



## July 2014 Medicaid Bulletin

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**Attention: All Providers****Nc Medicaid and N.C. Health Choice Preferred Drug List Changes**

Effective with a date of service of May 17, 2014, DMA made changes to the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL). These changes include:

- The prior authorization criteria were removed from the second generation anti-convulsant class.
- The use of only Spiriva<sup>®</sup> in the Chronic Obstructive Pulmonary Disease (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:
  - CARDIOVASCULAR: Sympatholytics and Combinations
  - ENDOCRINOLOGY: Sodium Glucose Co-Transporter 2 (SGLT2)
  - OPHTHALMIC: Antibiotics-Steroid Combinations
  - OTIC: Anti-Infectives and Anesthetics
  - TOPICALS: Antibiotics-Vaginal
  - MISCELLANEOUS: Estrogen Agent Combinations and Estrogen Agent Oral/Transdermal

In addition to these changes, the preferred brands with non-preferred generic equivalents were updated, as indicated on the following chart:

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

<b>Brand Name</b>	<b>Generic Name</b>
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 Services**  
**919-855-4300**

**Attention: All Providers****NCTracks Updates****Infant Toddler Program Claims with TPL**

When an Infant Toddler Program (ITP) service is denied by a third-party payer as non-covered, providers are encouraged to submit the claim electronically to N.C. Medicaid for processing. The electronic claim should be submitted through the NCTracks Provider Portal with a copy of the Third-Party Explanation of Benefit (EOB) uploaded as an attachment. The Third Party EOB must include an explanation of the claim denial codes. ITP claims previously paid incorrectly would need to be refiled as adjustments.

Electronic adjustments are the preferred method to report overpayments or underpayments to the ITP. There are two separate actions that must be filed:

- Providers must use “void” when they need to cancel or submit refunds for previously paid claims. The entire claim will be recouped under the void process.
- Providers must “replace” a claim if they are updating claim information or changing incorrectly billed information. This term “replacing claims” is interchangeable with “adjusting claims.” The entire claim will be recouped and reprocessed under the replacement process.

Adjustments can be filed on paper, following the instructions outlined in the Claim Submission section on the [Provider User Guides and Training page](#) of the NCTracks Provider Portal. However, filing adjustments electronically will facilitate more accurate submissions and expedite their processing.

**Check Medicaid Eligibility Later in the Day**

Beneficiary eligibility information often isn’t completed until the end of the first day of the month, and sometimes not until the middle of the second day. If eligibility is being renewed or extended at the end of the month, the new eligibility may not yet be in NCTracks.

Many providers check eligibility at the first of the month for the beneficiaries they expect to see that month. The N.C. Division of Health and Human Services (DHHS) recommends checking eligibility on the first couple of days of the month, only for beneficiaries who need services specifically on those days.

For an emergency, contact the Eligibility Information System (EIS) staff at DHHS at 1-919-855-4000.

## **New User Guide for Claim Adjustments, Time Limit and Medicare Overrides**

A new User Guide, titled “How to Submit Claim Adjustments and Time Limit and Medicare Overrides” has been added to the NCTracks Provider Portal.

The guide can be found under the heading of “Claim Submission” on the [Provider User Guides and Training Web page](#). Providers are encouraged to consult this guide before submitting claim adjustments, time limit and Medicare overrides to help expedite approval and processing of these requests.

## **Rate Change for PCS**

A rate change for Personal Care Services (PCS) was implemented in NCTracks on May 23, 2014. The updated fees can be found on the N.C. Division of Medical Assistance (DMA) Fee Schedules Web page at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

Two PCS Webinars, which outline the rate change, were conducted by DMA on May 23. A copy of the presentation can be found at

[www.ncdhhs.gov/dma/pcs/PCS\\_SPA13009\\_Provider\\_Webinar\\_Presentation.pdf](http://www.ncdhhs.gov/dma/pcs/PCS_SPA13009_Provider_Webinar_Presentation.pdf).

In addition, Liberty Healthcare – NC is conducting regional seminars for PCS providers. For more information, read the training announcement on the Liberty Healthcare - NC Website at [www.nc-pcs.com/training-announcement/](http://www.nc-pcs.com/training-announcement/).

For additional information about the PCS program, visit DMA’s PCS Web pages at [www.ncdhhs.gov/dma/pcs/pas.html](http://www.ncdhhs.gov/dma/pcs/pas.html).

## **Claims Pended for Incorrect Location**

When a claim is received with an incorrect billing, rendering, or attending provider location, the claim is pended in NCTracks. This occurs when the provider location submitted on the claim does not match the location(s) in the NCTracks provider record.

As of May 24, 2014, when a claim is pended for incorrect location, a secure message will be sent to the provider’s NCTracks Message Center Inbox in the provider portal, with a link to a screen that enables them to select the correct location from a drop-down list. The claim is then released to continue processing. This approach allows a provider to correct the claim, rather than having it deny for an incorrect provider location.

There will be one message for every incorrect location (billing, rendering, or attending) on a pended claim. If a single claim has more than one incorrect location, there will be multiple inbox messages.

For more information about claims pended for incorrect location, see the announcement posted on the NCTracks Provider Portal titled “[Claims Pended for Incorrect Location](#).”

## **Notice of Change in the Orthodontic Prior Approval Process**

To correct problems with NCTracks regarding payment of the panoramic films rendered as part of the orthodontic records claim, CSC will grant prior approval (PA) of orthodontic records. PA for the orthodontic records will be granted regardless of the outcome of the review (approval or denial), as long as the recipient has not exceeded the once per lifetime policy limit for orthodontic records.

Effective immediately, orthodontic records rendered on or after May 1, 2014 should be included on the request for orthodontic PA.

Providers **should** include orthodontic record procedure codes: D0330, D0340, D0470, and D8080.

Providers should **not** include codes D0150 or D8670.

CSC PA Staff will add Procedure code D8670 for cases that are approved for orthodontic services.

**Contact CSC at 1-800-688-6696**

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## **Attention: All Providers**

### **NCTracks Tip of the Month: Searching for Answers**

#### **Save Time by Taking Advantage of the Search Feature**

Both the NCTracks and N.C. Division of Medical Assistance (DMA) Websites have the capability to Search for keywords in announcements, Frequently Asked Questions (FAQs), articles, and Web pages. The Search box is found in the upper right corner of every page on both Websites.

“Searching” is a good place for providers to start if they are unsure if – or where – a topic might be covered on either of the Websites.

The information on the NCTracks Website deals with provider enrollment, claims processing and related activities, while the N.C. DMA Website provides N.C. Medicaid and N.C. Health Choice (NCHC) general policy, clinical policy and program information.

A quick Search can improve the accuracy and processing time of claims and enrollment submissions, and save providers a phone call to the NCTracks Call Center.

**Contact CSC at 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 policy is available on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/mp/](http://www.ncdhhs.gov/dma/mp/):

- *10A, Outpatient Specialized Therapies (7/1/14)*

These policies supersede previously published policies and procedures.

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

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**Attention: Nurse Practitioners, Physicians and Physician Assistants****Loxapine powder for inhalation (Adasuve™), HCPCS code C9497: Billing Guidelines**

Effective with date of service **February 1, 2014**, the N.C. Medicaid Program covers loxapine powder for inhalation (Adasuve™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 (Not otherwise classified, antineoplastic drugs). Adasuve™ is currently commercially available in 1000 mg/40 mL single use vials.

***For Medicaid Billing***

- The ICD-9-CM diagnosis codes required for billing the loxapine powder for inhalation (Adasuve™) are:
  - 295.00 - 295.95 - Schizophrenic disorders
  - 296.0 - Bipolar I disorder, single manic episode
  - 296.1 - Manic disorder, recurrent episode
  - 296.4 - Bipolar I disorder, most recent episode (or current) manic
  - 296.6 - 296.8 - Bipolar I disorder mixed and unspecified
- Providers must bill the Adasuve™ with HCPCS code J3490 (Loxapine, inhalation powder, 10 mg).
- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Adasuve™ is 10 mg (one inhaler). The maximum reimbursement per unit is \$156.60. One 10 mg dose contains 1 billable unit.
- Adasuve™ must be administered only by a health care provider. There is a safety monitoring program (REMS) associated with the use of this medication.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Adasuve™ 10 mg/dose are 57844-0510-11 and 57844-0510-55.
- The NDC units for loxapine powder for inhalation (Adasuve™) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.
- Providers must bill their usual and customary charge.
- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**



## Attention: Nurse Practitioners, Physicians and Physician Assistants

### **T**BO-filgrastim injection (Granix™), HCPCS code J1446: Billing Guidelines

Effective with date of service **February 1, 2014**, the N.C. Medicaid Program covers TBO-filgrastim injection (Granix™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J1446 (Not otherwise classified, antineoplastic drugs). Granix™ is currently commercially available in 300 mcg/0.5 mL and 480 mcg/0.8 mL vials.

#### *For Medicaid Billing*

- The ICD-9-CM diagnosis codes required for billing the TBO-filgrastim injection (Granix™) are:
  - 288.0 Neutropenia
  - 288.9 Unspecified disease of white blood cells
- Providers must bill Granix™ with HCPCS code J1446 (TBO-filgrastim, 5 mcg, injection).
- One Medicaid unit of coverage for Granix™ is 5 mcg. The maximum reimbursement rate per unit is \$4.31. One 300 mcg/ 0.5mL vial contains 60 billable units. One 480 mcg/ 0.8 mL vial contains 96 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Granix™ 300 mcg/0.5 mL are 63459-0910-11 and 63459-0910-15. The NDCs for Granix™ 480 mcg/ 0.8 mL are 63459-0912-11 and 63459-0912-15.
- The NDC units for TBO-filgrastim injection (Granix™) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.
- Providers must bill their usual and customary charge.

- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**

## Attention: Nurse Practitioners, Physicians and Physician Assistants

### **F**erric carboxymaltose injection (Injectafer<sup>®</sup>), HCPCS code J3490: Billing Guidelines

Effective with date of service **March 1, 2014**, the N.C. Medicaid Program covers ferric carboxymaltose injection (Injectafer<sup>®</sup>) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 (Unclassified drugs). Injectafer<sup>®</sup> is currently commercially available in 750 mg/15 mL single use vials.

#### *For Medicaid Billing*

- The ICD-9-CM diagnosis codes required for billing the ferric carboxymaltose injection (Injectafer<sup>®</sup>) are:
  - 280.0 Iron deficiency anemia secondary to blood loss (chronic)
  - 280.1 Iron deficiency anemia secondary to inadequate dietary iron intake
  - 280.8 Other specified iron deficiency anemias
  - 280.9 Unspecified iron deficiency anemia
- Providers must bill Injectafer<sup>®</sup> with HCPCS code J3490 (Unclassified drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Injectafer<sup>®</sup> is 1 mg. The maximum reimbursement rate per unit is \$1.16. One 750 mg/15 mL vial contains 750 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Injectafer<sup>®</sup> 750 mg/15 mL is 00517-0650-01.
- The NDC units for ferric carboxymaltose injection (Injectafer<sup>®</sup>) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.
- Providers must bill their usual and customary charge.

- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**

## Attention: Nurse Practitioners, Physicians and Physician Assistants

### **P**osaconazole injection (Noxafil<sup>®</sup>), HCPCS code J3490: Billing Guidelines

Effective with date of service **April 1, 2014**, the N.C. Medicaid Program covers posaconazole injection (Noxafil<sup>®</sup>) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 (unclassified drugs). Noxafil<sup>®</sup> is currently commercially available in 300 mg per 16.7 mL (18 mg per mL) solution for injection.

#### ***For Medicaid Billing***

- The ICD-9-CM diagnosis codes required for billing posaconazole (Noxafil<sup>®</sup>) are:
  - 288.03 Drug induced neutropenia with either:
    - 205 Acute myelogenous leukemia, or,
    - 38.7 Other lymphatic and hematopoietic tissues
  - 279 Disorders involving immune mechanisms
- Providers must bill Noxafil<sup>®</sup> with HCPCS code J3490 (Unclassified drugs)
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Noxafil<sup>®</sup> is 1 mg. The maximum reimbursement rate per unit is \$1.91. One 18 mg per mL injection contains 300 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Noxafil<sup>®</sup> 18 mg per mL injection is 00085-4331-01.
- The NDC units for posaconazole (Noxafil<sup>®</sup>) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.

- Providers must bill their usual and customary charge.
- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**

**Attention: Nurse Practitioners, Physicians and Physician Assistants****Coagulation factor XIII a-subunit (recombinant) (Tretten<sup>®</sup>),  
HCPCS code J7199: Billing Guidelines**

Effective with date of service **April 1, 2014**, the N.C. Medicaid Program covers coagulation factor XIII a-subunit (recombinant) (Tretten<sup>®</sup>) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified). Tretten<sup>®</sup> is currently commercially available in 2,500 IU vials.

***For Medicaid Billing***

- The ICD-9-CM diagnosis code required for billing coagulation factor XIII a-subunit (recombinant) (Tretten<sup>®</sup>) is 286.3 (congenital deficiency of other clotting factors).
- Providers must bill Tretten<sup>®</sup> with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Tretten<sup>®</sup> is 1 IU. The maximum reimbursement rate per unit is \$14.36. One 2,500 IU vial contains 2,500 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Tretten<sup>®</sup> 2,500 IU vials are 00169-7013-01 and 00169-7113-11.
- The NDC units for coagulation factor XIII a-subunit (recombinant) (Tretten<sup>®</sup>) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.

- Providers must bill their usual and customary charge.
- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**



## Attention: Nurse Practitioners, Physicians and Physician Assistants

### **E**losulfase alfa injection (Vimizim™), HCPCS code J3590: Billing Guidelines

Effective with date of service **March 1, 2014**, the N.C. Medicaid Program covers elosulfase alfa injection (Vimizim™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 (unclassified biologic drugs). Vimizim™ is currently commercially available in 5 mg/5 mL vials.

#### *For Medicaid Billing*

- The ICD-9-CM diagnosis codes required for billing the elosulfase alfa injection (Vimizim™) is 277.5 Mucopolysaccharidosis.
- Providers must bill the Vimizim™ with HCPCS code J3590 (Unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Vimizim™ is 1 mg. The maximum reimbursement per unit is \$230.69. One 1 mg dose contains 1 billable unit.
- Vimizim™ must be administered only by a health care provider. There is a safety monitoring program (REMS) associated with the use of this medication.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Vimizim™ 1 mg/dose is 68135-0100-01.
- The NDC units for elosulfase alfa injection (Vimizim™) 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.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf](http://www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf), for additional instructions.

- Providers must bill their usual and customary charge.
- The new fee schedule for the PDP is available on the DMA Website at [www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/).

**Contact CSC at 1-800-688-6696**

## Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at [www.ncdhhs.gov/dma/mpproposed/](http://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
<b>July</b>	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
<b>Aug</b>	8/07/2014	8/12/2014	8/13/2014
	8/14/2014	8/19/2014	8/20/2014
	8/21/2014	8/26/2014	8/27/2014
	8/28/2014	9/03/2014	9/04/2014

*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.*

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**Sandra Terrell, MS, RN**  
**Acting Chief Operating Officer**  
**Division of Medical Assistance**  
**Department of Health and Human Services**

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