September 2015 Medicaid Bulletin

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All Providers

Dental Providers

Nurse Practitioners, Physicians Assistants and Physicians

Attention: All Providers

NCTracks ICD-10 News

ICD-10 Provider Training Sessions in September

To prepare for the **Oct. 1, 2015,** launch of ICD-10, multiple ICD-10 webinars for providers are being offered in September. Providers can attend the webinars from any location with a telephone, computer and Internet connection. Each webinar is limited to 115 participants.

Course Name

ICD-10 System Changes

Course Dates and Times

- Thursday, Sept. 3 - 9:00 a.m. to 9:45 a.m.
- Tuesday, Sept. 8 - 3:00 p.m. to 3:45 p.m.
- Friday, Sept. 18 - 10:00 a.m. to 10:45 a.m.
- Monday, Sept. 21 - 3:00 p.m. to 3:45 p.m.

Course Overview

This course will give providers an overview of the NCTracks system changes for ICD-10.

Course Objectives

At the end of training, providers will be able to**:**

- Identify the NCTracks system changes related to ICD-9 and ICD-10 for **submitting**:
    - Institutional Claims
    - Pharmacy Claims
    - Professional Claims
    - Dental Claims
- Entering **Prior Approval (PA)** requests using ICD-10 for medical and dental PA types.

Training Enrollment Instructions:

Providers can register for this course in SkillPort, the NCTracks Learning Management System.

- Log on to the secure NCTracks Provider Portal.
- Click Provider Training to access SkillPort.
- Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**.
- The course can be found in the subfolder labeled **ILTs: Remote via WebEx**.

Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

ICD-10 Frequently Asked Questions

NCTracks maintains an ICD-10 Frequently Asked Questions (FAQ) web page. ICD-10 questions not addressed on the ICD-10 FAQ web page should be sent to NCTracks-Questioner@dhhs.nc.gov.

ICD-10 Crosswalk

Providers who want an example of ICD-10 codes to use on Oct. 1, 2015, may use the ICD-10 Crosswalk. The crosswalk allows users to enter an ICD-9 code and see the corresponding ICD-10 codes in NCTracks.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Tip of the Month

Caution about Unsubscribing from NCTracks Email Distribution List

NCTracks uses Constant Contact as its email list manager. Anyone can join the email list by:

1. Going to the Provider Communications page on the NCTracks portal and clicking on the link in the upper-right corner which states "Sign Up for NCTracks Communications," or

2. Clicking on the "Receive NCTracks Email Alerts Between Bulletin Articles" link on the top of each Medicaid Bulletin web page (from June 2014 on).

To stop receiving email communication from NCTracks, click on the "SafeUnsubscribe" link in the footer of any NCTracks email.

Note: Once unsubscribed, NCTracks can no longer send providers any email communication. Email is a key means of communicating with the provider community about important topics regarding NCTracks, such as outstanding issues, claims reprocessing, and upcoming system changes Therefore, providers are encouraged to remain subscribed to NCTracks email communication. A concerted effort is made to limit the number of emails sent.

To resubscribe, use one of the methods described above.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Updates

Changes in Crossover Claims for Services Rendered to Qualified Medicare Beneficiaries

N.C. Division of Medical Assistance (DMA) conducted a comprehensive review of changes made to its processing of Medicare crossover claims for services rendered to Qualified Medicare Beneficiaries (QMB). It has determined that changes implemented on **March 1, 2015**, are **not** aligned with the Centers for Medicare & Medicaid Services (CMS) guidance to state Medicaid agencies, resulting in the overpayment on some of these claims.

Based on recent guidance provided by CMS to DMA, the "lesser of" logic will be applied to services covered by both Medicare and Medicaid that are rendered to QMB recipients. **Specifically, payment for Medicare-covered services that are also covered in the Medicaid State Plan will be paid at the lesser of the Medicare cost-share (which is the sum of co-insurance, deductible and copay) or the difference between the amount paid by Medicare and the Medicaid State Plan rate (if any).** (More information can be found in the Oct. 7, 2013, NCTracks announcement *Medicare Crossover Update*).

For services **not** covered under the N.C. Medicaid State Plan, DMA will pay the Medicare cost share amount.

This methodology results in the provider receiving the Medicare or Medicaid allowable and the QMB recipient not being responsible for any additional monies for services covered by Medicaid and/or Medicare.

DMA will take the following actions to align the processing of Medicare crossover claims for services rendered to QMB recipients with CMS' guidance:

1. **Effective July 20, 2015**, DMA reverted to the pre-March 1 reimbursement methodology of paying all claims for services rendered to QMB recipients using the "lesser of" logic. This will result in some underpayments but avoid overpayment.

2. **In the fall of 2015**, DMA will begin processing claims for services rendered to QMB recipients by paying the Medicare cost share of non-Medicaid covered Medicare services and "lesser of" logic for services covered by Medicare and Medicaid. This will correct the underpayment of claims going forward.

3. **After the fall update,** the affected claims for services rendered to QMB recipients dating back to July 1, 2013, will be reprocessed and corrected. Additional payments will be made for claims that were underpaid prior to March

1, 2015 and from July 20, 2015 until the date in autumn that step two (above) becomes effective. Overpayments made from March 1 through July 20 will be recouped.

4. As these key milestone dates approach, NCTracks will inform providers of the impending changes and claim reprocessing.

These actions **supersede** the NCTracks announcement of Feb. 27, 2015, *Changes in Payment of Medicare Crossover Claims for QMB Cost Sharing*.

1099 Reporting/Pay-To Address on Provider Record

On Aug. 2, 2015, the existing "Pay-To Address" on all NCTracks provider records was renamed to "**1099 Reporting/Pay-To Address**." This is the address that will be used for distribution of 1099s.

Over the past two years, hundreds of 1099s have been returned to NCTracks due to incorrect mailing addresses. The designation of a 1099 Reporting Address on the provider record will help providers know which address is used for 1099 reporting – and to change it, if needed – to increase the success of first-time mailings to providers.
As part of this change, all NPIs with the same Taxpayer Identification Number (TIN) were given the same 1099 Reporting/Pay-To Address on their provider records. If there was more than one existing Pay-To Address among the NPIs associated with the same TIN, the system used the most recent record's Pay-To Address and copied it to all records with the same TIN.

Providers are encouraged to verify the 1099 Reporting/Pay-To Address on their provider record after Aug. 2. If the 1099 Reporting/Pay-To Address is not correct, submit a Manage Change Request (MCR) with the correct 1099 Reporting/Pay-To Address. Only one MCR is required to change the 1099 Reporting/Pay-To Address for a given TIN. When the change is made for one NPI, it will be replicated for all NPIs associated with that TIN.

NCTracks also updated "**Organization Name"** on the provider records so that it is the same for all NPIs with the same TIN. If there was more than one existing Organization Name among the NPIs associated with the same TIN, the system used the most recent record's Organization Name and copied it to all records with the same TIN.

"Organization Name" should be the legal name for the TIN. The system will no longer allow new providers to use a different Organization Name if the TIN is already in NCTracks. When a new NPI is enrolled in NCTracks using an existing TIN, the system will automatically insert the Organization Name associated with that TIN.
Providers will receive a letter for each update made to an Organization Name or 1099 Reporting/Pay-To Address, which also includes instructions on how to change the Organization Name, if needed.

Providers also have the opportunity to add/update their Doing Business as (DBA) Name. Many providers previously put their DBA Name in the Organization Name field.

Updating Third Party Liability Information for Recipients Whose Primary Insurance Does Not Cover Nursing Care

Note: This is a republished July 22, 2014, NCTracks announcement with updated fax number.

If a recipient is in a nursing home, but the recipient's primary insurance on file does not cover skilled nursing facility (SNF) care, the SNF claims may deny with EOB 00094. The description of EOB 00094 may be misleading. NCTracks does not recognize occurrence code 24 in this situation.

If it is a valid policy, but does not cover SNF care, the provider may have the record updated by faxing the following information to DMA Third Party Recovery at (919) 814-0038:

- NPI,
- Recipient ID,
- Recipient Name, and
- Admission Date.

The fax should specify that the recipient has a valid third party insurance policy, but it does not cover SNF care. DMA Third Party Recovery can update this information in NCTracks, and then the provider can resubmit the denied claim. This should only be done once for a given policy for the recipient.

Dialysis Initial Treatment Date Must be Included

Providers are reminded that they must enter the initial treatment date on dialysis claims. If a dialysis claim is submitted without a "First Treatment Date" on the claim, the claim will deny. The Explanation of Benefits (EOB) that will post on the paper Remittance Advice (RA) is EOB 00189 - MISSING OR INVALID FIRST TREATMENT DATE FOR DIALYSIS CLAIM. PLEASE RESUBMIT WITH FIRST TREATMENT DATE. Claims that deny must be resubmitted with the "First Treatment Date" to be processed.

For more information, see Clinical Coverage Policy 1A-34, *End Stage Renal Disease Services*, on the DMA Clinical Coverage Policy web page.

Durable Medical Equipment Procedure-to-Procedure Edits (National Correct Coding Initiative)

On Aug. 2, 2015, NCTracks added Durable Medical Equipment (DME) Procedure-to-Procedure (PTP) edits to the National Correct Coding Initiative (NCCI) edits used in claims processing. The DME PTP edits were added by CMS to NCCI editing effective with the fourth quarter 2012 and are included in each quarterly update issued by CMS. PTP edits for DME define pairs of HCPCS/CPT codes that should not be reported together. DME claims failing the PTP edits will deny and post EOB 49270 – NCCI EDIT on the provider's paper RA.

This edit change was effective upon implementation Aug. 2, 2015. No claims reprocessing will be performed.

For more information about NCCI and Medicaid, see the CMS website.

Change of Ownership Process in NCTracks

The following communication is intended to provide some clarification on what constitutes a change of ownership (CHOW) and how to process a CHOW in NCTracks.

A CHOW is constituted by:

1. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by Chapter 59 of the General Statutes.

2. In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC or when a business entity converts or merges into the LLC pursuant to Chapter 57A of the General Statutes.

3. In the case of an unincorporated sole proprietorship, the transfer of title and property of the provider that constitute the provider's business of providing services, goods, supplies, or merchandise to a Medicaid or NCHC recipient to another party.

4. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. Transfer of corporate stock or the merger of another corporation into the provider corporation will not constitute change of ownership. Merger of related provider corporations will not constitute a change in ownership.

5. The lease of all or part of a provider's facility that will continue to be utilized.

Processing a CHOW in NCTracks

There are two scenarios to consider when processing a CHOW in NC Tracks:

1. When all service locations are being purchased by buyer**:**

    - The seller is required to submit a MCR in NCTracks to terminate their record. The seller will remove all active health plans, enter the end date (the end date should be the (CHOW) transaction date), and select "Provider Terminated due to change of ownership" as the reason for ending coverage.

    - Once the record is terminated in NCTracks, the buyer will need to submit an initial enrollment application. The buyer can transfer the seller's NPI, **but we strongly encourage the buyer to retrieve a new NPI**. The EIN is not transferable.

2. Processing a CHOW when the seller is keeping one or more service location

    - The seller is required to submit a MCR to end-date the specific service location(s) being sold.

    - Buyer can submit an initial enrollment application.

Note: For either scenario, CSC strongly suggests the seller to submit the MCR 30 days prior to the CHOW transaction date. The MCR will not allow the health plans to be ended with a past date. The seller can only enter a current or future date when ending the health plans.

Note: Community Care of N.C./Carolina Access (CCNC/CA) providers must contact their DMA Regional Consultant prior to end-dating a CCNC/CA service location or provider record. Such actions jeopardize the continuity of service for CCNC/CA enrolled beneficiaries and providers should confirm the consequences for their enrolled beneficiaries with their DMA Regional Consultant prior to taking action to end-date a CCNC/CA service location or provider record.

If the previous owner is unable to terminate the record, the new owner can request to have the record terminated by submitting a written request and one of the following documentation as proof of the change in ownership:

- Bill of Sale
- Stock Transfer Agreement
- Letter relinquishing ownership from old owner
- Executed lease purchasing Agreement

Supporting documentation can be submitted to NCTracks via:

Fax:	1-855-710-1965
Email:	NCTracksprovider@nctracks.com
Mailing Address:	CSC, P.O. Box 300009, Raleigh, N.C. 27622-8009

Important Note for Community Care of N.C./Carolina Access (CCNC/CA) providers: CCNC/CA providers must contact their DMA Regional Consultants prior to end-dating a CCNC/CA service location or provider record. Such actions jeopardize the continuity of service for CCNC/CA enrolled beneficiaries and providers should confirm the consequences for their enrolled beneficiaries with their DMA Regional Consultant prior to taking action to end-date a CCNC/CA service location or provider record.

CSC, 1-800-688-6696

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the Division of Medical Assistance (DMA) Clinical Coverage Policy web page.

- 1A-6, *Invasive Electrical Bone Growth Stimulation* (8/1/15)
- 8A, *Enhanced Mental Health and Substance Abuse Services* (8/1/15)
- 8A-1, *Assertive Community Treatment (ACT) Program* (8/1/15)

These policies supersede previously published policies and procedures.

Clinical Services
DMA, 919-855-4260

Attention: All Providers

Provider Instructions for *Informal Reconsideration Review* of Claims Adversely Adjudicated By CSC

This article provides a detailed explanation of the N.C. Division of Medical Assistance (DMA) procedures for *Informal Reconsideration Review* of adverse claim actions (denials, disallowances and adjustments) made by its fiscal agent, CSC.

Requests for reconsideration are made by providers enrolled in N.C. Medicaid and N.C Health Choice (NCHC) to DMA. The request for reconsideration must be submitted by providers or their designees.

Note: This bulletin **does not address** the following provider requests for *Informal Reconsideration*:

- Reconsideration of an established rate
- Cost settlement disallowances/adjustments
- Program integrity actions

These issues and remedies are specified in 10A NCAC 22F.

Rules for Submission of a Denied Claim for an *Informal Reconsideration Review*

Fiscal Agent's Final Notification of Denial/Disallowance

Final notification of payment, payment denial, disallowances and payment adjustment means that **all administrative actions necessary to have a claim paid correctly have been taken by the provider** and DMA or CSC has issued a final adjudication.

Time Limit for Submission of Request

A provider may request a reconsideration review within **30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement and adjustments**. If no request is received within the respective 30 calendar day period, DMA's action will become final.

Required Elements of *Informal Reconsideration Review* Requests

A complete request for *Informal Reconsideration Review* will:

- Be made in writing
- Be signed by the provider

- Contain the provider's name, address and telephone number
- **State clearly in a cover letter** the specific dissatisfaction with DMA's action
- Contain any necessary supporting documentation including, but not limited to, original claim, remittance advice received, clinical notes/treatment rationales and other relevant medical records.

Note: Packets received without all required elements (including the provider's cover letter) will be considered incomplete and will be returned to the provider unprocessed by DMA.

A complete request with supporting documentation must be mailed to:

NC Division of Medical Assistance
Appeals Unit: Attention Provider Informal Reconsideration Reviews,
2501 Mail Services Center
Raleigh, NC. 27699 - 2501

Required Provider Notifications

When DMA Due Process/Appeals Unit receives an **appropriate and timely** request for *Informal Reconsideration Review* of a claim denied for payment, a DMA representative (reviewer) will be assigned. The DMA representative (reviewer) will contact the requesting provider to arrange a time and date to discuss the request. The provider may request a personal review meeting, or may accept a review of documents only, to a telephone discussion.

Submission of Additional Supporting Documentation

All necessary documentation must be submitted in a single packet to DMA. If the provider wishes to submit additional information that was not included in the original mailed request, the provider will be given an additional 14 calendar days from the date that the provider is contacted by the DMA representative (reviewer). Failure to submit written arguments within this time frame will be grounds for dismissal of the reconsideration, unless DMA agrees to a delay within the 14 calendar day period.

Final Agency Decision

Following the review, DMA will, within 30 calendar days – or such additional time thereafter as specified in writing during the 30 day period – render a decision in writing and send it by certified/trackable mail to the provider or his designee.

Provider Representatives

Providers may appoint other individuals to represent them. A written statement setting forth the name, address and telephone number of the representatives so designated will be included in the request for *Informal Reconsideration Review* packet. The representatives may exercise any and all rights given providers in the review process. DMA personnel will direct communication regarding meeting dates, requests for information, hearing decisions, etc. to authorized representatives. Copies of such documents will be sent to petitioners only if a written request is made.

Petition for a Contested Case Hearing

Providers who disagree with the reconsideration review decision may request a *Contested Case Hearing* in accordance with 10A NCAC 01.

Additional Information on *Informal Reconsideration Reviews* for Providers

Inappropriate Items for Requests for *Informal Reconsideration Review*

DMA has received more than 800 inappropriate requests for *Informal Reconsideration Review* during the 2014 calendar year. The most prevalent are:

1. **Adjustment requests, or a claim review for medically necessity**

    - *Claim Adjustment Requests*, *Claim Reviews for Medical Necessity* and *Medicaid Resolution Inquiries* all have action pathways within NCTracks. These items, with the appropriate CSC processing forms attached, should be sent by the provider to CSC.

    - It is the **responsibility of the provider** and the provider's designated agents/business partners to familiarize themselves with User Guides, Job Aids, E Forms and other tools related to claims inquiry and resolution. Review the appropriate NCTracks informational material ***Provider Adjustment, Time Limit and Medicare Override Job Aide*.**

    - **Providers should always review thoroughly their EOB statements and Job Aids before initiating an *Informal Reconsideration Review*.** This will assist the provider in making a determination of the proper and most efficient pathway for the claim, whether it be reprocessing, adjustment or *Informal Reconsideration Review*.

2. **Modifier 51**

    - If multiple surgeries are performed and modifier 51 is not present on the claim as required, the claim will deny for payment. The EOB instructs the provider to resubmit the claim with modifier 51 added. These claims should be resubmitted with modifier 51 appended as instructed.

3. **Resubmission of Claims per EOB instructions**

    - EOBs frequently instruct providers to **resubmit** medical records and/or modifiers with additional information. When resubmitting a claim for reprocessing electronically enter the claim through the NCTracks Provider Portal per CSC procedures.

4. **Requests with Missing Documentation or Cover Letters**

    - DMA is unable to process mailings arriving at DMA Appeals Unit without cover letters and necessary attachments. Packets must comply with all applicable N.C. Administrative Code rule.

5. **Requests for Time Limit Override**

    - Basic time limit override requests should be submitted through NCTracks on a *Medicaid Resolution Inquiry Form.*

Relevant State Statute

§ 150B-22. Settlement; contested cases
This statute codifies policy for "Informal Procedures" in settlement of disputes with state agencies.

Relevant North Carolina Administrative Code

10A NCAC 22J:
This administrative code provides definitions and procedures for a provider-requested *Informal Reconsideration Reviews*.

DMA is making every effort to assure prompt processing of all appropriate provider requests for *Informal Reconsideration Reviews* of adverse claims decisions. Providers may contact DMA Recipient Appeals with specific questions related to *Informal Reconsideration Reviews*.

Recipient Appeals
DMA, 919-855-4325

Attention: All Providers

NC Medicaid Electronic Health Records Incentive Program: Reporting Patient Volume in 2015

Under the N.C. Medicaid EHR Incentive Program, an Eligible Professionals (EP) Patient Volume (PV) reporting period is defined as 90 consecutive days either:

1. In the previous calendar year for which the EP is attesting (e.g., if attesting in Program Year 2015, the PV reporting period may be any consecutive 90 days in calendar year 2014); or,

2. In the 12 months immediately preceding the date of attestation (e.g., if attesting on Sept. 21, 2015, the PV reporting period may be any consecutive 90 days from Sept. 20, 2014 – Sept. 20, 2015).

EPs who passed PV requirements in Program Year 2014 using a PV reporting period from calendar year 2014 (Jan. 1 2014 – Dec. 31, 2014), may use the same PV reporting period for Program Year 2015.

Note: EPs must meet both PV and Meaningful Use (MU) to meet N.C. Medicaid EHR Incentive Program requirements. MU reporting periods are **not** synonymous with PV reporting periods. MU reporting periods must be a consecutive 90- or 365-day period in the calendar year for which the EP is attesting. For example, when attesting in Program Year 2015, EPs must use MU data from calendar year 2015.

For more information, visit the NC Medicaid EHR Incentive Program web page.

N.C. Medicaid EHR Incentive Program
DMA, NCMedicaid.HIT@dhhs.nc.gov **(preferred), 919-814-0180**

Attention: All Providers

DMA Credit Balance Reporting is Changing

Since October 2013, N.C. Medicaid providers have been required to file quarterly reports on outstanding credits owed to the N.C. Medicaid program that have not previously been listed on a Medicaid Credit Balance Report. Hospital and nursing facilities are required to report every calendar quarter, even if no credit balances exist.

Currently, Medicaid Credit Balance Reports are filed on paper forms. Providers will soon have the option of using **eCenter**, a web-based application maintained by the N.C. Division of Medical Assistance's (DMA) Third Party Liability vendor HMS, Inc. Many providers are already familiar with eCenter because it is used for other DMA Third Party Liability functions.

Providers will soon have the ability to log on to the secure site and report credit balances in an electronic format, as well as track previous submissions.

HMS, Inc. employees are developing a webinar to introduce and explain the features of the revised DMA Credit Balance Reporting Process and eCenter. DMA will announce the webinar date on its website and HMS, Inc. will distribute notification to all registered eCenter users.

ECenter training is scheduled for completion in fall 2015. Until that time, providers should continue using the paper Credit Balance Report Form. Providers may choose to submit paper-based reports manually following the implementation of the eCenter process. However, manual submissions will require a longer processing time.

Note: Paper copies are not required to be sent to CSC.

Questions or comments about the new eCenter process can be submitted to NCCreditBalance@hms.com.

Third Party Liability
DMA, 919-814-0240

Attention: All Providers

Respiratory Therapy Providers

Clinical Coverage Policy (CCP) 10D, *Respiratory Therapy Services Independent Practitioners*, has been revised. The revisions, which become effective **Sept. 1, 2015**, clarify a respiratory therapist's role in helping beneficiaries who have been diagnosed with:

- Asthma,
- Unspecified disease of respiratory system, or
- Respiratory disease (chronic), not otherwise specified.

In such cases, a respiratory therapist's primary objective is to educate beneficiaries and their legal parents, guardians or foster care providers such that they can independently follow and comply with the beneficiary's written Action Plan. N.C. Division of Medical Assistance (DMA) expects that the education can be conveyed during the first six months of service authorization and within 15 total visits.

Revisions to CCP 10D also expand coverage for respiratory therapy services provided by independent practitioners to N.C. Health Choice (NCHC) beneficiaries under 19 years of age. Requests for prior authorization must be submitted to The Carolinas Center for Medical Excellence (CCME) through the ChoicePA website.

More information can be found on DMA's CCP web page.

Clinical Section
DMA, 919-855-4260

All Providers

Preferred Drug List Review Panel Scheduled

The next Preferred Drug List (PDL) review panel will be held Wednesday, Sept. 16, 2015 from 1 to 5 p.m. at the State Library Building, 109 E. Jones St., Raleigh, N.C. 27601. Details are posted at the N.C. Division of Medical Assistance (DMA) PDL web page.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers

Calcitriol (Rocaltrol®) Coverage

Calcitriol is covered for the following conditions:

- **Predialysis Patients**

Calcitriol (Rocaltrol®) is indicated in the management of secondary hyperparathyroidism and resultant metabolic bone disease in patients with moderate to severe chronic renal failure (Ccr 15 to 55 mL/min), not yet on dialysis. In children, the creatinine clearance value must be corrected for a surface area of 1.73 square meters. A serum iPTH level of ≥ 100 pg/mL is strongly suggestive of secondary hyperparathyroidism.

- **Dialysis Patients**

Calcitriol (Rocaltrol) is indicated in the management of hypocalcemia and the resultant metabolic bone disease in patients undergoing chronic renal dialysis. In these patients, calcitriol (Rocaltrol) administration enhances calcium absorption, reduces serum alkaline phosphatase levels, and may reduce elevated parathyroid hormone levels and the histological manifestations of osteitis fibrosa cystica and defective mineralization.

- **Hypoparathyroidism Patients**

Calcitriol (Rocaltrol) also is indicated in the management of hypocalcemia and its clinical manifestations in patients with postsurgical hypoparathyroidism, idiopathic hypoparathyroidism, and pseudohypoparathyroidism.

Note: Ergocalciferol continues to be **non-covered** except for N.C. Health Choice (NCHC) beneficiaries, or N.C. Medicaid beneficiaries under the age of 21.

Pharmacy Services
DMA, 919-855-4300

All Providers

Hepatitis C Pharmacy Prior Authorizations

Use the Standard Drug Request Prior Authorization form in addition to the appropriate hepatitis C prior authorization form when requesting hepatitis C medications. The Standard Drug Request PA form must be the first page faxed when sending in the request. Doing so will expedite processing.

NCTracks will be adding the Standard Drug Request PA form to all hepatitis C prior authorization forms so providers do not have to download them separately.

Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Pharmacy Prior Authorization and Claim Inquiries

Inquiries regarding pharmacy prior authorization (PA) may be made only by the provider or patient. Inquires with regards to pharmacy claims may be made only by the prescriber, pharmacy or the patient. This information will not be shared with vendors working on behalf of a provider as neither N.C. Medicaid nor its fiscal agent, CSC, has a relationship with such vendors.

Pharmacy PA made using a service outside of NCTracks will not be accepted and will be voided. PA must be initiated by the prescriber and must use proper forms or be submitted via the NCTracks provider portal. Forms received through outside services often do not have correct information or use the wrong form when requesting a pharmacy PA.

Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Procedures for Prior Authorization of Synagis for Respiratory Syncytial Virus (RSV) Season 2015/2016

The clinical criteria used by N.C. Medicaid (Medicaid) for the 2015/2016 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the *American Academy of Pediatrics (AAP): 2015 Report of the Committee on Infectious Diseases, 30th Edition*. This guidance for Synagis® use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription. The coverage season is Nov. 1, 2015 through March 31, 2016. Providers are encouraged to review the AAP guidance prior to the start of the RSV season. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are evaluated for Synagis requests.

Guidelines for Evidenced-Based Synagis Prophylaxis

- **Infants younger than 12-months at start of season with diagnosis**
    - Prematurity: born before 29-weeks 0-days gestation
    - Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32-weeks 0-days gestation and required greater than 21 percent oxygen for at least 28 days after birth)
    - Hemodynamically significant acyanotic heart disease, receiving medication to control congestive heart failure, will require cardiac surgical procedures and moderate to severe pulmonary hypertension
    - Infants with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.
- **Infants during first year of life with diagnosis**
    - Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways

- **Infants less than 24-months of age with diagnosis**
    - Profound immunocompromise during RSV season
    - CLD of prematurity (see above definition) and continue to require medical support (supplemental oxygen, chronic corticosteroid or diuretic therapy) during six-month period before start of second RSV season
    - Cardiac transplantation during RSV season

Prior Approval (PA) Request

Submit all PA requests for coverage of Synagis during the coverage period electronically at www.documentforsafety.org. The web-based program will process PA information in accordance with the guidelines for use. A PA request can be automatically approved based on the information submitted. The program allows a provider to self-monitor the status of a request pending medical review. Up to five doses can be approved for coverage. Coverage of Synagis for neuromuscular disease or congenital anomaly that impairs ability to clear respiratory secretions from the upper airway will terminate when the beneficiary exceeds 12-months of age. Coverage of Synagis for CLD, profound immunocompromise or cardiac transplantation will terminate when the beneficiary exceeds 24-months of age.

Dose Authorization

Each Synagis dose will be individually authorized to promote efficient product distribution. Providers must submit a "**next dose request**" to obtain an authorization for each dose not exceeding the approved number of doses. Providers should ensure the previously obtained supply of Synagis is administered before submitting a next dose request. Providers will fax each single-dose authorization to the pharmacy distributor of choice.

If an infant received one or more Synagis doses prior to hospital discharge, the provider should indicate as part of the request the most recent date a dose was administered and the number of doses administered by the provider should be adjusted accordingly. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough laboratory confirmed RSV hospitalization, coverage of Synagis will be discontinued.

Pharmacy Distributor Information

Single-dose vial specific authorizations, not to exceed the maximum number of doses approved for the beneficiary, will be issued by Medicaid. It is important for the Synagis distributor to have the appropriate single-dose authorization on hand and a paid claim prior to shipping Synagis. An individual dose authorization is required for each paid

Synagis claim. The claim should not exceed the quantity indicated on the authorization. Payment for a Synagis claim will be denied if a dose request was not done by the provider.

Synagis claims processing will begin on Oct. 27, 2015 to allow sufficient time for pharmacies to provide Synagis by Nov. 1, 2015. Payment of Synagis claims with date of service before Oct. 27, 2015 and after March 31, 2016, will not be allowed. Point of sale claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to Medicaid. Claims for Synagis doses that include multiple-vial strengths must be submitted as a single compound-drug claim. Synagis doses that require multiple-vial strengths that are submitted as individual claims will be subject to recoupment. Physicians and pharmacy providers are subject to audits of beneficiary records by the N.C. Division of Medical Assistance (DMA). Maintain Synagis dose authorizations in accordance with required record keeping time frames.

Provider Information

Providers without Internet access should contact the Medicaid Outpatient Pharmacy Program at (919) 855-4300 to facilitate submission of a PA request for Synagis. More information about the Synagis program is available at www.documentforsafety.org.

Submitting a Request to Exceed Policy

The provider should use the *Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age* to request Synagis doses exceeding policy or for coverage outside the defined coverage period. The form, as well as more information about the EPSDT program, is available on DMA's EPSDT web page.

Technical Support

Technical support is available Monday to Friday from 8 a.m. to 5 p.m. am at 1-855-272-6576 (local: 919-926-3986). Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Dental Providers

Health Record Documentation and Retention

As required by state law 10A NCAC 22F.0107, providers are responsible for maintaining all records necessary to fully disclose the nature and extent of services billed to N.C. Medicaid and N.C. Health Choice (NCHC). These records must be retained for at least six years from the date of service, unless a longer retention period is required by federal or state law, regulations, or agreements.

Upon request, providers must furnish appropriate documentation including:

- Beneficiary records (chart notes including a signature by the treating dentist or auxiliary personnel)

- Supporting material (including but not limited to radiographs, photographs, models, pre-treatment narratives, operative notes, oral pathology reports, Supplement to Dental Prior Approval Forms and letters of medical necessity)

- Any information regarding payments claimed by the provider (including but not limited to ledgers, lab slips and third-party explanation of benefits)

These records may be requested by the N.C. Division of Medical Assistance (DMA), its agents, the Centers for Medicare & Medicaid Services (CMS), the Medicaid Investigations Division of the N.C. Attorney General's Office, and other entities as required by law. Providers cannot charge for records requested by N.C. Medicaid or NCHC.

The N.C. State Board of Dental Examiners applicable rule regarding patient records (21 NCAC 16T.0101) states that a dentist will maintain complete treatment records on all patients treated for a least 10 years.

HIPAA does not prohibit the release of records to N.C. Medicaid or NCHC (45 CFR 164.502).

Those with questions regarding the record retention policy can contact the DMA Dental Program.

Dental Program,
DMA, 919-855-4280

Attention: Nurse Practitioners, Physicians Assistants and Physicians

Ramucirumab (Cyramza™), HCPCS code J9999: Updated Billing Guidelines

Per the September 2014 bulletin, *Ramucirumab (Cyramza™), HCPCS code J9999: Billing Guidelines*, the N.C. Medicaid and N.C. Health Choice (NCHC) programs began coverage of Ramucirumab (Cyramza) for use in the Physician's Drug Program (PDP) with an effective date of service **May 1, 2014** when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs)

Ramucirumab (Cyramza) is commercially available in 100 mg/10 mL and 500 mg/50 mL vials.

See current ICD-9-CM diagnosis guidelines for Ramucirumab (Cyramza), HCPCS code J9999. Diagnosis and ICD-9-CM codes for Ramucirumab (Cyramza) claims are:

- Gastric and Gastroesophageal Junction Cancer:
    - 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.8, 151.9 with an effective date of May 1, 2014.
- Non-Small Cell Lung Cancer:
    - 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 with an effective date of Dec. 12, 2014.
- Colorectal Cancer:
    - 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8 with an effective date of April 24, 2015.

Pharmacy Services
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
October	10/01/15	10/06/15	10/07/15
	10/08/15	10/14/15	10/15/15
	10/15/15	10/20/15	10/21/15
	10/22/15	10/27/15	10/28/15
	10/29/15	11/03/15	11/04/15
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