



June 2015 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates

New Edit for Individual Practitioners Claims Billed Outside Nursing Facility Per Diem

On May 3, 2015, a new edit was implemented in NCTracks to deny payment for certain supplies and equipment billed by individual practitioners when the Medicaid recipient is a resident in a Skilled Nursing Facility. The cost for these supplies and equipment is considered to be included in the nursing facility per diem paid to the facility. **Services that are already included in the nursing facility's per diem rate may not be reimbursed to individual practitioners for dates of service that a recipient is residing in a nursing facility.**

See subsection 5.4.1 and Attachment B of clinical coverage policy 2B-1, *Nursing Facilities*, for a list of services included in the nursing facility per diem rate. The policy can be found on the [DMA Clinical Coverage Policy web page](#).

The new edit affects claims submitted to NCTracks on or after May 3, 2015, regardless of dates of service. A new explanation of benefits (EOB) 01792 - MEDICAL SUPPLIES/EQUIPMENT ARE INCLUDED IN THE NURSING FACILITY PER DIEM PACKAGE will post to the paper Remittance Advice (RA) for claim details that fail the edit.

2015 CPT Code Update Planned for End of May

This is an update on the [CPT Code Update: 2015](#) article published in the January 2015 Medicaid Bulletin.

The new 2015 CPT codes are not fully installed into NCTracks. Until that is complete, the rates will not be entered into the system. Some of the 2015 CPT codes have already been updated in NCTracks and remaining 2015 CPT codes are scheduled to be updated by the end of May. Until that time, claims submitted with some 2015 CPT codes will continue to pend in NCTracks for “no rate on file.”

The advantage of this process is that when the codes are fully implemented, the rate will be updated and the pended claims will automatically recycle for adjudication. This process allows the provider to bill the new codes immediately rather than hold claims or file adjustment claims when the CPT codes are fully implemented.

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

An announcement will be posted on the [NCTracks Provider Portal](#) when the remaining 2015 CPT codes have been updated in NCTracks.

Reminders for Submission of Sterilization Consent Forms and Hysterectomy Statements

Note: All of these requirements were published in articles titled *Sterilization Consent Form Requirements* and *Hysterectomy Statement Form Requirements* in the [November 2013 Medicaid Bulletin](#).

Some providers of OB/GYN services have received Sterilization Consent Form and Hysterectomy Statement denials. Many of the denials are due to the absence of several key requirements for approval, specifically:

1. Providers are not adhering to the DMA clinical coverage policies, Medicaid bulletin guidelines and regulations. Both clinical coverage policy 1E-3, *Sterilization Procedures* and 1E-1, *Hysterectomy*, can be found on the [DMA Clinical Coverage Policy web page](#).
2. **All signatures on both the Sterilization Consent Form and the Hysterectomy Statement must be legible. Signatures that are not legible should have a printed version of the recipient's name above or below the signature. If there is any question of the legibility of a signature, providers need to ensure there is a printed name on the consent form, prior to submitting it to NCTracks for its review. Any illegible signatures on Sterilization Consent Forms will result in a permanent denial of the consent that cannot be corrected.**
3. It is the responsibility of the rendering provider to send the Sterilization Consent Form and Hysterectomy Statement to NCTracks. Hospitals, anesthesia, pathology services, and other ancillary providers should **never** submit Sterilization Consent Forms and Hysterectomy Statements to NCTracks. The National Provider Identifier (NPI) of the rendering provider (surgeon) is the **only** acceptable NPI for Sterilization Consent Forms and Hysterectomy Statements.
4. Rendering providers (surgeons) should submit Sterilization Consent Forms and Hysterectomy Statements **within 30 days of the procedure** for NCTracks review and approval.
5. Sterilization Consent Forms and Hysterectomy Statements **cannot** be submitted electronically with the claim. All Sterilization Consent Forms and Hysterectomy Statements must be mailed to:

CSC
P.O. Box 30968
Raleigh, NC 27622

Common Errors on Sterilization Consent Forms and Hysterectomy Statements

The following are common errors on Sterilization Consent Forms and Hysterectomy Statements. Ensuring the accuracy of these forms will expedite their processing and approval. Verify that the following information is correct prior to submitting the form:

1. **Submitting Incorrect Hysterectomy Statement Form** - Effective November 1, 2013, providers began receiving denials for submitting an incorrect Hysterectomy Statement Form, signed on or after August 1, 2013. **After November 1, 2013**, use of the old form results in a denial as not correctable. If corrections are needed to the new form, providers should follow the instructions in subsection 5.3 of clinical coverage policy 1E-1, *Hysterectomy*, on the [DMA Clinical Coverage Policy web page](#).
2. **Missing NPI on Hysterectomy Consent Forms** - Providers must include their National Provider Identifier (NPI) and the Recipient Identification Number (RID) – previously known as the Medicaid Identification Number (MID) – for proper Hysterectomy Statement Form and claim matching. Hysterectomy Statement Forms submitted without an NPI cannot be matched to the correct claim and will be denied.
3. **Incorrect Sterilization Consent Form** - The Centers for Medicare & Medicaid Services (CMS) approved the current Sterilization Consent Form found in the Sterilization policy and the [DMA Forms web page](#). Sterilization Consent Forms signed on or after October 1, 2013 using the old form will be denied with an EOB that states:

“The consent form submitted is invalid. It is not the federally mandated form. Refer to DMA clinical coverage policy 1E-3. **This is not correctable.**”
4. **Use of Wite-Out® or Erasures When Correcting Sterilization Consent Forms** - **The use of Wite-out® or erasures on consent forms are prohibited.** If a provider receives a denial of the consent form from DMA’s fiscal agent due to a correctable error, **providers must strikethrough the error once on the original consent form, make the correction, and submit the revised copy of the form to the fiscal agent.**
5. **Failure to Use the Full Name of Physician Scheduled to Perform the Surgery** - According to clinical coverage policy, 1E-3, *Sterilization Procedures*, **the full name of the physician scheduled to perform the surgery must be on the form.** Abbreviations, initials, or “doctor on call” are not acceptable. For additional information, refer to clinical coverage policy 1E-3.
6. **Missing NPI on Sterilization Consent Form** - NPI of the rendering provider is **required** on each Sterilization Consent Form. Providers must include their NPI for proper Sterilization Consent Form and claim matching. Sterilization Consent Forms submitted without an NPI cannot be matched to the correct claim and will be denied.

- 7. Illegible Sterilization Consent Form** - In order to process the consent form, **all fields must be legible.**

CSC, 1-800-688-6696

Attention: All Providers**NCTracks ICD-10 Update****Most NCTracks Prior Approvals Do NOT Require Split for ICD-10 Transition**

Note: This is a correction to the article titled [NCTracks ICD-10 Update](#) published in the May 2015 Medicaid Bulletin.

Contrary to what was previously reported, providers will **not** need to split Medicaid and N.C. Health Choice (NCHC) prior approval (PA) requests that span the ICD-10 transition date of October 1, 2015 in the same way they will need to split claims.

If providers have an approved PA request with a begin date before October 1 and an end date on or after October 1, no action is required. It is possible for a claim to be submitted after October 1 with an ICD-10 code and the PA request to be approved with an ICD-9 code.

The ICD-10 transition won't affect PA requests because the diagnosis codes on PA requests aren't used to adjudicate claims. Instead, PA requests are used by clinicians to see if the service to be provided is appropriate for the diagnosis.

Therefore, most **PA requests** that span October 1 do not need to be split. However, **claims** submitted for services rendered on or after October 1 must use ICD-10 codes.

Note the following important PA considerations:

- All PA requests submitted to NCTracks on or after October 1 must use ICD-10 codes.
- Retroactive requests for PA for dates of service before October 1 must use ICD-9 codes.

Exceptions: The exceptions are the Sickle Cell and EHDI (Early Hearing Detection and Intervention) programs under the N.C. Division of Public Health (DPH). PA requests for Sickle Cell and EDHI services **cannot** span the October 1 implementation date. Providers must obtain a new PA for Sickle Cell and EDHI services rendered on or after October 1. (NCTracks will automatically end date existing PAs for Sickle Cell and EDHI that extend beyond September 30.)

Review of Claims

With regard to claims, a single claim **cannot** contain both ICD-9 and ICD-10 codes. When the date of service begins before the October 1 implementation of ICD-10 and ends afterwards, the provider must split them into two separate claims.

- For services rendered before October 1, one claim should be submitted using ICD-9 codes.
- For services rendered on October 1 and afterwards, a second claim should be submitted using ICD-10 codes.

This will only be required for situations in which the dates of service span the October 1 implementation date.

Exception for hospital inpatient claims. Inpatient claims with Diagnosis-Related Group (DRG) pricing **cannot** be split. Instead, use the ICD code based on the discharge date.

- If the discharge date is September 30 or earlier, hospitals must submit the claim with ICD-9 codes.
- If the discharge date is October 1 or later, hospitals must submit the claim with ICD-10 codes.

NCTracks will not accept ICD-9 codes for claims with dates of service starting October 1 or later, per policy from the Centers for Medicare and Medicaid Services (CMS).

Facts About ICD-10

CMS recently published some facts about ICD-10 intended to dispel myths and address common questions about the transition to ICD-10:

1. **The ICD-10 transition date is October 1, 2015:** The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.
2. **Providers don't have to use all 68,000 codes:** Medical practices don't use all of the 13,000 diagnosis codes available in ICD-9. Nor will they be required to use the 68,000 codes that ICD-10 offers. Each practice will use a very small subset of the codes.
3. **The process to look up ICD-10 codes is similar to the one used with ICD-9:** Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help with code selection.
4. **Outpatient and office procedure codes aren't changing:** The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Practices will continue to use CPT for those purposes.

Be sure to learn and understand what is changing so that your practice will be ready on October 1.

Take Advantage of the NCTracks ICD-10 Crosswalk

Providers can find out what ICD-10 codes map to the ICD-9 codes they currently use by taking advantage of the latest version of the [NCTracks ICD-10 Crosswalk](#).

The ICD-10 codes in the crosswalk are the ones that will be used in NCTracks when the switch to ICD-10 codes occurs on October 1.

Note: A few non-specific ICD-9 codes don't have corresponding ICD-10 codes in either the NCTracks or CMS crosswalks. If a provider enters a specific ICD-9 code in the crosswalk and does not receive the corresponding ICD-10 codes, alert NCTracks by emailing NCTracks-Questioner@dhhs.nc.gov. **(Remember that ICD-9 codes should be entered into the crosswalk without a decimal point.)**

ICD-10 Questions and Answers

From now until ICD-10 goes live in October, providers can send ICD-10 questions and comments to NCTracks-Questioner@dhhs.nc.gov. Providers will receive a personal reply, and NCTracks will get a better idea of the kinds of information providers need. Frequently asked questions and answers will be shared with everyone.

The NCTracks ICD-10 web page is <https://www.nctracks.nc.gov/content/public/providers/ICD10.html>.

CSC, 1-800-688-6696

Attention: All Providers**E**xtrapolation Error Rate Threshold

The N.C. Division of Medical Assistance (DMA) Program Integrity Section employs statistical sampling and extrapolation to project Medicaid overpayments, in accordance with N.C. General Statute § 108C-5 and rules contained in 10A NCAC 22F. Specifically, rule 10A NCAC 22F .0606 - *Technique for Projecting Medicaid Overpayments* states:

“(b) The agency may use a Disproportionate Stratified Random Sampling Technique in establishing provider overpayments.”

Overall DMA claims and paid error rates determine when extrapolation will be used. If either the current claims error rate or paid error rate is at least 5 percent, extrapolation will occur.

Program Integrity Section
DMA, 919-814-0000

Attention: All Providers**H**epatitis C TEMPORARY Prior Authorization Fax Forms

Fax forms are available on NCTracks to request Hepatitis C medications on the [NCTracks Pharmacy Forms web page](#). Use these 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.** It is expected the NCTracks PA Portal will be updated by December 31, 2015. When the NCTracks PA Portal is updated, providers will be able to request these PA's electronically and the use of fax forms 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.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers**S**peech/Language and Occupational Therapy Providers

Note: This article was originally published in the [September 2014 Medicaid Bulletin](#).

When submitting a claim for either Medicaid or N.C. Health Choice (NCHC), the N.C. Division of Medical Assistance (DMA) recognizes CPT code 92526, “treatment of swallowing dysfunction and/or oral function for feeding,” as defined in the *AMA Professional Edition Current Procedural Terminology 2014*.

For that reason, treatment should **not** be billed with CPT Code 92526 unless there are documented findings which address the following deficits consistent with a dysphagia diagnosis:

- Coughing and/or choking while eating or drinking;
- Coughing, choking or drooling with swallowing;
- Wet-sounding voice;
- Changes in breathing when eating or drinking;
- Frequent respiratory infections;
- Known or suspected aspiration pneumonia;
- Masses on the tongue, pharynx or larynx;
- Muscle weakness, or myopathy, involving the pharynx;
- Neurologic disorders likely to affect swallowing;
- Medical issues that affect feeding, swallowing, and nutrition; or,
- Oral function impairment or deficit that interferes with feeding.

These findings must be indicated through:

- Video fluoroscopic swallowing exam (VFSE), also sometimes called a modified barium swallow exam (MBS);
- Fiberoptic endoscopic evaluation of swallowing (FEES); or,
- Clinical feeding and swallowing evaluation.

Do **not** submit a Medicaid claim using CPT code 92526 for treatment to:

- Decrease food aversions
- Increase food repertoire, and,
- Expand tolerance to different textures of foods which pertain to nutritional feeding disorders and feeding development **unless** at least one of the deficits above is documented.

Failure to comply with these guidelines may result in a post payment review audit and/or recoupment.

Outpatient Specialized Therapies
DMA, 919-855-4308

Attention: All Providers

Speech/Language Therapy Providers: Use of '-52' Modifier

Use of the "-52" modifier on claims for outpatient speech/language therapy

As advised by The American Speech and Hearing Association (ASHA), when a beneficiary is evaluated only for language, with **no documentation of an assessment of speech** (formal or informal), speech/language therapy providers should bill 92523 with the "-52" modifier, indicating "reduced services." The "-52" modifier must **not** be used with any other CPT codes.

For more information, visit [ASHA's New CPT Evaluation Codes for SLPs](#) web page.

Outpatient Specialized Therapies
DMA, 919-855-4308

Attention: All Providers**New PTP-Associated Modifiers**

A [December 2014 Special Bulletin](#) and a [January 2015 Medicaid Bulletin](#), both announced that four new modifiers may be used in lieu of modifier 59 whenever possible. These new modifiers were developed to provide greater specificity in situations where modifier 59 was previously associated with procedure-to-procedure (PTP) editing,

Modifier 59 will remain a valid PTP-associated modifier. However, the coding instructions for modifier 59 specify that it should be used “only if no more descriptive modifier is available”. Therefore, providers should use one of the new modifiers, instead of modifier 59, if the clinical situation described by one of the new modifiers is present.

This change was made based on guidance from the Centers for Medicare & Medicaid Services (CMS), as part of the National Correct Coding Initiative.

On May 3, 2015, these new modifiers became active in NCTracks for claims with dates of service on or after January 1, 2015.

Claims already submitted with modifier 59 require no further action. Providers who submitted claims using one of the new modifiers prior to May 3, 2015 and received a denial can resubmit the claim.

Clinical Policy
DMA, 919-855-4260

Attention: Ambulatory Surgical Centers and Dental Providers

Billing for Dental Facility Charges by an Ambulatory Surgical Center (ASC)

An Ambulatory Surgical Center (ASC) must submit claims for dental facility use with an **electronic claim** in NCTracks. Paper claims are no longer accepted. These claims will be reimbursed based on the total time for each case, as follows:

ASC Group	Total Time	Reimbursement
1	Up to 30 minutes	\$307.50
2	31–60 minutes	\$411.85
3	61–90 minutes	\$470.95
4	Over 90 minutes	\$581.76

Providers must complete the claim as instructed below:

1. Enter the place of service code as “24” for the ASC.
2. Enter the dental procedure codes (*Code on Dental Procedures and Nomenclature CDT-2015*) for the services provided by the dentist.
 - a. **Note:** All dental codes begin with the “D” prefix. Only the dental procedure codes (CDT-2015) listed in the clinical coverage policy 4A, *Dental Services*, subsection 5.3, *Limitations or Requirements*, are valid for billing in ASC cases. The policy can be found on the [N.C. Division of Medical Assistance \(DMA\) Clinical Coverage Policy web page](#).
3. Enter modifier SG for each procedure code.
4. Enter all **charges on detail line 1** of the claim.
5. Enter the **total operating room time on detail line 1** of the claim (one unit = one minute).
6. For all remaining detail lines, enter the number of times (units) each dental procedure was provided with zero charges.
7. Submit all dental procedure codes on **one electronic claim** for the surgery date.

Dental Program
DMA, 919-855-4280

Attention: Dental Providers and Physicians**G**uidance for Billing of Procedure Codes D0145 and D1206

Claims that include procedure codes D0145 (Oral evaluation for a patient under 3 years of age and counseling with primary caregiver) and D1206 (Topical application of fluoride varnish) must be billed in a particular order for both to pay correctly. **Procedure code D1206 must be billed on the detail line before D0145.**

NCTracks is designed to adjudicate one detail line at a time, beginning with the first detail line on the claim and proceeding through the last. NCTracks must verify that D1206 has been paid before D0145 can be paid for the same date of service. Ensuring that claims are billed with the procedure codes in this order will expedite processing and payment.

If the claim is originally submitted to NCTracks with the procedure codes in the wrong order and only D1206 is paid, the provider must submit a new claim for D0145 only.

Dental Program
DMA, 919-855-4280

Attention: Hospitals**O**utpatient Cro-Fab Claims

Cro-Fab is a single source anti-venom product that currently has no rebate under the N.C. Medicaid or N.C. Health Choice (NCHC) programs. Because of this, claims are denying.

Providers who have claims for Cro-Fab that were denied must fax a copy of the denied claim to 919-715-1255 - ATTN: CRO-FAB DENIAL.

The N.C. Division of Medical Assistance (DMA) Outpatient Pharmacy Services Section will write a memo to NCTracks to override the denial edit and have the claim pay.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: Nurse Practitioners, Physician Assistants and Physicians**Ceftazidime; avibactam injection (Avycaz™) HCPCS code J3490:
Billing Guidelines**

Effective with date of service May 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers ceftazidime; avibactam injection (Avycaz™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490, unclassified drugs. Avycaz™ is currently commercially available in 2 g; 0.5 g injections.

Ceftazidime; avibactam injection (Avycaz™) is indicated for complicated intra-abdominal infections (cIAI); complicated urinary tract infections (cUTI), including pyelonephritis. The recommended dosage for ceftazidime; avibactam injection (Avycaz™) is:

- Estimated Creatinine Clearance (mL/min) > 50: 2.5 grams every eight hours.
- Estimated Creatinine Clearance (mL/min) 31 to 50: 1.25 grams every eight hours.
- Estimated Creatinine Clearance (mL/min) 16 to 30: 0.94 grams every 12 hours.
- Estimated Creatinine Clearance (mL/min) 6 to 15: 0.94 grams every 24 hours or
- Estimated Creatinine Clearance (mL/min) >=5: 0.94 grams every 48 hours.

The duration of therapy: cIAI is five to 14 days; cUTI is seven to 14 days.

For Medicaid and NCHC Billing

- Do not restrict based on ICD-9 code. Many approved indications are based on bacterial susceptibility. Providers should select the most appropriate ICD-9 diagnosis codes with the highest level of specificity to describe a beneficiary's condition. All codes must be supported with adequate documentation in the medical record.
- Providers must bill Avycaz™ with HCPCS code J3490, unclassified drugs.
- One Medicaid and NCHC unit of coverage for Avycaz™ is 1 g. The maximum reimbursement rate per 1 g is \$123.1200. One injection with a total daily dose of ceftazidime 2 g; avibactam 0.5 g contains 2.5 g.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Avycaz™ 2 g; 0.5 g injections is 00456-2700-10.
- The NDC units for ceftazidime; avibactam injection (Avycaz™) should be reported as "UN1".
- For additional information, refer to the [January 2012, Special Bulletin, National Drug Code Implementation Update](#).

- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs' \(OPA\)](#). 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](#).

CSC, 1-800-688-6696

Attention: Nurse Practitioners Physician Assistants and Physicians

Isavuconazonium sulfate injection (Cresemba[®]) HCPCS code J3490: Billing Guidelines

Effective with date of service May 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) Program covers isavuconazonium sulfate injection (Cresemba[®]), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490, unclassified drugs. Cresemba[®] is currently commercially available in 372 mg injections. Isavuconazonium sulfate injection (Cresemba[®]) is indicated for invasive aspergillosis and invasive mucormycosis.

The recommended dosage for isavuconazonium sulfate injection (Cresemba[®]) is a loading dose of 372 mg isavuconazonium sulfate (equivalent to 200 mg of isavuconazole) every eight hours for six doses (48 hours) via intravenous administration (one reconstituted vial).

A maintenance dose of 372 mg isavuconazonium sulfate (equivalent to 200 mg of isavuconazole) should be administered once daily intravenous (one reconstituted vial) starting 12 to 24 hours after the last loading dose.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing isavuconazonium sulfate injection (Cresemba[®]) is 117.3 Aspergillosis; 117.7 Zygomycosis (Phycomycosis or Mucormycosis).
- Providers must bill Cresemba[®] with HCPCS code J3490, unclassified drugs.
- One Medicaid and NCHC unit of coverage for Cresemba[®] is 1 mg. The maximum reimbursement rate per 1 mg is \$0.6925. One packaged product with a total daily dose of 372 mg contains 372 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Cresemba[®] 372 mg injections is 00469-0420-99.
- The NDC units for Isavuconazonium sulfate injection (Cresemba[®]) should be reported as "UN1".
- For additional information, refer to the [January 2012, Special Bulletin, National Drug Code Implementation Update](#).
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs' \(OPA\)](#). 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](#).

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**L**evonorgestrel intrauterine device (Liletta™) HCPCS code J7302:
Billing Guidelines

Effective with date of service May 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers levonorgestrel intrauterine device (Liletta™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7302 levonorgestrel-releasing intrauterine contraceptive system, 52 mg. Liletta™ is currently commercially available as a 52 mg intrauterine device.

Levonorgestrel intrauterine device (Liletta™) is indicated for the prevention of pregnancy for up to three years.

The recommended dosage for levonorgestrel intrauterine device (Liletta™) is to administer one device; the release rate of levonorgestrel is 18.6 mcg/day initially and declines progressively to approximately 16.3 mcg/day at one year, 14.3 mcg/day at two years, and 12.6 mcg/day at three years after insertion. Liletta™ can be removed at any time but must be removed by the end of the third year.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing levonorgestrel intrauterine device (Liletta™) are V25.02 Initiation of other contraceptive measures, V25.1 through V25.13 Insertion of intrauterine device, and V25.42 Surveillance of previously prescribed contraceptive methods (Intrauterine contraceptive device).
- Providers must bill Liletta™ with HCPCS code J7302 levonorgestrel-releasing intrauterine contraceptive system, 52 mg.
- Providers must indicate the number of HCPCS code units.
- One Medicaid and NCHC unit of coverage for Liletta™ is one device. The maximum reimbursement rate per one device is \$662.5000. One device contains 52 mg.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Liletta™ 52 mg devices is 52544-0035-54.
- The NDC units for levonorgestrel intrauterine device (Liletta™) should be reported as "UN1".
- For additional information, refer to the [January 2012, Special Bulletin, National Drug Code Implementation Update](#).

- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs' \(OPA\)](#). 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](#).

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Parathyroid hormone injection (Natpara[®]) HCPCS code J3590: Billing Guidelines

Effective with date of service May 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers parathyroid hormone injection (Natpara[®]), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590, unclassified biologics. Natpara[®] is currently commercially available in 25 mcg, 50 mcg, 75 mcg, and 100 mcg injections.

Parathyroid hormone injection (Natpara[®]) is adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism.

The recommended dosage for parathyroid hormone injection (Natpara[®]) is to administer individualized injections to achieve a serum calcium level in the lower half of the normal range. The starting dose of Natpara[®] is 50 mcg injected once daily in the thigh. The dose of Natpara[®] may be increased in increments of 25 mcg every four weeks up to a maximum daily dose of 100 mcg if serum calcium cannot be maintained above 8 mg/dL without an active form of vitamin D and/or oral calcium supplementation. The dose of Natpara[®] may be decreased to as low as 25 mcg per day if total serum calcium is repeatedly above 9 mg/dL after the active form of vitamin D has been discontinued and calcium supplement has been decreased to a dose sufficient to meet daily requirements.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing parathyroid hormone injection (Natpara[®]) is 252.1 Hypoparathyroidism.
- Providers must bill Natpara[®] with HCPCS code J3590, unclassified biologics.
- Providers must indicate the number of HCPCS code units.
- One Medicaid and NCHC unit of coverage for Natpara[®] is 1 mcg. The maximum reimbursement rate per 1 mcg is \$171.0000, \$85.5000, \$57.0000, or \$42.7500, respectively. One injection contains 25 billable units, 50 billable units, 75 billable units, or 100 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Natpara[®] 25 mcg, 50 mcg, 75 mcg, and 100 mcg injections are 68875-0202-02, 68875-0203-02, 68875-0204-02, and 68875-0205-02, respectively.
- The NDC units for parathyroid hormone injection (Natpara[®]) should be reported as "UN1".
- For additional information, refer to the [January 2012, Special Bulletin, National Drug Code Implementation Update](#).

- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs' \(OPA\)](#). 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](#).

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Nivolumab (Opdivo®) HCPCS code J9999: Updated Billing Guidelines

Effective with date of service March 5, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover the expanded U.S. Food and Drug Administration (FDA) indication of “metastatic squamous non-small cell lung cancer with progression on or after platinum-based chemotherapy” for Nivolumab (Opdivo®). ICD-9 diagnoses that can be billed for this indication include: 162.0, 162.2, 162.3, 162.4, 162.5, 162.8 or 162.9 for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs).

CSC, 1-800-688-6696

Attention: Nursing Facility Providers

Implementation of State Plan Amendment NC 14-040

According to N.C. Session Law 2013-360, subsequently modified by N.C. Session Law 2014-100, the following changes are required to the N.C. Medicaid Skilled Nursing Facility (SNF) rates:

1) Case Mix Index (CMI) Freeze – Effective January 1, 2015

The CMI used to adjust the direct care services component of the SNF per diem rate is hereby frozen at the rate in effect as of December 31, 2014. After recalculation and implementation of the SNF rates as affected by the CMI Freeze, SNF claims with Dates of Services (DOS) from January 1, 2015 through May 31, 2015 will be reprocessed.

The CMI Freeze will remain in effect until further direction from the North Carolina General Assembly.

2) Repeal of the Skilled Nursing Facility 3 percent rate reduction - Effective June 1, 2015

The 3 percent SNF rate payment reduction previously placed in effect on January 1, 2014 shall be removed from the direct and indirect cost components calculation.

Revised rate letters were placed in the mail to providers by June 1, 2015.

For more information, contact Reggie Little at 919-814-0021 (Reggie.Little@dhhs.nc.gov) or Michelle Counts at 919-814-0059 (Michelle.Counts@dhhs.nc.gov).

**Provider Reimbursement
DMA, 919-814-0060**

Attention: Personal Care Services (PCS) Providers

State Plan Personal Care Services Program Updates

Personal Care Services (PCS) Clinical Coverage Policy 3L

Clinical Coverage Policy 3L, *Personal Care Services (PCS)*, has been amended to include new PCS program requirements. These new requirements are effective **June 1, 2015**. The amended policy is available on the N.C. Division of Medical Assistance [Clinical Coverage Policy web page](#).

Those with questions regarding the PCS policy may contact the DMA Clinical Policy PCS Section at 919-855-4360 or send an email to PCS_program_questions@dhhs.nc.gov

On-Line PCS Service Plan Implementation

PCS providers will be required to submit individual PCS Services Plans for all beneficiaries accepted after **June 10, 2015**. QiRePort, the PCS Provider Interface, provides electronic access to the Independent Assessments used to development of the required online beneficiary Service Plans. Therefore, providers are required to become registered users of QiRePort. **PCS prior approval will not be generated until the Service Plan has been completed via QiRePort.**

Webinars on the On-line Service Plan functionality are currently being held and will continue through June 9.

In-Home Provider Webinar Dates / Times	
<u>May 27: 9:30 a.m. - noon</u>	<u>June 1: 1:30 p.m. - 4:00 p.m.</u>
<u>June 4: 9:30 a.m. - noon</u>	<u>June 8: 1:30 p.m. - 4:00 p.m.</u>

Residential Care Provider Webinar Dates / Times	
<u>May 27: 1:30 p.m. - 4:00 p.m.</u>	<u>May 28: 9:30am - noon</u>
<u>June 1: 9:30 a.m. - noon</u>	<u>June 3: 9:30am - noon</u>
<u>June 4: 1:30 p.m. - 4:00 p.m.</u>	<u>June 8: 9:30am - noon</u>
<u>June 9: 9:30 a.m. - noon</u>	

To register for a specific webinar, click above on the date/time link for the preferred webinar. Register for only **one** Webinar. Providers must pre-register to attend a webinar. Once registered, they will receive

email invitations providing details about joining and participating in the webinar. There are registration limits for each webinar, so early registration is encouraged.

Extra webinar sessions for residential care providers (adult care homes, family care homes, special care units, supervisory living facilities, etc.) have been scheduled to accommodate the larger number of residential care providers using PCS.

Questions and concerns regarding the implementation of the Service Plan may 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

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](#). 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
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
July	7/02/15	7/07/15	7/08/15
	7/09/15	7/14/15	7/15/15
	7/16/15	7/21/15	7/22/15
	7/23/15	7/28/15	7/29/15
	7/30/15	8/04/15	8/05/15

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