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Attention: All Providers

NCTracks Updates

Prior Approval FAQs Added and Updated

Frequently Asked Questions (FAQs) related to Prior Approval (PA) have been updated on the NCTracks Prior Approval FAQ page at https://www.nctracks.nc.gov/content/public/providers/prior-approval/faqs-for-pa.html.

For answers to FAQs from other topic areas, visit the NCTracks Main FAQ page at https://www.nctracks.nc.gov/content/public/providers/faq-main-page.html.

Verify Beneficiary Eligibility through NCTracks or with NCTracks Call Center

Providers can verify beneficiary Medicaid eligibility through NCTracks. If the eligibility period is not available, providers can call the NCTracks Call Center at 1-800-688-6696. The NCTracks Call Center has the ability to check beneficiary eligibility directly from NC FAST. The Call Center can only use NC FAST to verify the eligibility of beneficiaries enrolled in N.C. Medicaid and NCHC. The other payers and health plans served by NCTracks are not currently available through NC FAST. This service enables providers to confirm beneficiary eligibility before rendering health care services. Providers must still confirm that the beneficiary's eligibility information is in NCTracks before submitting a claim, or the claim may be denied.

Providers should attempt to verify NCTracks for beneficiary eligibility information prior to contacting the Call Center. Eligibility information can be verified through NCTracks using the provider portal, the Automated Voice Response System (AVRS) at 1-800-723-4337, or a 270/271 X12 transaction. Providers should review the provider training materials in SkillPort for more guidance regarding verification of beneficiary eligibility in NCTracks.

Med Solutions PA Exceptions

PA is not required for radiology in certain circumstances, including:

- Emergency room visits
- Urgent care center visits (only for urgent care, not primary care)
- Referrals from hospital emergency departments or urgent care centers

To indicate a procedure is performed in any of the above circumstances, providers must enter the appropriate CPT code with modifier U2. If the U2 modifier is not entered on the claim, the claim will be denied indicating a MedSolutions PA is needed.

Further information regarding these guidelines can be found in Clinical Coverage Policy 1K-7, *High Tech Imaging and Ultrasound Procedure Codes*. Clinical Coverage Policies can be found on the DMA Clinical Coverage Policy Web page at www.ncdhhs.gov/dma/mp/.

CAQH CORE Phase III Operating Rules Implemented in NCTracks

The Council for Affordable Quality Healthcare (CAQH) is a nonprofit alliance of health plans and trade associations. The Committee on Operating Rules for information Exchange (CORE) is a CAQH initiative to make it easier for physicians and hospitals to access patient eligibility, benefits and claim information at the point of care.

Implementation of the CAQH CORE operating rules is mandated by the Affordable Care Act. (For more information about CAQH CORE standards, visit www.caqh.org/.) In March 2014, system changes associated with Phases I and II of the CAQH CORE standards were incorporated into NCTracks. Enhancements to Beneficiary Eligibility Inquiry and Claim Status were made to the secure NCTracks Provider Portal, HIPAA X12 transactions, and the Automated Voice Response System (AVRS). For more information regarding the Phase I and II enhancements, see the NCTracks March 24, 2014 announcement titled *Updates to Recipient Eligibility Inquiry and Claim Status for CAQH CORE* at https://www.nctracks.nc.gov/content/public/providers/provider-communications/provider-announcements/CAQH-CORE-Phase-I-and-II-Now-Live.html

NCTracks has implemented the next phase (Phase III) of CAQH CORE rules, which provides access to more data and transactions, as summarized below:

- NCTracks can now support the CAQH CORE Connectivity Rule for transmission of the 835 and 820 X12 transactions, along with the 270/271 and 276/277 X12 transactions which were implemented in Phases I and II. This includes a provision for retransmission of 835 and 820 X12 transactions generated within the previous 90 days.

- To support CORE rules functionality, NCTracks now generates the 277P, 820, 834, and 835 X12 transactions by provider NPI/Atypical ID rather than by Transmission Supplier Number (TSN), as was done previously.

- Trading Partners and providers now have the ability to delete files from their mailboxes.

- There is a new Trading Partner Roles Page in the NCTracks secure Provider Portal for user provisioning associated with CAQH CORE. Any existing CAQH CORE transaction roles will need to be re-established using the new Trading Partner Roles Page.

In addition, the Electronic Funds Transfer (EFT) enrollment process and the Electronic Remittance Advice (ERA or 835 X12 transaction) on the Secure Provider Portal were

modified to match CAQH CORE standards. However, existing providers do **not** need to make any changes to their EFT or ERA enrollment.

The CAQH CORE changes in NCTracks do not affect delivery of the paper remittances to the provider Message Center Inbox or delivery of standard X12 files to provider mailboxes.

The NCTracks Connectivity Guide, as well as the Companion Guides for the 835 and 820 X12 transactions, were updated to reflect changes associated with CAQH CORE. The Guides can be found on the NCTracks Trading Partner Information page at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html. More detailed information was sent separately to Trading Partners.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Update: ICD-10

New CMS "Road to 10" Webcasts

The U.S. Department of Health and Human Services (HHS) issued a rule on July 31, 2014, which finalized **October 1, 2015** as the new compliance date for health care providers, plans, and clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

The Centers for Medicare & Medicaid Services (CMS) created the “Road to 10” to help providers prepare for the transition to ICD-10. CMS has posted several Webcasts in its “Road to 10” series, including:

- Introducing the “Road to 10”
- Training and Preparation on the “Road to 10”
- Clinical Documentation and Coding on the “Road to 10”
- Risk Management on the “Road to 10”

To access these Webcasts, visit CMS “Road to 10” Web page at www.roadto10.org/roadto10-webcasts/.

Providers are encouraged to take advantage of these resources. Additional information on ICD-10 will be posted on the NCTracks Provider Portal and in the Medicaid Bulletin.

CSC, 1-800-688-6696

Attention: All Providers

Procedures for Prior Authorization of Synagis for Respiratory Syncytial Virus (RSV) Season 2014/2015

The clinical criteria used by N.C. Medicaid for the 2014/2015 Respiratory Syncytial Virus (RSV) season are consistent with guidance published online July 28, 2014 by the American Academy of Pediatrics (AAP) Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. This revised guidance for Synagis use among infants and children at increase risk of hospitalization for Respiratory Syncytial Virus (RSV) infection found at http://pediatrics.aappublications.org/content/134/2/415.full.html **replaces** the *2012 Red Book 29th edition* recommendations.

NOTE:

- The coverage season is November 1, 2014 through March 31, 2015.
- **Prior authorization (PA) is required for N.C. Medicaid coverage of Synagis.**
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are considered for Synagis requests.
- The updated guidelines narrow the criteria for evidence-based use of Synagis. Providers are encouraged to review the new AAP guidance prior to the start of the RSV season.

Updated Guidelines for Evidenced-Based Synagis Prophylaxis

A. Infants younger than 12 months at start of season with diagnosis:

1. 1. Prematurity – Born before 29 weeks 0 days gestation

2. 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)

3. Hemodynamically significant acyanotic heart disease and receiving medication to control congestive heart failure which will require cardiac surgical procedures and; moderate to severe pulmonary hypertension.

4. Infants with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.

B. Infants during first year of life with diagnosis:

1. Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways

C. Infants less than 24 months of age with diagnosis:

1. Profound immunocompromise during RSV season

2. CLD of prematurity (see above definition) and continue to require medical support (supplemental oxygen, chronic corticosteroid or diuretic therapy) during 6 month period before start of second RSV season

3. Cardiac transplantation during RSV season

PA Request

Submit all PA requests for coverage of Synagis during the coverage period electronically to www.documentforsafety.org. The Web-based program will process PA information in accordance with the updated criteria. A PA request can automatically approve based on the criteria 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. After the initial approval, providers must submit a "***next dose request***' to obtain an authorization for each subsequent dose up to 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 their 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 an 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, up to the maximum number of doses approved for the beneficiary, will be issued by the N.C. Division of Medical Assistance (DMA). 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 October 28, 2014 to allow sufficient time for pharmacies to provide Synagis by November 1, 2014. Payment of Synagis claims with date of service before October 28, 2014 and after March 31, 2015, 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 DMA.

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 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 is available on DMA's EPSDT Web page at www.ncdhhs.gov/dma/epsdt/. Information about EPSDT coverage can also be found on DMA's EPSDT Web page.

Technical Support

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

Outpatient Pharmacy
DMA, 919-855-4300

All Providers

Current Status of A+KIDS Program

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Starting in November 2014, safety documentation for A+KIDS (Antipsychotics - Keeping It Documented for Safety) will be transitioning into the NCTracks Provider Portal Website, an online system where providers can submit prior approval requests. The last date that providers will be able to submit A+KIDS safety documentation through www.documentforsafety.com is **October 31, 2014.** The A+KIDS fax form will also remain available.

A widespread educational effort about A+KIDS safety documentation will occur when the NCTracks Provider Portal begins accepting A+KIDS requests.

History of A+KIDS

In April 2011, the N.C. Division of Medical Assistance partnered Community Care of North Carolina to implement a registry to document the use of antipsychotic therapy in N.C. Medicaid and N.C. Health Choice beneficiaries ages 0 through 17. A+KIDS was created due to well-documented safety concerns and limited information about the efficacy of using antipsychotic agents in children. A+KIDS encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population.

Outpatient Pharmacy
DMA, 919-855-4300

All Providers

Preferred Drug List (PDL) Changes are Posted for Public Comment

The PDL changes for 2014-2015 are open for public comment. Submit comments at www.ncdhhs.gov/dma/mpproposed/. This list will be reviewed at the PDL Public Panel meeting. Details for this meeting will be posted at www.ncdhhs.gov/dma/pharmacy/pdl.htm when finalized.

Outpatient Pharmacy
DMA, 919-855-4300

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 N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy Website at www.ncdhhs.gov/dma/mp/:

- 1E-7, Family Planning Services (10/1/14)
- 10A, Outpatient Specialized Therapies (10/1/14)
- 10B, Independent Practitioners (IP) (10/1/14)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Enrollment Criteria for Ordering, Prescribing and Referring (OPR) Providers

Notice to Providers: This article originally ran in August 2014 with the title "Providers Not Enrolled in Medicaid."

42 CFR 455.410 requires that all Ordering, Prescribing and Referring (OPR) physicians – as well as other professionals providing services under the N.C. Medicaid, N.C. Health Choice (NCHC) or their respective waiver programs – be enrolled as participating providers. This includes anyone who orders, refers, or prescribes services or items (such as pharmaceuticals) to N.C. Medicaid and NCHC beneficiaries and seeks reimbursement.

The National Provider Identifier (NPI) of the OPR health care professional must be included in all claims for payment.

More information for OPR professionals can be found on the N.C. Division of Medical Assistance (DMA) Provider Enrollment Web page at www.ncdhhs.gov/dma/provenroll/.

Enrollment criteria are being developed for providers with taxonomy codes that are not currently being processed by NCTracks. Future updates will be posted on the N.C. Division of Medical Assistance (DMA) Website and announced via the NCTracks Provider Portal.

Provider Relations
DMA, 919-855-4050

Attention: Pharmacists and Providers

Prescribers Not Enrolled in Medicaid

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

The Affordable Care Act (ACA) established a new rule that prohibits Medicaid and Children's Health Insurance Programs [such as N.C. Health Choice (NCHC)] from paying for prescriptions written by prescribers who are not enrolled in N.C. Medicaid and NCHC programs.

On January 1, 2013, pharmacy providers began to receive a message at point-of-sale for prescriptions written by prescribers not enrolled in the N.C. Medicaid program. The edit, 00951, states "M/I Presc ID – No ID on File" with an Explanation of Benefit (EOB) 02951 message "Prescriber NPI not on file. Contact prescriber and refile with Correct NPI."

Prescription claims that are written by prescribers not enrolled in N.C. Medicaid or NCHC will be denied starting on November 1, 2014. This will hold true for original prescriptions and refills.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: 'Be Smart' Family Planning Service Providers

'Be Smart' Program Transitions from Waiver to State Plan Amendment

An amendment to the Medicaid State Plan was approved by the Centers for Medicare & Medicaid Services (CMS) to convert the "Be Smart" Family Planning Waiver - to the "Be Smart" Family Planning Program, **effective October 1, 2014**.

The name change reflects that the program is no longer a waiver (demonstration), but the "Be Smart" designation will be maintained to minimize confusion.

Under the "Be Smart" program, eligible beneficiaries receive basic family planning services and supplies: annual exams and physicals, most FDA-approved birth control, screenings and treatment for sexually transmitted infections, screening for HIV, and sterilizations for both women and men.

Changes to the "Be Smart" program associated with the State Plan Amendment include:

- Expanded coverage to include the same family planning services and supplies that general (full-coverage) Medicaid beneficiaries receive. The program will continue to cover one annual exam or physical per year and up to six inter-periodic visits per year.

- Removal of eligibility restrictions based on age. It will cover family planning services and supplies to all individuals who meet the state's income and other eligibility guidelines.

- Expanded coverage, screening and treatment for sexually transmitted infections (STI) and screening for HIV, which can occur at any of the six inter-periodic family planning visits per year. Under the Waiver, screening and treatment for STIs and screening for HIV was limited to one visit and one course of treatment per year, all of which were required to be performed in conjunction with, or pursuant to, the annual exam.

- Coverage of non-emergency medical transportation to and from family planning appointments. This service was not previously covered under the Waiver.

Examples of services **not** covered under the new program are:

- Emergency room visits

- Ambulance services

- Inpatient hospital services

- Treatment for complicated women's health care problems, such as endometriosis

- Non-family planning services, including psychological and psychiatric services, infertility services, hysterectomies, abortions, AIDS and cancer treatment, dental and optical services, chiropractic services, or services required to manage or treat a medical condition, such as diabetes or hypertension, and,

- Other health care problems discovered during a screening, such as breast lumps.

Eligible beneficiaries of the new family planning program will have incomes of no greater than 195% of the federal poverty level. There are no co-payments for the "Be Smart" program.

More information about the "Be Smart" Family Planning Program can be found on DMA's Family Planning Web page at http://www.ncdhhs.gov/dma/services/familyplanning.htm.

'Be Smart' Family Planning Program
DMA, 919-855-4260

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers

Intensive In-Home Service

To comply with Session Law 2014-100, the N.C. Division of Medical Assistance (DMA) is mandated to modify the service definition for Intensive In-home Service (IIH) for the Medicaid Fee-for-Service (FFS) and N.C. Health Choice (NCHC) programs to reflect a **team-to-family ratio of one IIH team to 12 families**.

Due to the increased billing capacity for each team, this change in the service definition results in a decrease in the current per diem reimbursement rate of $258.20. After completing a rate analysis of this policy change and reviewing stakeholder input, **a revised rate of $239.66 has been established.**

The required State Plan Amendment (SPA) for this change has been posted to DMA's State Plan Web page at www.ncdhhs.gov/dma/plan/. If CMS approves the SPA, the new rate and policy change will go into effect on the CMS approval date.

The Local Management Entities – Managed Care Organizations (LME-MCOs) are responsible for the management and reimbursement of behavioral health services for N.C. Medicaid beneficiaries aged 3 and over and have the flexibility to set reimbursement rates.

DMA, Clinical Policy and Programs, 919-855-4260
DMA, Rate Setting, 919-814-0070

Attention: LME/MCO, Physicians and Psychiatric Hospitals

Communication Points Regarding Medical/Psychiatric In-Patient Cases

Prior Approval (PA) Reviews for Psychiatric Inpatient Stays

Hospitals are required to seek Prior Approval (PA) for psychiatric admissions from Value Options for N.C. Health Choice (NCHC) beneficiaries and for N.C. Medicaid beneficiaries age 3 and younger. Local Management Entities/Managed Care Organizations (LME/MCOs) are required to conduct PA reviews for all other psychiatric inpatient stays.

These PA requirements include hospitalization of beneficiaries who receive primarily psychiatric treatment on a medically designated floor, rather than a psychiatric floor. PA should not be denied based on bed type, as some facilities have no psychiatric beds. In cases where it is unclear whether the stay will be for psychiatric reasons until later in the hospitalization, the LME/MCO must conduct a retrospective review of the case.

Correct Coding

Claims billed to NCTracks that are classified in a psychiatric Diagnosis-Related Group (DRG) will be denied and the provider will be instructed to bill the LME/MCO. If the claim classifies to a psychiatric DRG, all discussions concerning the admission should be with the respective LME/MCO. Compliance with N.C. Division of Medical Assistance (DMA) policy requires that National Correct Coding Initiative (NCCI) guidelines be applied during claims processing. The first diagnosis listed must be the primary reason for admission. Some claims are denied through NCTracks as psychiatric because the diagnoses are filed numerically, causing the claim to appear to be psychiatric when it is medical in nature.

Split Claims

If an N.C. Medicaid or N.C. Health Choice (NCHC) beneficiary is admitted to a hospital for medical reasons, but requires inpatient psychiatric services after the medical conditions are managed, the admission must be split. The beneficiary should be discharged from the acute hospital and those claims submitted to NCTracks, then the beneficiary should be admitted for inpatient psychiatric care. The psychiatric portion of the claim should receive PA from the MCO and be billed (upon discharge) to the MCO.

Requests for Justifiable Overrides of the NCTracks Edit Requiring PA for Psychiatric Diagnosis

Edit 00232 triggers the need for authorization by the behavioral health LME/MCO and refers the provider to submit claims to the LME/MCO. If the LME/MCO's medical director has reviewed a case and believes it is medical rather than psychiatric, the MCO may send the denied claim, documentation and rationale for denial to the N.C. Division of Medical Assistance (DMA) for reconsideration review. Send reconsideration review requests to Monica Hamlin at:

Email: monica.hamlin@dhhs.nc.gov

Fax: 919 715-9451

Mail:
Division of Medical Assistance
Behavioral Health Section
2501 Mail Service Center
Raleigh, NC 27699-2501

Cases sent by hospitals to DMA for review, without LME/MCO review and denial, will be returned.

Behavioral Health
DMA, 919-855-4289

Attention: Nurse Practitioners, Physician Assistants and Physicians

Siltuximab injection (Sylvant™), HCPCS code J3590: Billing Guidelines

Effective with date of service July 1, 2014, the N.C. Division of Medical Assistance (DMA) covers siltuximab injection (Sylvant™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 (unclassified biologics). Sylvant™ is currently commercially available in 100 mg and 400 mg vials.

Siltuximab injection (Sylvant™) is indicated for Multicentric Castleman's disease (MCD) in patients who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative. The recommended dosage for siltuximab injection (Sylvant™) as an 11 mg/kg dose given over 1 hour by intravenous infusion every 3 weeks.

For N.C. Medicaid and N.C. Health Choice (NCHC) Billing

- The ICD-9-CM diagnosis codes required for billing siltuximab injection (Sylvant™) are 229.0 Benign neoplasm of lymph nodes, 238.79 Other lymphatic and hematopoietic issues, and 785.6 Enlargement of lymph nodes.
- Providers must bill Sylvant™ with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One N.C. Medicaid or NCHC unit of coverage for Sylvant™ is 1 mg .The maximum reimbursement rate per mg is $8.9964. One 100 mg vial contains 100 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Sylvant™ 100 mg and 400 mg vials are 57894-0420-01 and 57894-0421-01.
- The NDC units for siltuximab injection (Sylvant™) should be reported as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's Medicaid Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge.
- The fee schedule for the PDP is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Dalbavancin hydrochloride (Dalvance™), HCPCS code J3490: Billing Guidelines

Effective with date of service July 1, 2014, the N.C. Division of Medical Assistance (DMA) covers dalbavancin hydrochloride (Dalvance™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 unclassified drugs. Dalvance™ is currently commercially available in 500 mg vials.

Dalbavancin hydrochloride (Dalvance™) is indicated for acute bacterial skin and skin structure infections (ABSSSI). The recommended dosage for dalbavancin hydrochloride (Dalvance™) is a two-dose regimen; 1000 mg followed one week later by 500 mg.

For N.C. Medicaid and N.C. Health Choice (NCHC) Billing

- The ICD-9-CM diagnosis codes required for billing dalbavancin hydrochloride (Dalvance™) are 680 – 686 Infections of Skin and Subcutaneous Tissue.
- Providers must bill Dalvance™ with HCPCS code J3490 unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One N.C. Medicaid or NCHC unit of coverage for Dalvance™ is 1 mg .The maximum reimbursement rate per mg is $3.2184. One 500 mg vial contains 500 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Dalvance™ 500 mg vials is 57970-0100-01.
- The NDC units for dalbavancin hydrochloride (Dalvance™) should be reported as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's Medicaid Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Tedizolid phosphate injection (Sivextro™), HCPCS code J3490: Billing Guidelines

Effective with date of service July 1, 2014, the N.C. Division of Medical Assistance (DMA) covers tedizolid phosphate injection (Sivextro™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 (unclassified drugs). Sivextro™ is currently commercially available in 200 mg vials.

Tedizolid phosphate injection (Sivextro™) is indicated for acute bacterial skin and skin structure infections (ABSSSI). The recommended dosage for tedizolid phosphate injection (Sivextro™) is 200 mg administered once daily as an intravenous (IV) infusion over 1 hour for six (6) days.

For N.C. Medicaid and N.C. Health Choice (NCHC) Billing

- The ICD-9-CM diagnosis codes required for billing tedizolid phosphate injection (Sivextro™) are 680-686 Infections of Skin and Subcutaneous Tissue.
- Providers must bill Sivextro™ with HCPCS code J3490 (unclassified drugs).
- Providers must indicate the number of HCPCS units.
- One N.C. Medicaid or NCHC unit of coverage for Sivextro™ is 1 mg .The maximum reimbursement rate per mg is $1.2690. One 200 mg vial contains 200 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Sivextro™ 200 mg vials is 67919-0040-01.
- The NDC units for tedizolid phosphate injection (Sivextro™) should be reported as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's Medicaid Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Coagulation factor VIII (recombinant), Fc fusion protein (Eloctate™), HCPCS code J7199: Billing Guidelines

Effective with date of service July 1, 2014, the N.C. Division of Medical Assistance (DMA) covers coagulation factor VIII (recombinant), Fc fusion protein (Eloctate™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 Hemophilia clotting factor, not otherwise classified. Eloctate™ is currently commercially available in 250 IU, 500 IU, 750 IU, 1000 IU, 1500 IU, 2000 IU, and 3000 IU vials.

Coagulation factor VIII (recombinant), Fc fusion protein (Eloctate™) is indicated for hemophilia A (congenital Factor VIII deficiency). The recommended dosage for coagulation factor VIII (recombinant), Fc fusion protein (Eloctate™) is split into two dosing calculations depending on whether it is for a bleeding episode or routine prophylaxis.

1. Dosing formula for bleeding episodes and perioperative management:
    a. Estimated Increment of Factor VIII (IU/dL or % of normal) = [Total Dose (IU)/body weight (kg)] x 2 (IU/dL per IU/kg), **OR,**
    b. Required Dose (IU) = Body Weight (kg) x Desired Factor VIII Rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL)

2. Dosing for routine prophylaxis:

    a. 50 IU/kg every 4 days; it may be adjusted based on patient response with dosing in the range of 25-65 IU/kg at 3-5 day intervals. More frequent or higher doses up to 80 IU/kg may be required in children less than 6 years of age.

For N.C. Medicaid and N.C. Health Choice (NCHC) Billing

- The ICD-9-CM diagnosis code required for billing coagulation factor VIII (recombinant), Fc fusion protein (Eloctate™) is 286.0 Congenital FVIII disorder.
- Providers must bill Eloctate™ with HCPCS code J7199 Hemophilia clotting factor, not otherwise classified.
- Providers must indicate the number of HCPCS units.
- One N.C. Medicaid or NCHC unit of coverage for Eloctate™ is 1 IU. The maximum reimbursement rate per IU is $2.142. One 250 IU vial contains 250 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Eloctate™ 250 IU, 500 IU, 750 IU, 1000 IU, 1500 IU, 2000 IU, 3000 IU vials are 64406-0801-01, 64406-0802-01, 64406-0803-01, 64406-0804-01, 64406-0805-01, 64406-0806-01, and 64406-0807-01, respectively.

- The NDC units for coagulation factor VIII (recombinant), Fc fusion protein (Eloctate ™) should be reported as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's Medicaid Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: OB/GYN Providers

Sterilization Consent Forms and Hysterectomy Statements: Reminders

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

1. N.C. Division of Medical Assistance (DMA) Clinical Coverage Policies (CCP) and Medicaid Bulletin guidelines and regulations are not being followed. The CCPs for sterilization procedures (1E-3, *Sterilization Procedures*) and hysterectomies (1E-1, *Hysterectomy*) are located on the DMA Clinical Policy Web page at www.ncdhhs.gov/dma/mp/.

2. All signatures on both Sterilization Consent Forms and Hysterectomy Statements must be legible. Signatures that are illegible should have a printed version of the person's name above or below the signature. If there is any question of legibility of a signature, ensure there is a printed name on the consent form prior to submitting it to CSC for review.

3. It is the responsibility of the surgeon to send Sterilization Consent Forms and Hysterectomy Statements to CSC. Hospitals, anesthesiologists, pathology services, and other ancillary providers should **never** send Sterilization Consent Forms and Hysterectomy Statements to CSC. **The National Provider Identifier (NPI) of the rendering provider (surgeon) shall be the only acceptable NPI for Sterilization Consent Forms and Hysterectomy Statements.**

4. Rendering providers (surgeons) should submit Sterilization Consent Forms and Hysterectomy Statements within 30 days after the procedure for review and approval.

5. Sterilization Consent Forms and Hysterectomy Statements should **not** be submitted electronically with the claim at this time. All Sterilization Consent Forms and Hysterectomy Statements shall be mailed to:

   CSC
   P.O. Box 30968
   Raleigh, NC 27622

CSC, 1-800-688-6696

Attention: Physicians

3 Percent Rate Reduction Update for Physicians Only

Note: This article updates a January 2014 Medicaid Bulletin article titled *3 Percent Rate Reduction,* which can be found at www.ncdhhs.gov/dma/bulletin/0114bulletin.htm#shared.

As required by N.C. Session Law 2013-360, the N.C. Department of Health and Human Services (DHHS) submitted N.C. State Plan Amendment (SPA) 14-012 to the Centers for Medicare & Medicaid Services (CMS) requesting approval to implement a three percent rate reduction for physician services **effective January 1, 2014**. CMS approved SPA 14-012 on June 27, 2014.

Primary care providers who have attested for the enhanced reimbursement under the Affordable Care Act (ACA) are excluded from this three percent rate reduction until January 1, 2015.

Due to the changes required to separate the primary care ACA physicians from the non-ACA physicians, the reimbursement rates to the non-ACA physicians have not been implemented in the NCTracks claims processing system.

Beginning October 26, 2014, NCTracks will process all claims for non-ACA physicians at the new reimbursement rate, which is equal to 97 percent of the previous reimbursement rates.

Claims with dates of service January 1, 2014 through October 26, 2014 will be reprocessed at a later date. DMA will provide updates and additional details in upcoming Medicaid bulletins, stakeholder meetings and via Webinars.

Provider Reimbursement
DMA, 919-814-0060

Attention: Home, Adult, and Family Care Home Providers; Supervised Living Homes Billing PCS Services

Personal Care Services (PCS) Update

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

Reprocessing of PCS Claims

In September 2014, NCTracks began reprocessing Personal Care Services (PCS) claims from October 1, 2013, to May 22, 2014, to recover the reduction in reimbursement rates for PCS services associated with N.C. State Plan Amendments 13-009 and 14-009. The details of the reprocessing plan are outlined in a letter to affected PCS providers, which was posted to their Message Center Inbox in the NCTracks secure Provider Portal on Friday, August 22, 2014.

Prior to the September 9, 2014 checkwrite, PCS providers received letters stating their estimated total payment adjustment amount. All amounts owed to the N.C. Division of Medical Assistance (DMA) that are not satisfied within 30 days from the Systematic Payment Adjustment begin date will incur penalty and interest.

Systematic Payment Adjustments began with the September 9 checkwrite and will continue through April 2015. The adjustments apply to claims with Dates of Service from October 1, 2013 through May 22, 2014.

Month of Service	Date of Service Begin Date	Date of Service End Date	Systematic Payment Adjustment Begin Date
October 2013	October 1, 2013	October 31, 2013	September 9, 2014
November 2013	November 1, 2013	November 30, 2013	October 7, 2014
December 2013	December 1, 2013	December 31, 2013	November 12, 2014
January 2014	January 1, 2014	January 31, 2014	December 9, 2014
February 2014	February 1, 2014	February 28, 2014	January 2015[1]
March 2014	March 1, 2014	March 31, 2014	February 2015
April 2014	April 1, 2014	April 30, 2014	March 2015
May 2014	May 1, 2014	May 22, 2014	April 2015

[1] Check-write calendar for calendar year 2015 is not available. Dates for 2015 adjustments will be confirmed once available.

Providers can pay the balance owed to DMA at any point in the adjustment process by sending a check to:

Miscellaneous Medicaid Payments
PO Box 602885
Charlotte, NC 28260-2885

Send only one check per National Provider Identifier (NPI) or funds will not be posted correctly. Payments will be posted to accounts faster if they are submitted with the accounts receivable page from the remittance advice statement. Checks will be placed in a lockbox.

Additional information regarding the PCS Payment Adjustment is available on DMA's PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html.

QiReport - PCS Provider Interface – Mandatory Registration

Registration on the QiReport Provider Interface is REQUIRED for all PCS Providers. The PCS QiReport Provider Interface is a Web-based information system to support PCS Independent Assessments. The interface helps collect, store, and communicate beneficiary information such as decision notices, change of status assessment request, discharge reporting and the independent assessments required to develop beneficiary plans of care.

To register, providers must complete the QiReport Registration form, which is available on the DMA PCS Web page under "Forms" and at www.QiReport.net. Once the registration form is complete, send it to VieBridge, Inc. QiReport Support:

By Fax: 919- 301-0765

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

On-line Plan of Care

DMA plans to implement the PCS On-line Plan of Care (POC) effective November 1, 2014. Providers must use QiReport to access the independent assessments necessary to develop the beneficiaries' On-Line POC. An introduction to the On-line POC tool will be provided during Fall Regional Trainings.

PCS Provider Regional Training Sessions

Fall regional training sessions will be held October 13-27, 2014. Additional trainings will be announced on DMA's PCS Web page. Those with questions or suggestions for training topics can contact DMA at 919-855-4340 or Liberty Healthcare Corporation-NC at 1-855-740-1400 or www.nc-pcs.com. Registration is required.

Monday, October 13, 2014 – Asheville
Doubletree by Hilton – Biltmore, *Burghley Room*

Tuesday, October 21, 2014 – Greenville
City Hotel and Bistro – *Ballroom*

Wednesday, October 22, 2014 – Raleigh
James S. McKimmon Conference and Training Center – NC State University

Monday, October 27, 2014 – Wilmington
Holiday Inn/Wrightsville Beach **–** *Lumina Ball Room*

Wednesday, October 29, 2014 – Charlotte
Great Wolf Lodge Convention Center – *White Pine 2 & 3 Room*

Thursday, October 30, 2014 – Winston Salem
Embassy Suites Winston Salem – *Grand Pavilion Room*

PCS Beneficiary Discharge Process

Section 5.4.5(c) of Clinical Coverage Policy 3L – *Personal Care Services*, requires that PCS providers report discharges to the Independent Assessment Entity (IAE) within 30 calendar days of a beneficiary's discharge. Providers enrolled on QiReport can save time by reporting beneficiary discharges via the QiReport Provider Interface. Instructions are available on the provider interface. Clinical coverage policies can be found on the DMA clinical coverage policy Web page at www.ncdhhs.gov/dma/mp/.

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

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to:

Richard K. Davis
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2014 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
October	10/02/14	10/07/14	10/08/14
	10/09/14	10/15/14	10/16/14
	10/16/14	10/21/14	10/22/14
	10/23/14	10/28/14	10/29/14
	10/30/14	11/04/14	11/05/14
November	11/06/14	11/12/14	11/13/14
	11/13/14	11/18/14	11/19/14
	11/20/14	11/25/14	11/26/14
	11/27/14	12/02/14	12/03/14

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

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

Paul Guthery
Executive Account Director
CSC