mg vials/kits are 00078-0641-61, 00078-0641-81, 00078-0642-61, 00078-0642-81, 00078-0643-61, and 00078-0643-81.
- The NDC units for pasireotide suspension (Signifor® LAR) 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 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: Pharmacists and Prescribers**N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes**

Effective **June 5, 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) showing preferred and non-preferred oral antipsychotic medications. The use of a non-preferred anti-psychotic medication will require the trial and failure of only one (1) preferred anti-psychotic medication or a prior authorization (PA).

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 [®])	

Pharmacists: In the event of a prior authorization (PA) requirement, remember to use the 72-hour override (3 in the Level of Service Field) to prevent gaps in therapy.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers**Off-Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 (A+KIDS) and Off Label Antipsychotic Safety (ASAP-adults) to be Re-instated June 5, 2015**

Effective **June 5, 2015**, the N.C. Division of Medical Assistance (DMA) will re-instate the A+KIDS and ASAP programs. Providers will be required to fill out an A+KIDS or ASAP prior authorization (PA) for any preferred or non-preferred antipsychotic medication for children 17 and younger. Providers will be required to fill this PA through the [NCTracks Provider Portal](#) or by calling CSC at 1-866-246-8505. **THERE WILL BE NO FAX FORMS.**

For more information, refer to Clinical Coverage Policy A6, *Off Label Antipsychotic Safety Clinical Coverage Policy No: 9D Monitoring in Beneficiaries Through Age 17*, located on the DMA website at www.ncdhhs.gov/dma/mp/.

Pharmacists: Pharmacists can use an “11” in the Submission Clarification Field to override both types of PA requirements to ensure patients obtains their medications. This can only be used **two** times, so inform the prescriber the need for PA. In addition, “Meets PA Criteria” may be written on adult antipsychotic prescriptions, and prescribers may use a “1” in the PA Type Code field or a “2” in the Submission Clarification field to override the PA edits. All non-preferred medication requests will require the non-preferred ASAP or A+KIDS PA to be processed. There is no override. Use the 72-hour override, (a “3” in the Level of Service field), to ensure no gaps in therapy.

Outpatient Pharmacy
DMA, 919-855-4300

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
May	5/07/15	5/12/15	5/13/15
	5/14/15	5/19/15	5/20/15
	5/21/15	5/27/15	5/28/15
	5/28/15	6/02/15	6/03/15
June	6/04/15	6/09/15	6/10/15
	6/11/15	6/16/15	6/17/15
	6/18/15	6/23/15	6/24/15

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