



June 2014 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates: General

Notice to Providers: All the NCTracks documents noted in this article can be accessed from the left-side menu of the main NCTracks provider page at <https://www.nctracks.nc.gov/content/public/providers.html>, unless otherwise noted.

New Frequently Asked Questions (FAQs) Added to the Provider Portal

A new [Manage Change Requests page](#) was added to the Frequently Asked Questions (FAQs) on the NCTracks Provider Portal. It includes information about Manage Change Requests from throughout the site, as well as questions received from the NCTracks Call Center and Provider Relations Department.

In addition, a new question was added to the [NCTracks User Setup & Maintenance FAQ page](#) which addresses “How to Update the Office Administrator on a Terminated Provider Record.”

New questions also have been added to the [ICD-10 Frequently Asked Questions \(FAQs\) page](#). The questions specifically address how ICD-10 affects behavioral health providers.

New User Guides Added to the Provider Portal

Two new User Guides about provider enrollment have been added:

- How to Enroll in North Carolina Medicaid as an Individual Practitioner
- How to Enroll in North Carolina Medicaid as an Organization

In addition, a new User Guide, titled “How to Select a Taxonomy Code in NCTracks,” explains which drop-down menus to use when selecting taxonomy.

Updated version of 835 Companion Guide Now Available

An updated version of the 835 Companion Guide is now available on the [Trading Partner Information page](#) of the NCTracks Provider Portal. Changes include submitting the Benefit Plan Description on the 835 (2110 REF segment), and reporting Fee-For-Service (FFS) and Encounters within same 835 file (2100 CAS segment).

All trading partners and providers who receive an 835 from NCTracks are encouraged to review the changes documented in the companion guide.

Notice of Return Request to Provider Letter (Prior Approvals)

A “Notice of Return Request to Provider” letter is sent to the provider’s NCTracks inbox when CSC is unable to process a prior approval (PA). There is a link to view the submitted document in the inbox.

- Providers who are not enrolled in NCTracks will receive hard copies via U.S. mail.
- This letter is generated as a result of invalid information submitted on paper (including fax) or if information is missing from the PA request.
- To avoid processing delays, ensure that all information (numbers, letters, and check marks in boxes) is completed within the space provided.

The most common reasons for rejection of paper PA submissions are:

PA Reject Reason Codes	Reject Reason Description
1501	Recipient ID Missing
1502	Requestor Provider ID Missing
1503	Requesting Provider Taxonomy Missing
1504	Requesting Provider Address Missing
1505	Requesting Provider ZIP Code Missing
1506	Requested Service/Procedure Code Missing
1507	Referring Provider ID Missing
1508	Referred to Provider ID Missing
1509	Referring Provider Address Missing
1510	Referring Provider ZIP Code Missing
1511	Drug Name Missing
1512	Drug Strength Missing
1513	Drug Length of Therapy Missing
1514	Prescriber Signature Missing
585	No Valid Service Lines

To avoid processing delays with PA requests, CSC recommends submitting PA request and attachments via NCTracks.

Those who receive a “Notice of Return Request to Provider” must submit a corrected PA request to obtain authorization.

Pharmacy EPSDT Requests

Federal law requires that Medicaid provides all medically necessary health care services to Medicaid-eligible children under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. A service not covered under the N.C. Medicaid State Plan may be covered for beneficiaries under 21 years of age if the service is listed at 1905(a) of the Social Security Act (www.ssa.gov/OP_Home/ssact/title19/1905.htm) and if all EPSDT criteria are met.

Requests for pharmacy services under EPSDT are now being processed by NCTracks for dates of service on or after April 1, 2014. The N.C. Division of Medical Assistance (DMA) will continue to process such requests for dates of service prior to April 1, 2014.

To submit a pharmacy EPSDT request, providers will need to complete two forms:

- Non-Covered State Medicaid Plan Services Requisition Form for Recipients under 21 Years Old; and,
- Pharmacy PA Standard Drug Request Form

Both forms can be found under Drug Request Forms on the NCTracks Pharmacy Services page at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html>. Complete the information on each form and fax them to 1-855-710-1969. Questions should be directed to the Pharmacy Prior Approval Department at 1-866-246-8505.

Contact CSC at 1-800-688-6696

Attention: All Providers

NCTracks Tip of the Month: Remember to ‘Add’ Attachments

Important Step When Submitting Claims and PAs Using the NCTracks Provider Portal

One of the most common errors when submitting claims and prior approval (PA) requests using the NCTracks Provider Portal is not clicking the “Add” button when including attachments. After keying in the required information a claim or PA, such as a diagnosis code or procedure code, the “Add” button must be clicked.

Some providers have been getting to the “Attachment” tab when keying in a claim or PA request, uploading the attachment, but not clicking the “Add” button after it is uploaded.

If providers click “Submit” on the “Attachment” tab without clicking the “Add” button first, the attachments **will not** be submitted with the claim or PA request. Missing this step results in delays in processing the claim or PA.

Contact CSC at 1-800-688-6696

Attention: All Providers**P**rocedure Code Update: Laminoplasty

Notice to Providers: This article was originally published in May 2014.

Effective June 1, 2014 Medicaid will cover:

- **Procedure Code 63050:** Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; and
- **Procedure Code 63051:** Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire, suture, mini-plates), when performed.

These procedures require prior approval which can be submitted through NCTracks.

**Clinical Policy,
DMA, 919-855-4318**

Attention: All Providers**P**rocedure Code Update: CPT 69210 with Modifier 50

The description for CPT procedure code 69210 was **updated January 1, 2014** by the Centers for Medicare & Medicaid Services (CMS). The description was changed from “removal impacted cerumen, 1 or both ears” to “removal impacted cerumen requiring instrumentation, unilateral.”

The 2014 CPT Manual states “for bilateral procedure, report 69210 with modifier 50.” Modifier 50, bilateral procedure, was not allowed before January 1, 2014. This has caused providers to receive denials when billing 69210 with modifier 50.

Effective only for claims with the date of service on or after January 1, 2014, providers are now allowed to bill code 69210 with modifier 50. Providers with denied claims related to billing CPT procedure code 69210 with modifier 50, that have been filed in a timely manner may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Questions should be directed to CSC at 1-800-688-6696.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Procedure Code Update: 2014 CPT Annual Update and Modifier 78

During the 2014 Annual CPT Update, the new CPT procedure codes with zero global days were set up in NCTracks with an incorrect secondary pricing factor code causing claims to pend for payment. System changes have been made to correct this issue. These codes include:

19281	19283	19285	19287	33366	43191	43195	43197	43198	43211
43212	43213	43214	43229	43233	43253	43254	43266	43270	43274
43275	43276	43277	43278	49405	49406	49407	52356	64642	64644
64646	64647	93582							

Effective with date of service on or after January 1, 2014, providers with denied claims related to EOB 05814 (secondary factor code x percentage segment date missing or invalid) that have been filed in a timely manner may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Questions should be directed to CSC at 1-800-688-6696.

**Clinical Policy and Programs
DMA, 919-855-4260**

Attention: All Providers**O**utpatient Specialized Therapies Providers

The N.C. Division of Medical Assistance (DMA) has revised Clinical Coverage Policy 10A covering policy limits for beneficiaries over 21 years of age. The revised policy limits can be found in Clinical Coverage Policy 10A, Subsection 5.5 on DMA's Clinical Policy Web page at www.ncdhhs.gov/dma/mp. Therapy treatment visits already completed in 2014 count towards the revised policy limits.

Outpatient Specialized Therapy
DMA, 919-855-4260

Attention: All Providers**C**linical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/mp/:

- *10A, Outpatient Specialized Therapies (6/1/14)*
- *10B, Independent Practitioners (IP) (6/1/14)*
- *10C, Local Education Agencies (LEAs) (6/1/14)*
- *1A-8, Hyperbaric Oxygenation Therapy (5/1/14)*
- *3L, Personal Care Services (10/1/13)*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**D**rug Screening

Note: This article, in a slightly different layout, was originally published in August 2011. The article is being republished because CSC and the N.C. Division of Medical Assistance (DMA) found that provider payments were being delayed due to these coding errors.

HCPCS Codes 0430 and 0434

Effective with date of service April 1, 2011, DMA **end-dated HCPCS code G0430 and replaced it with HCPCS code G0434** (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter).

HCPCS code G0434 should be billed per patient encounter regardless of the number of drug classes testing or the use or presence of the QW modifier on the claim. If more than one patient encounter occurs, providers should bill repeat testing with an appropriate modifier.

HCPCS Code 0431

HCPCS code G0431QW was end-dated with an effective date of service April 1, 2011 **but all other modifier combinations for G0431 are currently active.**

Providers who received claim denials for HCPCS codes G0431 or G0431QW with EOB 7747 (Exceeds one procedure per day limitation) for dates of service prior to April 1, 2010 will need to resubmit new claims for processing.

Note: The description for G0431 was changed to “Drug screen, qualitative; multiple drug classed by high complexity test method (e.g., immunoassay; enzyme assay), per patient encounter.”

HCPCS Code 80100

CPT code 80100 (Drug screen, qualitative; multiple drug classes chromatographic method, each procedure) has also been **end-dated** with an effective date of service April 1, 2011.

Contact CSC at 1-800-688-6696

Attention: All Providers**P**ost-Enrollment Site Visit: What to Expect**Application Physical and Site Addresses**

Public Consulting Group (PCG) is scheduling post-enrollment site visits to fulfill Federal regulations [42 CFR 455.410](#) and [455.450](#), which require all participating providers to be screened according to their categorical risk level.

The on-site visit will be scheduled for the primary address listed in the enrollment application, when no service locations are listed. It is not permissible to request the on-site visit take place at a location which is **NOT** listed in the provider's enrollment application. Providers should complete a Manage Change Request Form to change their primary address.

Enrollment applications listing multiple service locations require an on-site visit at every location listed in the application. It is not permissible to schedule an on-site visit for one service location, but not all of the service locations. Providers should complete a Manage Change Request Form to correct (add/remove) service locations to meet federal regulations for on-site visits.

Before the Post-Enrollment Site Visit

[42 CFR 455.450](#) establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a post-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. [Session Law 2011-399 §108C-3](#) further defines provider types that fall into each category.

On **Monday June 9, 2014**, PCG will begin scheduling post-enrollment site visits for applicable providers. Screenings will take place both upon initial enrollment and re-enrollment and on-site visits will be scheduled for those providers screened as moderate- or high-risk.

While PCG also conducts program integrity visits, the post-enrollment visit is structured – and conducted – differently than a program integrity visit.

To confirm an appointment for a post-enrollment site visit, contact PCG at 1-877-522-1057. When there are several providers requiring a post-enrollment site visit at the same location, PCG can coordinate one appointment with all providers to minimize repeat visits to the same location.

During the Post-Enrollment Site Visit

Post-enrollment site visits will last at least two hours. There will be two PCG representatives conducting the post-enrollment site visit.

Providers will be expected to demonstrate a working knowledge of N.C. Medicaid through responses to a series of questions. Resources for success with this visit are:

- The *North Carolina Provider Claims and Billing Assistance Guide* at <https://nctracks.nc.gov/content/public/providers/provider-manuals.html>
- Provider Administrative Participation Agreement,
- NCTracks Website at www.nctracks.nc.gov; and,
- The clinical coverage policies that covers the services which the provider delivers. These are located on DMA's clinical coverage Web page at www.ncdhhs.gov/dma/mp/.

After the Post-Enrollment Site Visit

Using a system of “pass/fail,” PCG will report the results of the post-enrollment site visit to CSC. CSC will notify each provider that he or she has either passed or failed, by way of a “Welcome Letter” or an “Incomplete Letter.” CSC call center staff will not have access to any of the details, e.g., which answers were correct versus incorrect.

*Providers with “fail” results are able to reapply but are strongly encouraged to wait until **AFTER** the incomplete notification has been received. If a provider chooses to reapply all appropriate fees would need to be repaid.*

Provider Relations
DMA, 919-855-4050

Attention: All Providers**R**eceiving Email Alerts Through NCTracks

Note to Providers: This article was originally published in September 2013.

Providers can subscribe to email alerts through the NCTracks Provider Portal at www.nctracks.nc.gov/. Alerts are sent when there is important information to share between monthly issues of the Medicaid Provider Bulletin. Past email alerts have included information on such topics as:

- Common Billing Errors
- Enhanced Payments under the Affordable Care Act
- HIPAA/ICD-10
- Medicare Crossover Claims
- Prior Approval
- Updating and Amending Applications
- Using Skillport

To receive email alerts and other communications from NCTracks, visit <https://www.nctracks.nc.gov/content/public/providers/provider-communications.html>. Use the link “Click here to join mailing list” under the heading “Sign Up for NCTracks Communications” in the upper right corner of the page. Providers who currently receive email alerts will continue to receive them through NCTracks. No other actions are required.

Email addresses will never be shared, sold or used for any purpose other than Medicaid and N.C. Health Choice email alerts and NCTracks communications.

Contact CSC at 1-800-688-6696

Attention: Dental Providers and Health Department Dental Centers

American Dental Association Code Updates

Effective with date of service **January 1, 2014**, the following dental procedure codes have been added for the N.C. Medicaid Dental Program. These additions are a result of the Current Dental Terminology (CDT) 2014 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, Dental Services will be updated to reflect these changes.

CDT 2014 Code	Description and Limitations
D2949	Restorative foundation for an indirect restoration <ul style="list-style-type: none"> • requires prior approval • limited to recipients ages 16 and older • limited to teeth prepared for a crown that has been approved as a non-covered service • placement of restorative material to yield a more ideal form, including the elimination of undercuts
D3355	Pulpal regeneration – initial visit <ul style="list-style-type: none"> • limited to recipients under age 21 • includes opening tooth, preparation of canal spaces, and placement of medication
D3356	Pulpal regeneration – interim medication replacement <ul style="list-style-type: none"> • limited to recipients under age 21
D3357	Pulpal regeneration – completion of treatment <ul style="list-style-type: none"> • limited to recipients under age 21 • does not include final restoration

The following procedure code was end-dated effective with date of service **December 31, 2013**.

End-Dated CDT Code	Description
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration

The following procedure code descriptions were revised effective with date of service January 1, 2014.

CDT Code	Revised Description
D2950	Core buildup, including any pins when required
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352	Apexification/recalcification – interim medication replacement
D3410	Apicoectomy – anterior

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For more information on Clinical Coverage Policy 4A, refer to the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy Web page at www.ncdhhs.gov/dma/mp/.

Dental Program
DMA, 919-855-4280

Attention: Dental Providers and Health Department Dental Centers

Billing for Partial and Complete Dentures

Providers must use the date of delivery as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed and delivered. N.C. Medicaid or N.C. Health Choice (NCHC) payment may be recouped for claims filed using a date other than the delivery date.

Note: If the beneficiary's N.C. Medicaid or NCHC eligibility expires **between** the final impression date and delivery date, the provider shall use the final impression date as the date of service. This exception is allowed **only** when the dentist has completed the final impression on a date for which the beneficiary is eligible **and** has actually delivered the denture(s). The delivery date **must** be recorded in the beneficiary's chart.

Billing for Non-deliverable Partial and Complete Dentures

Dentists shall make every effort to schedule partial and complete denture delivery **before** requesting payment for a non-deliverable denture. This must include contact with the beneficiary's county social worker, who must be allowed at least two (2) weeks to assist in scheduling an appointment for denture delivery. If a reasonable time has elapsed and circumstances beyond the dentist's control prevent denture delivery, then a claim for payment of non-deliverable dentures may be filed. The dentist shall submit the following:

1. A completed claim form clearly marked "Non-deliverable dentures"
2. Any supporting material documenting the reason for non-delivery
3. A copy of the lab bill indicating a charge for the dentures
4. A copy of the dental record indicating dates and methods by which the beneficiary was notified and dates of any appointments for impressions or try-ins

These claims must be sent to the N.C. Division of Medical Assistance (DMA) at the address listed below.

DMA Dental Program - 20
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Reimbursement is determined on a case-by-case basis. The dentist shall retain the dentures, lab work orders, lab bills, and record documentation for six (6) years as proof that dentures were constructed. Do **not** mail dentures to DMA.

Dental Program
DMA, 919-855-4280

Attention: Dental and Orthodontic Providers

NCTracks Updates: Dental

Correct Marking of ADA Form for Claims Versus Prior Approval

The most common error dental and orthodontic providers make when seeking prior approval (PA) is incorrectly marking Box 1 on the American Dental Association (ADA) form. The box **must** indicate whether the form is for “Statement of Actual Services” (claims for payment), or “Request for Predetermination/Preauthorization.” If this box is marked incorrectly or left blank, it will be rejected with reject reason 585. Examples of these errors include:

- A PA Marked as a Claim For Payment (This will be rejected)

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preauthorization

EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

[Redacted]

- A PA With No Indicators (This will be rejected)

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preauthorization

EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

[Redacted]

CSC will keep the mailed orthodontic models/records for those requests that fail with reject reason 585 causing the provider to receive a “Notice of Return Request to Provider letter.” Resubmit a valid PA request form with the correct marking in Box 1 (indicating “Request for Predetermination/Preauthorization”) and the case will be reviewed in the order received.

For instructions on how to submit a PA request via the NCTracks provider portal, refer to the User Guide “How to Enter a Dental or Orthodontic Prior Approval in NCTracks” found at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>.

EPSDT Prior Approval for Dental and Orthodontic Services

Beginning April 1, 2014, CSC began processing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requests for non-covered services and services outside the policy limit for recipients under age 21. The N.C. Division of Medical Assistance (DMA) will continue to process these requests received prior to April 1, 2014.

Providers submitting a PA request for EPSDT services on or after April 1, 2014, may use the “Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old” or a cover letter to document medical necessity. The form can be found at <https://www.nctracks.nc.gov/content/public/providers/prior-approval.html>.

Providers submitting a PA request via the NCTracks provider portal should upload this form or a cover letter by attaching it electronically to the PA request. If submitting via mail/fax, attach this form or cover letter and send it along with the required ADA form.

For more information, refer to the “EPSDT Update” section of the “NCTracks Update” which appeared in the [May 2014 Medicaid Bulletin](#).

Contact CSC at 1-800-688-6696

Attention: Hospital Providers**NCTracks Updates: Hospitals****Acute Care Hospitals Can Now Bill Lower Level of Care Beds for Patients Awaiting Nursing Home Placement**

NCTracks was updated to enable acute care hospitals to bill Lower Level of Care (LLOC) beds for Medicaid beneficiaries residing in their facilities who are awaiting placement into nursing homes. This change is effective with date of processing April 21, 2014. Providers can bill claims with prior dates of service, within the timely filing guidelines. For more information about billing for LLOC, read Clinical Coverage Policy (CCP) No: 2A-1 at the N.C. Division of Medical Assistance (DMA) CCP Web page at www.ncdhhs.gov/dma/mp/.

Processing of Medicare Coordination of Benefits Agreement (COBA) claims

Claim types 13X and 14X are the “type of bill” associated with Medicare Part B crossover claims from hospitals. Providers were previously required to submit claim types 13X and 14X to NCTracks because they did not crossover automatically from Medicare. NCTracks is now receiving claim types 13X and 14X directly from Group Health Incorporated (GHI), the Medicare vendor for the Centers for Medicare & Medicaid Services (CMS), so providers should no longer submit these types of claims to NCTracks.

13X and 14X claims submitted to NCTracks will be denied as duplicate claims.

Contact CSC at 1-800-688-6696

Attention: Hospitals and OB/GYN Providers**Update on Presumptive Eligibility**

State approved medical providers may screen patients for Medicaid for Pregnant Women (MPW) eligibility. When presumptively eligible, a woman may receive prenatal ambulatory services until the end of the month following her Medicaid application. This allows beneficiaries adequate time to apply for Medicaid at their local Department of Social Services (DSS) or online at www.epass.nc.gov/.

If the pregnant woman fails to apply for Medicaid within this time period, she is eligible for limited Medicaid services until the last calendar day of the month following the month she is determined presumptively eligible. For example, if the woman receives medical services under presumptive eligibility in April, she has until May 31 to apply for

Medicaid. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the county makes a determination on her application.

During the presumptive eligibility period, Medicaid will cover **only** ambulatory prenatal services provided by a Medicaid enrolled provider. This includes prescriptions.

Undocumented Individuals

Undocumented individuals requesting Medicaid coverage for medical emergencies must meet categorical and financial eligibility requirements, including state residency. In addition, the medical services rendered must meet the federal definition of “emergency medical service.” The definition of an emergency medical service includes vaginal or C-section delivery. Undocumented individuals are only authorized for Medicaid services for the actual days they receive an emergency medical service. For all other emergency services, including miscarriages and other pregnancy terminations, the N.C. Division of Medical Assistance (DMA) determines the eligibility coverage.

Note: Sterilizations do not meet the definition of “emergency medical service” and are **not reimbursed** for undocumented individuals.

Resubmitting Denied Claims

If pregnancy-related claims are submitted before a beneficiary applies or determination was made by DSS, the claims will be denied with Edit/Explanation of Benefit (EOB) Code 00268/00139. The provider can submit a paper claim *with* a copy of the Remittance Status displaying the denial code to:

DMA Claims Analysis
2501 Mail Service Center
Raleigh, NC 27699-2501

The DMA Claims Analysis Unit will research the eligibility files for DSS approval. If approval is found, the Claims Analyst will special batch the claim and override presumptive denial. If no approval is found, the claim will be returned to the provider with an explanation.

Claims Analysis Unit
DMA, 919-855-4045

Attention: Nurse Practitioners and Physicians Assistants**P**rocedure Code Update: CPT 51798 and 99239

Individual nurse practitioners have had claims denied for CPT code 99239 (hospital discharge day management; more than 30 minutes) and CPT code 51798 (measurement of post voiding residual urine and/or bladder capacity by ultrasound, non-imaging).

System changes have been made to correct this issue and add physician assistants to the above codes.

Effective with dates of service on or after July 1, 2013, providers who have filed timely claims with CPT Codes 51798 and 99239 and have been denied with Explanation of Benefit (EOB) 353 (“This service is not payable to your provider type or specialty in accordance with Medicaid guidelines”) may resubmit with a new claim (**not** as an adjustment request) for processing.

Questions should be directed to CSC at 1-800-688-6696.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Nurse Practitioners and Physician Assistants**P**rocedure Code Update: CPT Code 99183

The description for CPT procedure code 99183 was updated January 1, 2013 by Centers for Medicare & Medicaid Services (CMS). The new description states “physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session.” N.C. Division of Medical Assistance (DMA) has updated policy number 1A-8, Hyperbaric Oxygen Therapy (www.ncdhhs.gov/dma/mp) to include nurse practitioners and physician assistants as “other qualified health care professionals” allowed to bill using that code. System changes have been made to allow claims from these providers to process.

Effective with date of service on or after January 1, 2013, providers with denied claims related to EOB 353 (“this service is not payable to your provider type or specialty in accordance with Medicaid guidelines”) that have been filed in a timely manner may resubmit the denied charges as a new claim (not as an adjustment request) for processing. Questions should be directed to CSC at 1-800-688-6696.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Nurse Practitioners, Physicians and Physician Assistants

Obinutuzumab injection (Gazyva[®]), HCPCS code J9999: Billing Guidelines

Effective with date of service **November 5, 2013**, the N.C. Medicaid Program covers obinutuzumab injection (Gazyva[®]) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs). Gazyva[®] is currently commercially available in 1000 mg/40 mL single use vials.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing the Obinutuzumab injection (Gazyva[®]) is:
 - 204.1 Chronic lymphoid leukemia without mention of having achieved remission.
- Providers must bill the Gazyva[®] with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Gazyva[®] is 1 mg (0.25 mL). The maximum reimbursement rate per unit is \$34.83. One 1000 mg/40 mL vial contains 1,000 billable units.
- The doses administered on the first two days of Cycle 1 should be prepared from a single vial, per instructions found in the product labeling.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Gazyva[®] 1,000 mg/40 mL vial is 50242-0070-01.
- The NDC units for Obinutuzumab injection (Gazyva[®]) 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*, on the N.C. Division of Medical Assistance (DMA) Medicaid Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- The new 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, Physicians and Physician Assistants

New NDC for Nexplanon (etonogestrel implant) 68mg Radiopaque

Nexplanon has a new National Drug Code (NDC) due to manufacturing changes to the EVA28 polymer used in the drug.

Product	Old NDC	New NDC
Nexplanon® (etonogestrel implant) 68mg Radiopaque	00052-0274-01	00052-4330-01

Both NDCs are currently active in NCTracks.

Contact CSC at 1-800-688-6696

Attention: Optometrists and Optical Service Providers

NCTracks Updates: Visual Aids

Common Errors with Visual Aids Prior Approvals

Procedure codes are not required when entering requests for visual aids via the NCTracks portal. Do not enter procedure codes; Leave this field blank.

Before submitting requests for visual aids via NCTracks be sure the frame information and prescription are complete and correctly entered, including the papillary distance (PD). Be sure to enter the “+” and “-” as the system defaults to “+” powers.

Contact CSC at 1-800-688-6696

Attention: Pharmacists and Prescribers**Makena Is Available Via Point of Sale**

Notice to Providers: This article was originally published in May 2014.

Makena is still available through the Physicians Drug Program (PDP) at a rate of \$2.87 per milligram. In addition, the N.C. Division of Medical Assistance (DMA) also covers the compounded product, 17P, through the PDP program. The compounding product may be unavailable soon. In order to prevent any barrier in obtaining the product, DMA has allowed Makena to be dispensed at point-of-sale (POS) **starting June 1, 2014**. DMA may impose a prior authorization requirement in the near future.

Makena may have limited distribution. Visit the manufacturer's (Lumara Health) Makena Web page at www.makena.com/pages/dtc/care-connection/LearnHowToAccessMakena.aspx or call the company at 1-877-567-7676 to learn more about obtaining Makena through the PDP program or through POS.

**Outpatient Pharmacy
DMA, 919-855-4300**

Attention: Pharmacists and Prescribers

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

Notice to Providers: This article was originally published in May 2014. Effective with date of service of **May 17, 2014**, the N.C. Division of Medical Assistance (DMA) made changes to the N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL). Below are highlights of some of the changes:

- The prior authorization criteria was removed from the second generation anti-convulsant class
- The use of only Spiriva® in the COPD class is required before moving to a non-preferred agent
- Adderall XR and Adderall generics were removed from the PDL entirely. Prior authorization is required for these generic products.
- New classes were added:
 - CARDIOVASULAR, Sympatholytics and Combinations
 - ENDOCRINOLOGY, Sodium Glucose Co-Transporter 2 (SGLT2)
 - OPHTHALMIC, Antibiotics-Steroid Combinations
 - OTIC, Anti-Infectives and Anesthetics
 - TOPICALS, Antibiotics-Vaginal; and,
 - MISCELLANEOUS, Estrogen Agent Combinations and Estrogen Agent Oral/Transdermal

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

Brand Name	Generic Name
Accolate	Zafirlukast
Adderall	Amphetamine Salt Combo
Adderall XR	Amphetamine Salt Combo ER
Alphagan P	Brimonidine
Aricept ODT	Donepezil ODT
Astelin/Astepro	Azelastine Hydrochloride
Benzaclin	Clindamycin/Benzoyl Peroxide
Cardizem LA	Diltiazem LA
Catapress-TTS	Clonidine Patches

Brand Name	Generic Name
Derma-Smoothe-FS	Fluocinolone 0.01% Oil
Differin	Adapalene
Diovan HCT	Valsartan Hydrochlorothiazide
Dovonex Cream	Calcipotriene 0.005% Cream
Diastat / Diastat Accudial	Diazepam Rectal & Rectal Device
Exelon	Rivastigmine
Gabitril	Tiagabine
Kadian ER	Morphine Sulfate ER
Gris-Peg	Griseofulvin Ultramicrosize
Lovenox	Enoxaparin
Marinol	Dronabinol
Metrogel Vaginal	Metronidazole Gel Vaginal
Opana ER	Oxymorphone ER
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Budesonide 0.25mg/2ml, 0.5mg/2ml
Retin-A Micro	Tretinoin Microsphere
Singulair Granules	Montelukast Granules
Tobradex Suspension	Tobramycin/Dexamethasone Susp
Toprol XL	Metoprolol Succinate
Travatan	Travoprost
Trilipix	Fenofibric Acid
Uroxatral	Alfuzosin
Vancocin	Vancomycin
Zovirax Ointment	Acyclovir Ointment

**Outpatient Pharmacy
DMA, 919-855-4300**

Attention: All Personal Care Services (PCS) Providers**P**ersonal Care Services (PCS) Program Highlights

Notice to Providers: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternatives Program (CAP) program.

QiRePort - PCS Provider Interface – Mandatory Registration

Registration on the QiRePort Provider Interface is now REQUIRED for all Personal Care Services (PCS) Providers. The PCS QiRePort Provider Interface is a Web-based information system used to support PCS Independent Assessments. The interface collects, stores, and communicates beneficiary information including decision notices, independent assessments that are required to develop beneficiary plans of care, change of status assessment request, and discharge reporting.

To register, providers must complete the QiRePort Registration form, which is located under “Forms” on the N.C. Division of Medical Assistance (DMA) PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html, as well as at www.QiRePort.net. Once the registration form is complete, send it

By Fax: VieBridge, Inc. QiRePort Support – 1-919-301-0765

By Mail: VieBridge, Inc. QiRePort Team
8130 Boone Boulevard, Suite 350
Vienna, VA 22182

PCS On-Line Plan of Care

DMA is preparing for the implementation of On-Line Plan of Care approval. Once the on-line tool becomes available, all PCS providers will be required to use it to obtain approval from the designated Independent Assessment Entity for plans of care. More information about the On-Line Plan of Care, including implementation dates and training sessions, will be announced on the DMA PCS Web page. Those with questions should contact the PCS program at 919-855-4340.

PCS Regional Training Sessions

In May, DMA hosted PCS Regional Training Sessions across the state. Providers may access training material, presentations and upcoming training sessions on the DMA PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html. Those with questions should contact DMA at 919-855-4340 or Liberty Healthcare Corporation NC at 1-855-740-1400, www.nc-pcs.com.

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

Attention: Personal Care Service (PCS) Providers**Update: PCS State Plan Amendment 13-009 (N.C. Session Law 2013-306)**

Note: This article does not apply to providers billing for Personal Care Services under the Community Alternatives Program (CAP).

The N.C. Division of Medical Assistance (DMA) submitted a request on September 30, 2013 to the Centers for Medicare & Medicaid Services (CMS) to amend the Personal Care Services (PCS) Medicaid State Plan Option to implement PCS Additional Safeguards Criteria as mandated by N.C. Session Law (SL) 2013-306.

The DMA Medicaid State Plan has been amended and approved by CMS. For details, visit DMA's Medicaid State Plan Web page at www.ncdhhs.gov/dma/plan/, go to the heading titled "Updates," click on the heading "2014" and then click on "May 20, 2014 (246)."

Implementation of SPA 13-009: N.C. Session Law 2013-306 Webinar

On Friday May 23, 2014, DMA conducted Webinars to outline the implementation of N.C. Session Law 2013-306. The presentation, which applies to both providers and beneficiaries of State Plan PCS services, is available at www.ncdhhs.gov/dma/pcs/PCS_SPA13009_Provider_Webinar_Presentation.pdf. Additional questions on the implementation of N.C. Session Law 2013-306 may be submitted to PCS_Program_Questions@dhhs.nc.gov

More information about PCS State Plan Amendment can be found on DMA's PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html.

3L, Personal Care Services Policy

"Clinical Coverage Policy 3L, Personal Care Services" has been updated to include the allowed additional safeguards mandated by N.C. Session Law 2013-306. Changes specify that a provider must implement a person-centered plan of care that addresses all unmet needs identified in the independent assessment before providing services to beneficiaries. "Clinical Coverage Policy 3L, Personal Care Services" is available at www.ncdhhs.gov/dma/mp/.

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

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.

2014 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
June	6/05/2014	6/10/2014	6/11/2014
	6/12/2014	6/17/2014	6/18/2014
	6/19/2014	6/24/2014	6/25/2014
July	7/03/2014	7/08/2014	7/09/2014
	7/10/2014	7/15/2014	7/16/2014
	7/17/2014	7/22/2014	7/23/2014
	7/24/2014	7/29/2014	7/30/2014
	7/31/2014	8/05/2014	8/06/2014

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
 Acting Chief Operating Officer
 Division of Medical Assistance
 Department of Health and Human Services

Paul Guthery
 Executive Account Director
 Computer Sciences Corp. (CSC)