



August 2015 Medicaid Bulletin

In this Issue.....Page

All Providers:

NCTracks Updates.....2
 NCTracks ICD-10 Tip of the Month..... 5
 Occupational Therapy, Physical
 Therapy and Speech/Language
 Therapy Providers.....6
 Change in the Notification Process
 for N.C. Medicaid Recovery Audit
 Contractor (RAC) Audits8
 Physician Drugs: 1 Percent Rate
 Reduction.....9
 Review of Possible Institution for
 Mental Diseases (IMD) 10
 Increased Enrollment of Medicaid and
 NCHC Beneficiaries with
 Community Care of NC (CCNC)
 Providers..... 11

Adult Care Homes:

Revised Notice of Transfer/Discharge
 and Hearing Request Forms..... 13

CCNC/CA Providers:

CCNC/CA Providers Who are
 Changing a National Provider
 Identifier (NPI) 12

Dental Providers:

Submitting Prior Approval Requests for
 Comprehensive Orthodontic
 Treatment Requiring Orthognathic
 Surgery..... 14

In this Issue.....Page

**Nurse Practitioner, Physicians
 Assistants and Physicians:**

Meningococcal Group B Vaccine
 Injection (Bexsero®) CPT code
 90620: Billing Guidelines..... 16
 Human Papillomavirus 9-Valent
 Vaccine, Recombinant Injection
 (Gardasil® 9) CPT Code 90651:
 Billing Guidelines..... 18
 Meningococcal Group B Vaccine
 (Trumenba®), CPT 90621:
 Billing Guidelines..... 20
 Fluocinolone Acetonide Intravitreal
 Implant (Iluvien®) HCPCS Code
 J3490: Billing Guidelines..... 22
 Coagulation Factor IX (Recombinant)
 Vials (Ixinity®) HCPCS Code
 J7199: Billing Guidelines..... 23
 Anticoagulation Factor (Recombinant)
 Vials (Novoeight®) HCPCS code
 J7182: Billing Guidelines..... 24
 Fluocinolone Acetonide Intravitreal
 Implant (Retisert®) HCPCS code
 J7311: Billing Guidelines..... 26

Nursing Facilities:

Revised Notice of Transfer/Discharge
 and Hearing Request Forms..... 13

Prescribers:

“Meets PA Criteria” Proper Use to
 Override a Required Prior
 Authorization (PA) 27

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

Attention: All Providers**NCTracks Updates****Manage Change Requests**

On August 2, 2015, changes will simplify the NCTracks Manage Change Request (MCR) process.

NCTracks providers use MCRs to update their provider records, including license renewal information, bank account changes for Electronic Funds Transfers (EFT), new taxonomy codes, and new provider locations. Currently, only the provider's Office Administrator (or the owner or managing employee) can create and submit MCRs. This may delay the creation of MCRs, especially for large provider organizations where the Office Administrators may be responsible for multiple NPIs.

In addition, submitting an MCR traditionally required stepping through each of the online screens before the request can be submitted. This approach is essential for some types of provider record changes, such as the addition of a new taxonomy code, but other changes are more straightforward, such as changing EFT information for the deposit of funds from NCTracks.

The changes coming to the MCR process on August 2, 2015 will address many of these challenges. Specifically:

Office Administrators Will Be Able To Designate Enrollment Specialists

- Enrollment Specialists may initiate and complete MCRs, new enrollment, re-enrollment, or re-verification applications.
- Completed MCRs and enrollment applications will route to the Office Administrator for approval before submission.
- Office administrators may designate any NCTracks user with access to the NPI as an "Enrollment Specialist." There is no maximum number of enrollment specialists.

This approach will free up time for Office Administrators, while allowing them to maintain control over changes to provider records in NCTracks.

Some Provider Record Changes Will Not Require a Full MCR Process

Changes in the following categories will involve navigating fewer online screens:

- EFT
- Provider/group affiliation
- Method of claim submission and electronic transactions
- Billing agents

This abbreviated MCR process does not require credentialing; most changes take effect immediately upon submission. Enrollment Specialists may submit abbreviated MCR changes with some

restrictions. For example, only Office Administrators may submit EFT change requests and a pre-note period is still required.

The abbreviated MCR options will be on the Status and Management page of the secure NCTracks Provider Portal.

Change to Document Submission Capabilities

Also in August 2015, providers may **upload documents supporting some applications after the applications have been submitted in NCTracks**. Applications affected include:

- Re-enrollment
- MCR
- Re-verification
- Maintain Eligibility

Currently, additional documentation needed to support a provider enrollment-related application must be printed and mailed to CSC. The new online capability will expedite the review and approval of enrollment-related applications.

More information, including training opportunities, will be posted soon to the [NCTracks Provider Portal](#).

Important Information about Sterilization Claims

Electronic Sterilization Claims for Undocumented Aliens

Inpatient delivery claims for “Undocumented Aliens” who had a non-covered sterilization provided during the stay may be submitted electronically using the NCTracks provider portal with the non-covered charges listed in the non-covered column.

Electronic sterilization claims submissions in NCTracks must be accompanied by a printed version of the UB claim with the sterilization charges moved to the non-covered column **and** a statement in the remarks field indicating charges for sterilization were entered in the non-covered column. This is based on Clinical Coverage Policy 1E-3, *Sterilization Procedures*, which can be found on the N.C. Division of Medical Assistance (DMA) [Clinical Coverage Policy web page](#).

Electronic Sterilization Claims for Non-Covered Sterilization Claims

Inpatient delivery claims that include non-covered sterilization services not related to “Undocumented Aliens” must be submitted electronically. Otherwise the claim will be denied with EOB 00041 (Federal Sterilization Consent Form Required).

After receiving a denial, providers must submit a paper adjustment request form with supporting documentation. The adjustment request must include a UB claim form with the sterilization charges in the non-covered column **and** a statement in the remarks field indicating non-covered charges are for

sterilization. Adjustment instructions and documentation requirements can be found on the NCTracks provider portal.

This is based on Clinical Coverage Policy 1E-3, *Sterilization Procedures*, which can be found on the DMA [Clinical Coverage Policy web page](#).

Note: Failure to complete both the non-covered column and the remarks field will result in denial.

No Fax or Email for Sterilization, Hysterectomy or Adjustment Forms

As a reminder, Sterilization Consent Forms and Hysterectomy Statements must should **not** be faxed or emailed. Mail the forms to:

CSC
P.O. Box 30968
Raleigh, NC 27622

Medicaid Resolution Inquiry Forms and Medicaid Adjustment Request Forms must **not** be faxed or emailed. Mail the forms to:

CSC
P.O. Box 300009
Raleigh, NC 27622

CSC, 1-800-688-6696

Attention: All Providers**NCTracks ICD-10 Tip of the Month****Most Common ICD-10 Error: ICD Qualifier on 837 Transactions**

Provider and Trading Partner testing for ICD-10 continues to reveal common errors that may result in payment delays this fall. **Beginning October 1, 2015**, every 837 transaction submitted to NCTracks must include one or more ICD qualifiers that indicate whether the claim is using ICD-9 or ICD-10 codes.

A single claim may include either ICD-9 codes **OR** ICD-10 codes, depending on the dates of service, **but not both**. An 837 transaction **may include both** ICD-9 and ICD-10 claims.

Errors observed in testing include:

- Claims did not contain any ICD qualifier
- Claims contained an ICD-9 qualifier with a date of service after October 1, or an ICD-10 code for a date of service before October 1

Claims with a missing or incorrect ICD qualifier will be denied with EOB 02671 - ICD VERSION INVALID FOR DATE OF SERVICE.

An X12 List of ICD Qualifiers has been posted to the Quick Links section of the [Trading Partner Information page](#) on the NCTracks Provider Portal. This list includes information to correctly populate the ICD Version on each type of claim in an X12 837 transaction as referenced in the Technical Report Type 3 (TR3).

Anyone who submits X12 837 transactions to NCTracks is encouraged to review the X12 List in preparation for the upcoming implementation of ICD-10.

CSC, 1-800-688-6696

Attention: All Providers

Occupational Therapy, Physical Therapy and Speech/Language Therapy Providers

N.C. Division of Medical Assistance (DMA) Outpatient Specialized Therapies provides **guidelines** for the frequency of services to beneficiaries under 21 years of age, and identifies factors that warrant a tapering or discontinuation of services.

The expected range for the frequency of services shown below considers factors such as **age, diagnosis, prognosis, motivation, and potential for medical regression**. “Frequency of Service” is the combined frequency of services for each therapy discipline from all provider types in all clinical settings (outpatient clinic, office, home, school, and daycare).

Factors to Consider	Frequency of Service (maximum frequency for all provider types in all clinical settings combined)			
	<i>Two visits/week</i>	<i>One visit/week</i>	<i>One to Two visits/month</i>	<i>Episodic/As Needed</i>
Potential to participate and benefit from the therapy process	Beneficiary has potential for rapid progress, or potential for rapid decline or loss of functional skills, due to medical condition	Beneficiary demonstrates continuous meaningful progress toward established functional goals	Beneficiary demonstrates slow rate of attainment of goals and/or does not regress	Therapist uses clinical decision making and problem-solving skills to recommend solutions to specific newly identified issues
Critical period* for skill acquisition or for potential regression related to medical condition	Extremely critical period	Critical period	Not a critical period, or episodically critical period, related to change in life stage or medical condition	Specific challenges identified by beneficiary or parent that requires specific adaptations

Factors to Consider	Frequency of Service (maximum frequency for all provider types in all clinical settings combined)			
	<i>Two visits/week</i>	<i>One visit/week</i>	<i>One to Two visits/month</i>	<i>Episodic/As Needed</i>
Amount of clinical decision making and problem solving needed from licensed therapist	Requires the clinical skills and problem solving of a licensed therapist; only a limited part of the therapy program can be safely performed by beneficiary or parent	Requires the clinical skills and problem solving of a licensed therapist for a significant part of the therapy program; some activities can be safely performed by the beneficiary or parent	Requires the clinical skills and problem solving of a licensed therapist to periodically reassess condition and update home program; beneficiary or parent can safely perform home program	Home program can be carried out safely by beneficiary and/or caregiver. Clinical skills and problem solving of a licensed therapist needed for specific challenges identified by the family or beneficiary.

* A **critical period** is an important life-stage for beneficiaries to:

- Acquire a particular developmental skill that is indispensable in their life span and which can influence future development; or,
- Lose skills, or develop an additional disability, from medical regression or intervention.

The following factors would indicate a tapering or discontinuation of services:

- Behaviors are present that interfere with progress or participation in therapy, or there is a change in the beneficiary’s medical condition limiting the benefits of therapy at the time.
- Poor attendance, the beneficiary refuses to cooperate, or the beneficiary's motivation is so low as to preclude therapeutic intervention.
- Maximum benefit from services has been reached or functional skills have been achieved.
- There is a plateau in the progress achieved with intervention services (beneficiary has not demonstrated any significant measurable progress over a 90-day time frame), and parent education has been provided to optimize and preserve the skills obtained.

Outpatient Specialized Therapies
DMA, 919-855-4260

Attention All Providers

Change in the Notification Process for N.C. Medicaid Recovery Audit Contractor (RAC) Audits

42 CFR §455 Subpart F, which provides guidance for Medicaid Recovery Audit Contractor (RAC) audits, requires that states and RAC contractors work together to develop education and outreach programs that include notification to providers of audit policies and protocols.

In October 2012, the N.C. Division of Medical Assistance (DMA) published Medicaid Bulletin article [N.C. Medicaid Recovery Audit Contractors \(RAC\)](#), which identified HMS as the second RAC vendor for the State of North Carolina. The article also identified the type of reviews that would be conducted by HMS.

Effective August 1, 2015, information detailing targeted RAC audits performed by HMS will be published on the [HMS North Carolina Medicaid RAC website](#) and **not** in the monthly Medicaid Bulletin. Updates are expected to post on the [RAC website](#) every Friday. Providers should check the site regularly for the most up-to-date information.

Program Integrity
DMA, 919-814-0000

Attention: All Providers

Physician Drugs: 1 Percent Rate Reduction

As required by the [N.C. Session Law 2014-100](#), the N.C. Department of Health and Human Services (DHHS) submitted [N.C. State Plan Amendment \(SPA\) 14-021](#) to the Centers for Medicare & Medicaid Services (CMS) requesting approval to implement a 1 percent rate reduction for Physician Drugs **effective January 1, 2015**.

CMS approved SPA 14-021 on December 12, 2014.

Beginning in August 2015, NCTracks will reimburse all claims for Physician Drug Services rendered to Medicaid and N.C. Health Choice (NCHC) beneficiaries at the new reimbursement rate, which is equal to 1 percent less than the previous reimbursement rate.

Current fee schedules will be adjusted to reflect the 1 percent fee reduction and will be posted to the N.C. Division of Medical Assistance (DMA) website.

Claims with dates of service January 1, 2015 through the rate implementation date will be reprocessed at a later time. DMA will provide updates in future Medicaid bulletins.

Provider Reimbursement

DMA, 919-814-0060

Attention: All Providers

Review of Possible Institution for Mental Diseases (IMD)

The Centers for Medicare & Medicaid Services (CMS) requires the N.C. Division of Medical Assistance (DMA) to undertake ongoing reviews of facilities to determine whether they meet the federal definition of an Institution of Mental Diseases (IMD). Medicaid funding is **not** available to, or for the benefit of, Medicaid beneficiaries living in facilities that have been determined to be IMDs.

42 CFR § 435.1010. **Definition relating to institutional status:**

“A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases”.

Facility owners who have facilities included in this review will receive written notification of the upcoming process.

**Director’s Office
DMA, 919-855-4317**

Attention: All Providers

Increased Enrollment of Medicaid and NCHC Beneficiaries with Community Care of NC (CCNC) Providers

The N.C. Division of Medical Assistance (DMA) will be auto-assigning an eligible population of Medicaid and NC Health Choice (NCHC) beneficiaries with a Community Care of N.C. (CCNC) primary care provider (PCP), also referred to as a health home. It is anticipated that this initiative will begin in late summer or early fall of 2015.

CCNC is an enhanced primary care case management program which provides patient-centered, community-based, and evidence-based health care. Its goals are to improve quality and access to care, support appropriate utilization of services, and promote cost-effectiveness through care coordination within health homes.

Using the NCTracks Medicaid Management Information System (MMIS), targeted Medicaid and NCHC beneficiaries will be linked to a CCNC PCP in their county of residence.

Medicaid caseworkers in the county department of social services offices will answer beneficiary questions about assigned CCNC providers.

Providers with questions may contact the DMA Call Center at 919-855-4780 or the [CCNC Managed Care Consultant](#).

Provider Relations
DMA, 919-855-4050

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

CCNC/CA Providers Who are Changing a National Provider Identifier (NPI)

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers may change National Provider Identifiers (NPIs) due to a Change of Ownership (CHOW) or situations where beneficiaries were linked to an individual NPI when they should have been linked to a group NPI. To ensure the change is as smooth as possible, providers must adhere to the following:

- When there is a NPI change for a CCNC/CA provider, the new NPI must be credentialed for both N.C. Medicaid and CCNC/CA for continued participation.
- A Managed Change Request (MCR) must be submitted through NCTracks to end-date the old NPI for CCNC/CA participation.
- Primary Care Providers (PCPs) are encouraged to wait until after the new NPI is effective for CCNC/CA participation **before** end-dating the old NPI.
- NPI transfer will always be effective the first day of an ongoing month. Claims with dates of service prior to beneficiaries being assigned to the new NPI will require the use of the old NPI as the CCNC/CA referral authorization.
- End-dating CCNC/CA participation under the old NPI will allow Division of Medical Assistance (DMA) regional consultants to request a transfer of beneficiaries to the new NPI.
- Providers affiliated with a CCNC network must [contact their network](#) to amend or sign a new CCNC agreement under the new NPI.

[Regional consultants](#) can answer questions regarding Carolina ACCESS.

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

Attention: Adult Care Home and Nursing Facility Providers

Revised Notice of Transfer/Discharge and Hearing Request Forms

N.C. Division of Medical Assistance (DMA) Adult Care Home and Nursing Home Notice of Transfer/Discharge, and Hearing Request forms have been revised. They can be accessed on the N.C. DMA [Provider Forms web page](#), at the Department of Health and Human Resources (DHHS) [On-Line Manuals web page](#), or directly by clicking on the links below:

- [Nursing Home Hearing Request Form](#)
- [Nursing Home Notice of Transfer/Discharge](#)
- [Adult Care Home Hearing Request Form](#)
- [Adult Care Home Hearing Notice of Transfer/Discharge](#)

Contact the DMA Hearing Office at 919-814-0090 with questions.

**Hearing Office,
DMA, 919-814-0090**

Attention: Dental Providers**Submitting Prior Approval Requests for Comprehensive Orthodontic Treatment Requiring Orthognathic Surgery**

The following records are required when submitting prior approval requests for combined comprehensive orthodontic treatment of the adolescent dentition (D8080) and orthognathic surgery to correct a skeletal imbalance:

1. Diagnostic Models
 - a. Trimmed to centric occlusion
 - b. Bite registration required
 - c. Description of centric relation-centric occlusion shifts greater than 2mm

2. Three Extraoral Photographs
 - a. Full face with patient at rest
 - b. Right profile with patient at rest
 - c. Full face with patient smiling as fully as possible

3. Five Intraoral Photographs
 - a. Maxillary occlusal view
 - b. Mandibular occlusal view
 - c. Right lateral view in centric occlusion
 - d. Left lateral view in centric occlusion
 - e. Frontal view in centric occlusion

4. Radiographic Images
 - a. Panoramic (labeled right and left)
 - b. Lateral cephalometric with tracing and analysis (right lateral with teeth in occlusion and the patient in a relaxed lip posture)
 - c. Posterioroanterior cephalometric if asymmetry present
 - d. Individual periapical films as needed for special diagnostic concerns

5. Treatment Plan
 - a. Necessary extractions
 - b. Pre-surgical orthodontic treatment goals with specific measurements in all three dimensions
 - c. Pre-treatment lateral cephalometric predictions showing anticipated orthodontic and surgical movements and resulting soft tissue profile
 - d. Estimated time to complete pre-surgical orthodontics
 - e. Post-surgical orthodontic treatment goals and estimated time to complete treatment
 - f. Retention plan

6. Consultation notes from the provider who will be rendering the orthognathic surgery services indicating agreement with the proposed treatment plan

The following orthodontic records are allowed for the initial consultation visit for combined comprehensive orthodontic treatment and orthognathic surgery:

Procedure Code	Description
D0160	Detailed and Extensive Oral Evaluation
D0330	Panoramic film
D0340	Cephalometric film
D0470	Diagnostic casts
D0290	Posterior-anterior radiographic image (if needed)

When the patient is ready for surgery, additional records are needed as the interim records. These records must be submitted with the prior approval request for the orthognathic surgery. The Division of Medical Assistance (DMA) will grant an override of the lifetime limit to allow payment for the additional records required for the surgery request.

Note: The same records are required for orthognathic surgery requests submitted on behalf of beneficiaries who initiated their orthodontic treatment through a private-pay arrangement. Providers with questions can contact the CSC Call Center:

- Phone: 800-688-6696
- Fax: 919-851-4014
- Email: NCTracksprovider@nctracks.com

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

Attention: All Providers**Meningococcal Group B Vaccine Injection (Bexsero®) CPT code 90620: Billing Guidelines**

Note: The section of this article titled “North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)” relates to N.C. Medicaid **only**, not N.C. Health Choice (NCHC).

The sections of this article titled “CDC Guidelines for Medicaid and NCHC” and “For Medicaid and NCHC Billing” relate to both NCHC and Medicaid.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Medicaid program covers childhood vaccines according to guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). The N.C. Immunization Program (NCIP) distributes all recommended childhood vaccines to local health departments, hospitals, and private providers under NCIP guidelines.

Effective July 1, 2015, the NCIP began offering providers meningococcal group B vaccine injection (Bexsero) for VFC-eligible children who are at increased risk for meningococcal group B disease. Visit the [N.C. Department of Public Health, Immunizations web page](#) for the NCIP coverage criteria for all NCIP-provided products, including Bexsero.

CDC Guidelines for Medicaid and NCHC

N.C. Medicaid and NCHC cover vaccines according to guidelines from the CDC and the ACIP.

Effective with date of service July 1, 2015, N.C. Medicaid and NCHC cover meningococcal group B vaccine injection (Bexsero), for use in the Physician’s Drug Program (PDP) when billed with CPT code 90620 (Meningococcal recombinant protein and outer membrane vesicle, serogroup B, 2-dose schedule, for intramuscular use). Bexsero is currently commercially available in 0.5 ml injections.

Meningococcal group B vaccine injection (Bexsero) is indicated for active immunization to prevent invasive disease caused by *Neisseria meningitidis* serogroup B. Bexsero is approved for use in individuals 10 through 23 years of age.

The recommended dosage for meningococcal group B vaccine injection (Bexsero) is 2 doses (0.5 mL each) of Bexsero at least one month apart.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing meningococcal group B vaccine injection (Bexsero) is V01.84 (Contact with or exposure to meningococcal).
- Providers must bill Bexsero with CPT code 90620 (Meningococcal recombinant protein and outer membrane vesicle, serogroup B, 2-dose schedule, for intramuscular use).
- Providers must indicate the number of CPT code units.

- Medicaid covers the cost of the administration of Bexsero for VFC-eligible beneficiaries 10 through 18 years of age.
- Medicaid reimburses the cost of Bexsero and the cost of administration for Medicaid-eligible beneficiaries 19 through 23 years of age.
- One Medicaid unit of coverage for Bexsero is 0.5 ml. NCHC bills according to Medicaid units. The maximum reimbursement rate per 0.5 ml is \$173.4750. One 0.5 ml injection contains 1 billable unit.
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: All Providers

Human Papillomavirus 9-Valent Vaccine, Recombinant Injection (Gardasil® 9) CPT Code 90651: Billing Guidelines

Note: The section of this article titled “North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)” relates to N.C. Medicaid **only**, not N.C. Health Choice (NCHC).

The sections of this article titled “CDC Guidelines for Medicaid and NCHC” and “For Medicaid and NCHC Billing” relate to both NCHC and Medicaid.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Medicaid program covers vaccines in accordance with guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). The N.C. Immunization Program (NCIP) distributes all recommended childhood vaccines to local health departments, hospitals, and private providers under NCIP guidelines.

Effective July 1, 2015, the NCIP began offering providers human papillomavirus 9-valent vaccine (Gardasil 9) for VFC eligible children. Visit the [N.C. Department of Public Health, Immunizations web page](#) for the NCIP coverage criteria for all NCIP-provided products, including those for human papillomavirus.

CDC Guidelines for Medicaid and NCHC

N.C. Medicaid and NCHC cover human papillomavirus 9-valent vaccine, recombinant injection (Gardasil 9), for use in the Physician’s Drug Program (PDP) when billed with **CPT code 90651** (Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use). Gardasil 9 is currently commercially available in 0.5 ml injections.

Human papillomavirus 9-valent vaccine, recombinant injection (Gardasil 9) is covered by N.C. Medicaid for girls and women 9 through 20 years of age and boys 9 through 18 years of age.

The recommended dosage for human papillomavirus 9-valent vaccine, recombinant injection (Gardasil 9) is 0.5-mL suspension for intramuscular injection at the following schedule: 0-months, 2-months, 6-months.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing human papillomavirus 9-valent vaccine, recombinant injection (Gardasil 9) is V04.89 (Need for prophylactic vaccination and inoculation against certain viral diseases or Other viral diseases); V05.8 (Need for other prophylactic vaccination and inoculation against single diseases).
- Providers must bill Gardasil 9 with CPT code 90651 (Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use).
- Providers must indicate the number of CPT code units.

- Medicaid covers the administration of Gardasil 9 for VFC-eligible female beneficiaries 9 through 18 years of age and VFC-eligible male beneficiaries 9 through 18 years of age.
- Medicaid covers the vaccine cost and the administration cost for Medicaid-eligible females 19 through 20 years of age.
- One Medicaid unit of coverage for Gardasil 9 is 0.5 ml. NCHC bills according to Medicaid units. The maximum reimbursement rate per 0.5 ml is \$177.8438. One 0.5 ml injection contains one billable unit.
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: All Providers**Meningococcal Group B Vaccine (Trumenba®), CPT 90621: Billing Guidelines**

Note: The section of this article titled “North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)” relates to N.C. Medicaid **only**, not N.C. Health Choice (NCHC).

The sections of this article titled “CDC Guidelines for Medicaid and NCHC” and “For Medicaid and NCHC Billing” relate to both NCHC and Medicaid.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Medicaid program covers childhood vaccines according to guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). The N.C. Immunization Program (NCIP) distributes all recommended childhood vaccines to local health departments, hospitals, and private providers under NCIP guidelines.

Effective July 1, 2015, the NCIP began offering providers Meningococcal group B vaccine (Trumenba) for VFC-eligible children at increased risk of meningococcal disease. Visit the [N.C. Department of Public Health, Immunizations web page](#) for the NCIP coverage criteria for all NCIP-provided products, including Trumenba.

CDC Guidelines for Medicaid and NCHC

The N.C. Medicaid Program covers vaccines according to guidelines from the CDC and the ACIP.

Effective with date of service July 1, 2015, N.C. Medicaid and NCHC cover meningococcal group B vaccine (Trumenba), for use in the Physician’s Drug Program (PDP) when billed with CPT code 90621 (Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use). Trumenba is currently commercially available in 120 mcg/0.5 mL syringes.

Meningococcal group B vaccine (Trumenba) is an active immunization indicated to prevent invasive disease caused by *Neisseria meningitidis* serogroup B. Trumenba is approved for use in individuals 10 through 23 years of age.

The recommended dosage for meningococcal group B vaccine (Trumenba) is three doses (0.5 mL each) by intramuscular injection according to a 0-, 2-month, and 6-month schedule.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing meningococcal group B vaccine (Trumenba) is V01.84 (Contact with or exposure to meningococcal).
- Providers must bill Trumenba with CPT code 90621 (Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use).
- Providers must indicate the number of CPT code units.

- Medicaid covers the administration cost of Trumenba for VFC-eligible recipients 10 through 18 years of age. Medicaid reimburses the vaccine cost and the administration cost for Medicaid eligible beneficiaries 19 through 23 years of age.
- One Medicaid unit of coverage for Trumenba is 0.5 mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per 0.5 mL is \$124.8750. One 120 mcg/0.5 mL syringe contains 1 billable unit.
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: Physicians, Physician Assistants and Nurse Practitioners**F**luocinolone Acetonide Intravitreal Implant (Iluvien®) HCPCS Code J3490: Billing Guidelines

Effective with date of service June 1, 2015, N.C. Medicaid covers fluocinolone acetonide intravitreal implant (Iluvien), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 (Unclassified drugs). Iluvien is currently commercially available in 0.19 mg implants.

Fluocinolone acetonide intravitreal implant (Iluvien) is indicated for diabetic macular edema in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure.

The recommended dosage for fluocinolone acetonide intravitreal implant (Iluvien) is one intravitreal implant inserted up to every three years.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing fluocinolone acetonide intravitreal implant (Iluvien) is 362.07 (Diabetic macular edema).
- Providers must bill Iluvien with HCPCS code J3490 (Unclassified drugs).
- One Medicaid unit of coverage for Iluvien is one implant. The maximum reimbursement rate per one implant is \$9,504. One implant contains 0.19 milligrams.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Iluvien 0.19 mg implants is 68611-0190-02.
- The NDC units for fluocinolone acetonide intravitreal implant (Iluvien) should be reported as "UN1."
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs must bill the cost that is reflective of their acquisition cost. Providers must 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: Physicians, Physician Assistants and Nurse Practitioners**Coagulation Factor IX (Recombinant) Vials (Ixinity®) HCPCS Code J7199: Billing Guidelines**

Effective with date of service June 1, 2015, N.C. Medicaid and N.C. Health Choice (NCHC) cover coagulation factor IX (recombinant) vials (Ixinity), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified). Ixinity is currently commercially available in 500 IU, 1000 IU, and 1500 IU vials.

Coagulation factor IX (recombinant) vials (Ixinity) is indicated for coagulation factor IX (recombinant) indicated in adults and children ≥ 12 years of age with hemophilia B for control and prevention of bleeding episodes, and for perioperative management.

The recommended dosage for coagulation factor IX (recombinant) vials (Ixinity) is one international unit (IU) per kg body weight increases the circulating activity of factor IX by 0.98 IU/dL.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing coagulation factor IX (recombinant) vials (Ixinity) is 286.1 (Congenital factor IX disorder).
- Providers must bill Ixinity with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified).
- One Medicaid unit of coverage for Ixinity is 1 IU. NCHC bills according to Medicaid units. The maximum reimbursement rate per 1 IU is \$1.602. One vial contains 500, 1,000, and 1,500 international units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Ixinity 500 IU, 1,000 IU and 1,500 IU vials are 53270-0270-05, 53270-0271-05, 53270-0271-06, 53270-0272-05, and 53270-0272-06.
- The NDC units for coagulation factor IX (recombinant) vials (Ixinity) should be reported as "UN1."
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: Physicians, Physician Assistants and Nurse Practitioners**Anticoagulation Factor (Recombinant) Vials (Novoeight®) HCPCS code J7182: Billing Guidelines**

Effective with date of service June 1, 2015, N.C. Medicaid and N.C. Health Choice (NCHC) cover anticoagulation factor (recombinant) vials (Novoeight), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7182 [Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU]. Novoeight is currently commercially available in 250 IU, 500 IU, 1000 IU, 1500 IU, 2000 IU, and 3000 IU vials.

Anticoagulation factor (recombinant) vials (Novoeight) are indicated for adults and children with hemophilia A for:

- Control and prevention of bleeding,
- Perioperative management, and,
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

The recommended dosage for anticoagulation factor (recombinant) vials (Novoeight) is determined using the following formula:

$$\text{Dosage Required (IU)} = \text{Body Weight (kg)} \times \text{Desired Factor VIII Increase (IU/dL or \% normal)} \times 0.5 \text{ (IU/kg per IU/dL)}$$

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing anticoagulation factor (recombinant) vials (Novoeight) is 286.0 (Congenital factor VIII disorder).
- Providers must bill Novoeight with HCPCS code J7182 [Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU].
- One Medicaid of coverage for Novoeight is 1 IU. NCHC bills according to Medicaid units. The maximum reimbursement rate per 1 IU is \$1.719. One vial contains 250, 500, 1000, 1500, 2000, and 3000 international units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Novoeight 250 IU, 500 IU, 1000 IU, 1500 IU, 2000 IU, and 3000 IU vials are 00169-7810-01, 00169-7815-01, 00169-7820-01, 00169-7825-01, 00169-7830-01, and 00169-7850-01.
- The NDC units for anticoagulation factor (recombinant) vials (Novoeight) should be reported as "UN1".
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: Physicians, Physician Assistants and Nurse Practitioners**F**luocinolone Acetonide Intravitreal Implant (Retisert®) HCPCS code
J7311: Billing Guidelines

Effective with date of service June 1, 2015, N.C. Medicaid and NC Health Choice (NCHC) cover fluocinolone acetonide intravitreal implant (Retisert), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7311 (Fluocinolone acetonide, intravitreal implant). Retisert is currently commercially available in 0.59 mg implants.

Fluocinolone acetonide intravitreal implant (Retisert) is indicated for chronic noninfectious uveitis affecting the posterior segment of the eye.

The recommended dosage for fluocinolone acetonide intravitreal implant (Retisert) is one intravitreal implant inserted up to every 30 months.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing fluocinolone acetonide intravitreal implants (Retisert) are:
 - 363.0 (Focal chorioretinitis and focal retinochoroiditis)
 - 363.1 (Disseminated chorioretinitis and disseminated retinochoroiditis)
 - 363.2 (Other and unspecified forms of chorioretinitis and retinochoroiditis)
 - 363.54 (Central choroidal atrophy, total)
- Providers must bill Retisert with HCPCS code J7311 (Fluocinolone acetonide, intravitreal implant).
- One Medicaid unit of coverage for Retisert is one implant. NCHC bills according to Medicaid units. The maximum reimbursement rate per 1 implant is \$20,547. One implant contains 0.59 milligrams.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Retisert 0.59 mg implants is 24208-0416-01.
- The NDC units for fluocinolone acetonide intravitreal implants (Retisert) should be reported as "UN1."
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).
- Providers must 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 must bill the cost that is reflective of their acquisition cost. Providers must 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: Prescribers

“Meets PA Criteria” Proper Use to Override a Required Prior Authorization (PA)

A prescriber may indicate “Meets PA Criteria” on the following types of prescriptions:

- Antipsychotics for Adults
- Second Generation Anticonvulsants
- Oral Inhaled Steroids
- Millipred[®] Solution, or,
- Veripred[®] Solution

This may be handwritten on the face of the prescription or may be entered in the comment block on e-prescriptions. This statement overrides any prior authorization (PA) requirement for these products. The following guidelines **must** be followed before prescribing:

1. Antipsychotics for Adults (18 or older):

A patient must have the following diagnosis:

- Schizophrenia
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Brief psychotic disorder
- Shared psychotic disorder
- Psychotic disorder Not Otherwise Specified (NOS)
- Bipolar disorder
- Major depressive disorder with psychotic features
- Treatment resistant depression (antipsychotic use for TRD is adjunctive only)
- Tourette syndrome
- Other psychoses

2. Second Generation Anticonvulsants:

- A patient must have a seizure diagnosis

3. Oral Inhaled Steroids:

A patient must meet one of the following exemptions:

- Patients with a documented contraindication, intolerable side effects, or allergy to QVAR (beclomethasone dipropionate) are exempt from the criteria.

- Patients who are currently stable on long-acting inhaled beta-agonist/steroid combination products for symptom control are exempt from the criteria.
- Patients whose condition is severe enough to warrant combination therapy are exempt from the criteria.
- Patients with COPD are exempt from the criteria.
- Children 4-years to up to 5-years old may use Flovent (fluticasone) without PA.

4. Millipred or Veripred Solution:

- A patient must be 12-years old or younger.

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

Proposed Clinical Coverage Policies

According to 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 N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

2015 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
August	8/06/15	8/11/15	8/12/15
	8/13/15	8/18/15	8/19/15
	8/20/15	8/25/15	8/26/15
	8/27/15	9/01/15	9/02/15
September	9/03/15	9/09/15	9/10/15
	9/10/15	9/15/15	9/16/15
	9/17/15	9/22/15	9/23/15
	9/24/15	9/29/15	9/30/15

Sandra Terrell, MS, RN
 Director of Clinical
 Division of Medical Assistance
 Department of Health and Human Services

Paul Guthery
 Executive Account Director
 CSC