October 2015 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates

Determining the Right ICD-10 Code

Providers can use the NCTracks ICD-10 Crosswalk and, after October 1, the DMA policies to determine the correct ICD-10 code**. Neither the agents in the NCTracks Contact Center, CSC staff, or any Division of Medical Assistance (DMA) employee can determine what the right diagnosis code is for any particular situation. Determining the correct diagnosis code can only be done by a medical professional.**

Clarification of Letters Terminating Unused Atypical Provider Number

Termination letters are being sent to atypical providers who never completed the Currently Enrolled Provider (CEP) registration process. In other words, their Atypical Provider Numbers were never validated in NCTracks and have not been used in the system in over two years. The first batch of letters was sent June 26, 2015. Additional batches will follow.

Some providers may have had both an Atypical Provider Number and an NPI. **This activity does not affect active NPIs.** Only Atypical Provider Numbers that were never validated in NCTracks and have not been used in the system in over two years are being terminated. Providers can find the affected Atypical Provider Number in the upper-right corner of the letter.

NCTracks Re-credentialing Notices – Update

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicaid providers are re-credentialed at least every five years. DMA is reviewing the status of enrolled providers to ensure compliance.

Providers will receive the re-credentialing notice as both a letter from the U.S. Postal Service and as a notice in the Message Center Inbox on the secure NCTracks Provider Portal. The notices are sent out when re-credentialing is due. Due dates are specific to each provider. Therefore, all providers will **not** receive notices at the same time. (This is not a new process.)

It is crucial that all providers who receive notices promptly begin the re-credentialing process. All N.C. Medicaid and N.C. Health Choice (NCHC) providers are **required** to re-credential every five years as part of the N.C. Division of Health and Human Services (DHHS) Provider Administrative Participation Agreement.

The process is not optional. **If it is not completed, the provider record may be subject to termination. Providers who have received a notice, but have not started the process, should not wait for a second notice.**

Providers who believe they have received a notice by mistake should immediately notify DMA using the contact information included in the notice.

Session Law 2011-145 Section 10.31(f)(3) mandated that DMA collect a $100 enrollment fee from providers upon initial enrollment with the Medicaid/NCHC programs, upon program re-enrollment and when the providers are re-credentialed.

Note: Re-credentialing does not apply to any time-limited enrolled providers such as out-of-state (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.

Physician Drugs: 1 Percent Rate Reduction

As required by the N.C. Session Law 2014-100, DHHS submitted N.C. State Plan Amendment (SPA) 14-021 to CMS requesting approval to implement a 1 percent rate reduction for physician drugs effective Jan. 1, 2015.

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

On Aug. 19, 2015, NCTracks began reimbursing all claims for physician drug services rendered to N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries at the new 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 Jan. 1, 2015, through the rate implementation date, will be reprocessed at a later time. DMA will provide updates in future Medicaid bulletins.

(This article was reprinted from the August 2015 Medicaid Bulletin article, *Physician Drugs: 1 Percent Rate Reduction*, with the implementation date added.)

Identification Required by NCTracks Contact Center

To comply with HIPAA guidelines and protect the privacy of those who receive DHHS services, the NCTracks Contact Center is required to verify the identity of all callers.

In order for the Contact Center to provide any information to a caller, customer service agents (CSAs) are required to verify two of the following five pieces of information:

1. National Provider Identifier (NPI)
2. Atypical Provider ID
3. Address and Phone Number
4. Provider Legal Name
5. Primary Email

In addition, if the caller is not the provider, the CSAs are required to record the first and last name of the caller, telephone number, and relationship to the provider. (See the Dec. 6, 2013, NCTracks newsletter.) Callers who cannot verify two pieces of information or do not provide the required contact information will not be assisted.

Note: With the recent update to the NCTracks "Organization Name" field on provider records, callers must remember to provide the legal name for NPIs that share the same Taxpayer Identification Number (TIN), as reflected on the provider record in NCTracks.

Electronic Delivery of PS&R Summary Reports

Provider Statistical and Reimbursement (PS&R) reports accumulate statistical and payment data for hospital providers. The PS&R reports are used to create the annual cost reporting submitted by hospital providers participating in the Medicaid program.

NCTracks now provides electronic delivery of *PS&R Summary Reports*. The *PS&R Summary Report* is automatically generated 90 days following the end of the fiscal year listed in the NCTracks provider record. The first reports (per the new electronic posting process) were generated in the Aug. 11, 2015, checkwrite.

When the *PS&R Summary Report* has been generated, a message will be posted to the Message Center Inbox in the secure NCTracks Provider Portal with a link to access the report. This is the same approach currently used with the paper Remittance Advice (RA) after each checkwrite.

The *PS&R Summary Report* will be in PDF format. Clicking on the link in the Message Center Inbox will allow the provider to read, print or download the report. Everyone who has an NCID with access to the NPI in the secure NCTracks Provider Portal will be able to view the PS&R Summary Report.

This delivery mechanism for the *PS&R Summary Reports* does not affect the process in place for request and delivery of *PS&R Detailed Reports*. See the March 13, 2015, NCTracks announcement for more information on the *PS&R Detailed Report* process.

Updates to Modifiers

On July 19, 2015, the following CPT modifiers were added to NCTracks as an acceptable modifier to use with the NCCI Procedure-to-Procedure (PTP) edits as indicated in the January 2013 Medicaid Bulletin article *National Correct Coding Initiative: Additional Procedure-to-Procedure (PTP) Modifiers*.

24 -Unrelated evaluation and management service by the same physician during a postoperative period
57 - Decision for surgery

If appropriate, where a modifier is allowed with a NCCI PTP code pair, modifiers 24 and 57 can now be used. For more information about the National Correct Coding Initiative (NCCI) in Medicaid, see the CMS website. Providers who billed with modifiers 24 or 57 and had claims denied with EOB 49270 – NCCI EDIT or 49280 - NCCI OUTPATIENT HOSPITAL SERVICES EDIT can resubmit the claims.

In addition, the January 2015 Medicaid Bulletin, *National Correct Coding Initiative: New PTP-Associated Modifiers*, included an article about four new PTP-associated "X" modifiers to be used in the place of modifier 59. **On Aug. 11, 2015**, changes were made in NCTracks to accommodate the new "X" modifier combinations. **For dates of service on or after Jan. 1, 2015,** the "X" modifiers may now be used, when appropriate, in lieu of modifier 59. Providers who billed with one of these "X" modifiers on these dates of service and had claims denied with EOB 07701 - COMBINATION OF BILLED MODIFIERS IS INVALID. PLEASE REVIEW AND RESUBMIT WITH CORRECT BILLING COMBINATION can resubmit the claims.

(This is an update to the May 19, 2015, announcement posted on NCTracks.)

Disclosure of CCNC/CA PCP Information

To adhere to the DHHS approved process for patient referrals, the NCTracks Operations Contact Center can only verify names, addresses and telephone numbers for Community Care of N.C./Carolina ACCESS (CCNC/CA) primary care physician (PCP) referrals. An NPI cannot be given out or confirmed.

Providers can also obtain CCNC/CA PCP information using the secure NCTracks Provider Portal or the Automated Voice Response System (AVRS) at 1-800-723-4337. As when calling the Contact Center, the provider must have the Recipient ID and date of service to access the information on the portal or AVRS. The information provided is the same – name, address, and telephone number for the CCNC/CA PCP. (Those without access to the NCTracks Provider portal should contact their Office Administrator.)

To obtain the NPI for the CCNC/CA PCP, use the name, address or telephone number to contact the referring provider directly. This is essential to avoid submitting inaccurate claims.

For more information regarding the process for patient referrals, visit the DMA Community Care of North Carolina/Carolina ACCESS web page.

New Prior Approval (PA) Forms for Hepatitis C Medications

There are several methods by which Prior Approval (PA) requests for hepatitis C medications can be submitted to NCTracks, including the secure provider portal, fax and mail. New forms for requesting PA for the hepatitis C medications have been posted to the NCTracks website on the Drug Request Forms web page under the heading "Temporary Hepatitis C Forms." New hepatitis C forms and supporting documentation are required for all methods of PA submission for hepatitis C medications.

PA for hepatitis C medications can be requested via the secure provider portal using Drug Type:

- Preferred for Viekira, or
- Non-Preferred for the other hepatitis C agents.

When submitting a PA request for hepatitis C medications via the NCTracks portal, the required forms and documentation must be uploaded using the attachment feature. Requesting these

medications through the provider portal is the fastest and most efficient method for obtaining PA. Refer to the User Guides page on the NCTracks provider portal for *How to Submit Prior Approval Attachments in NCTracks* under the heading "Prior Approval."

When submitting a PA request for hepatitis C medications by fax or mail, providers must submit the Standard PA Request Form as the top page followed by the required new hepatitis C form and documents indicating criteria has been met. (The Standard Prior Approval Request Form also can be found on the NCTracks Drug Request Forms web page.) The hepatitis C form and documents should be the second and subsequent pages in the fax or mailed package. Only submit one PA request per fax.

Note: When requesting Daklinza for genotype 3 HCV, also send a request for Sovaldi. Both medications are required for genotype 3 and each requires a separate PA.

PA for hepatitis C medications requires that the provider submit medical records and documentation of the diagnosis of chronic hepatitis C with genotype and subtype, if applicable. Specific drug requirements and needed documentation are outlined on the Prior Approval Drugs and Criteria web page of the NCTracks website, under the "Hepatitis C Medications" link.

Below is a summary of the forms and documentation that must be submitted with the PA request, regardless of the method of submission:

NEW HEPATITIS C FORM(S)	The forms can be found on the Drug Request Forms web page under the heading "Temporary Hepatitis C Forms," based on the type of hepatitis C medication requested.
DOCUMENT 1	Medical record documentation for diagnosis of chronic hepatitis C with genotype and subtype (if applicable)
DOCUMENT 2	Medical record documentation for Fibrosis stage
DOCUMENT 3	Actual lab results (not progress notes) showing HCV RNA levels. For initial requests, lab results must be collected in the previous six months. For continuation, lab results must be collected four or more weeks after the first prescription fill date.
DOCUMENT 4	Additional information such as patient's health status and history, treatment plan, contra-indications, etc. (if applicable). The patient "readiness to treat" form is required for initial PAs, regardless of submission method, and must be signed and dated by the beneficiary and attached.

Updates to Frequently Asked Questions

Updates have been made to several categories of Frequently Asked Questions (FAQs) on the NCTracks Provider Portal, including:

- **Manage Change Request FAQs:** Based on questions asked during training on MCR changes
- **ICD-10 FAQs**: Based on questions received in the ICD-10 Inbox
- **NCTracks Glossary**: Based on questions posed to Provider Relations Representatives

In many cases, providers may be able to save time and avoid calling the Contact Center by checking the FAQs first.

CSC, 1-800-688-6696

Attention: All Providers

Influenza Vaccine and Reimbursement Guidelines for 2015-2016 for N.C. Medicaid and N.C. Health Choice

Composition of the influenza vaccines for the 2015-2016 influenza season includes:

- Trivalent vaccines composed of the following virus strains:
  - An A/California/7/2009 (H1N1)-like virus,
  - An A/Switzerland/9715293/2013 (H3N2)-like virus, and
  - A B/Phuket/3073/2013-like (Yamagata lineage) virus.

- Quadrivalent influenza vaccines will contain these vaccine viruses and a B/Brisbane/60/2008-like (Victoria lineage) virus, which is the same Victoria lineage virus recommended for quadrivalent formulations in 2013-14 and 2014-15.

For further details on the 2015-2016 influenza vaccine, visit the Centers for Disease Control (CDC) Flu Season web page.

N.C. Division of Medical Assistance (DMA) does not expect that providers will be vaccinating beneficiaries with the 2015-2016 influenza season's vaccine after date of service June 30, 2016, when the injectable vaccine expires.

N.C. Immunization Program/Vaccines for Children (NCIP/VFC)

Under N.C. Immunization Program/Vaccines for Children (NCIP/VFC) guidelines, the N.C. Division of Public Health (DPH) Immunization Branch distributes all required childhood vaccines to local health departments, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), hospitals and private providers.

For the 2015-2016 influenza season, NCIP/VFC influenza vaccine – all quadrivalent – is available at no charge to providers for children 6 months through 18 years of age who are eligible for the Vaccines for Children (VFC) program, according to the NCIP coverage criteria. The current NCIP coverage criteria and definitions of VFC categories can be found on DPH's Immunization Branch web page.

Eligible VFC children include N.C. Health Choice (NCHC) beneficiaries who are American Indian and Alaska Native (AI/AN). These beneficiaries can be identified as AI/AN in one of two ways:

1. They are either identified as MIC-A and MIC-S on their NCHC Identification Cards or,
2. Beneficiaries/parents may self-declare their VFC eligibility status according to NCIP/VFC program policy.

When NCHC beneficiaries self-declare their status as AI/AN, and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with $0.00 and may bill NCHC for the administration costs only. For further details, refer to the June 2012 Medicaid Bulletin article *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients*.

All other NCHC beneficiaries are considered **insured (not VFC eligible)** and must be administered privately purchased vaccines.

For VFC/NCIP vaccines administered to VFC-eligible children, providers must report only the vaccine code. Providers may bill DMA for the administration fee for Medicaid and eligible AI/AN NCHC beneficiaries.

Providers must purchase vaccines for children who are **not** VFC-eligible (including all NCHC children who are not AI/AN) and adult patients. For Medicaid-eligible beneficiaries age 19 and older, purchased vaccine and administration costs may be billed to N.C. Medicaid, according to the guidelines stated in Tables 2 and 3 below. To determine who is eligible for NCIP influenza and other vaccines, visit DPH's Immunization Branch Web page.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

The following tables indicate the vaccine codes that may be either reported (with $0.00 billed) or billed (with the usual and customary charge) for influenza vaccine, depending on the age of the beneficiaries and the formulation of the vaccine. The tables also indicate the administration codes that may be billed, depending on the age of the beneficiaries and the vaccine(s) administered to them.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for **Health Check beneficiaries** can be found in the *Health Check Billing Guide*.

Table 1
Influenza Billing Codes for Medicaid Beneficiaries Less Than 19 Years of Age Who Receive VFC Influenza Vaccine

Vaccine CPT Codes to Report

Vaccine CPT Code to Report	CPT Code Description
90685	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-free administered to children 6 months through 35 months of age, for intramuscular use
90686	Quadrivalent inactivated influenza vaccine (IIV4), administered to individuals age 3-18 years, for intramuscular use
90687	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing administered to individuals 6 months through 35 months of age, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3-18 years, for intramuscular use
90672	Quadrivalent live attenuated influenza vaccine (LAIV4), preservative–free

Administrative CPT Codes to Bill

Administration CPT Code(s) to Bill	CPT Code Description
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472EP as appropriate.
90473EP	Immunization administration by intranasal or oral route; **one vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.
90460EP	Immunization administration through 18 years via any route of administration, with counseling by physician or other qualified health care professional.

Table 2
Influenza Billing Codes for Medicaid Beneficiaries 19 and 20 Years of Age

Use the following codes to bill Medicaid for an influenza vaccine **purchased** and administered to beneficiaries aged **19-20 years.**

Note: The VFC/NCIP provides influenza products for recipients aged 6 months through 18 years **only**. The VFC/NCIP will **NOT** provide influenza vaccine for recipients 19 years and older.

Vaccine CPT Codes to Report

Vaccine CPT Code to Report	CPT Code Description
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years and older, for intramuscular use
90686	Quadrivalent inactivated influenza vaccine (IIV4 administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), preservative-containing, when administered to individuals 3 years and older, for intramuscular use
90672	Influenza virus vaccine, live, for intranasal use. Preservative-free.

Administrative CPT Codes to Report

Administration CPT Code(s) to Bill	**CPT Code Description**
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).
90473EP	Immunization administration by intranasal or oral route; **one vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.

Table 3
Influenza Billing Codes for Medicaid Beneficiaries 21 Years of Age and Older

Use the following codes to **bill** Medicaid for an *injectable* influenza vaccine **purchased** and administered to beneficiaries **21 years of age and older.**

Note: The VFC/NCIP provided influenza products for VFC-age (6 months through 18 years of age) beneficiaries **only**. The VFC/NCIP will **not** provide influenza vaccine for beneficiaries 19 years and older.

Medicaid does not reimburse for purchased Live Attenuated Influenza Vaccine (LAIV) for those beneficiaries 21 years and older.

Vaccine CPT Code to Report

Vaccine CPT Code to Report	CPT Code Description
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years and older, for intramuscular use
90686	Quadrivalent inactivated influenza vaccine (IIV4 administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3 years and older, for intramuscular use

Administration CPT Code(s) to Bill

Administration CPT Code(s) to Bill	CPT Code Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For beneficiaries 21 years or older receiving an influenza vaccine, an evaluation and management (E/M) code **cannot** be reimbursed to any provider on the same day that injection administration fee codes (e.g., 90471 or 90471 and +90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

Billing/Reporting Influenza Vaccines for NCHC Beneficiaries

The following table indicates the vaccine codes that may be either reported (with $0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on an NCHC beneficiary's VFC eligibility (that is, if the beneficiary is AI/AN) and the formulation of the vaccine. The table also indicates the administration codes that may be billed.

Table 4

Influenza Billing Codes for NCHC Beneficiaries 6 Years through 18 Years of Age Who Receive VFC Vaccine (MIC-A and MIC-S Eligibility Categories or Beneficiaries in Other Categories who Self-Declare AI/AN Status) or Purchased Vaccine (All Other NCHC Eligibility Categories)

Vaccine CPT Code to Report

Vaccine CPT Code to Report	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years and older, for intramuscular use
90686	Quadrivalent inactivated influenza vaccine (IIV4), administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), preservative-containing, when administered to individuals 3 years and older, for intramuscular use
90672	Quadrivalent live attenuated influenza vaccine (LAIV4), preservative-free

Administrative CPT Code(s) to Bill

Administration CPT Code(s) to Bill	CPT Code Description
90471TJ	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
+90472TJ (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472 as appropriate.
90473TJ	Immunization administration by intranasal or oral route; **One vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.
+90474TJ (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is ***not*** applicable at this time.
90460TJ	Immunization administration through 18 years via any route of administration, with counseling by physician or other qualified health care professional.

Notes

- The EP modifier should **not** be billed on NCHC claims. The TJ modifier should be used.
- There is no co-pay for office visits and wellness checks.

Immunization Billing for Medicaid and NCHC Beneficiaries from FQHCs and RHCs

- ***For beneficiaries 0 through 20 years of age***

If **vaccines are provided through the NCIP/VFC**, the center/clinic shall report the CPT vaccine codes (with $0.00 billed) under Physician Services NPI and may bill for the administration codes (CPT procedure codes 90471EP through 90474EP OR 90460EP). This billing is appropriate when only vaccines are provided at the visit, or if vaccines were provided in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with $0.00 billed) under Physician Services NPI and an administration code shall not be billed.

If **purchased vaccines (non-VFC eligible)** were administered, the center/clinic may bill the CPT vaccine codes (with their usual and customary charge) under the Physician Services NPI for the vaccines administered and may bill for the administration codes (with the usual and customary charge). This billing is appropriate if only vaccines were given at the visit or if vaccines were given in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with $0.00 billed) under the Physician Services NPI provider number and the administration codes shall not be billed. For detailed billing guidance, refer to the *Health Check Billing Guide*.

Note: When billing for NCHC beneficiaries, refer to the detailed billing guidance above including Table 4 and the Core Visit policy in DMA's Provider Library web page.

- ***For beneficiaries 21 years of age and older***

When purchased vaccines are administered, CPT vaccine codes may be billed (with the usual and customary charge) and administration codes may be billed (with the usual and customary charge) under the Physician Services NPI. This is applicable when vaccine administration was the only service provided that visit. When a core visit is billed, the CPT vaccine code shall be reported (with $0.00 billed) under the Physician Services NPI and an immunization administration code may not be billed.

For influenza vaccine and administration fee rates, refer to the Physician's Drug Program fee schedule on DMA's Fee Schedule Web page.

CSC, 1-800-688-6696

Attention: Pharmacists and Prescribers

NC Medicaid and N.C. Health Choice Preferred Drug List Changes

Effective with an estimated date of service of **Nov. 1, 2015,** the N.C. Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL). Visit the DMA Outpatient Pharmacy Services web page for current and future PDL.

Below are highlights of some of the changes that will occur:

- The use of only one rectal Ulcerative Colitis will be required before moving to a non-preferred agent
- New classes are being added:
  - TOPICALS, Rosacea Agents
  - MISCELLANEOUS, Opioid Antagonist
- Update on preferred brands with non-preferred generic equivalents - preferred brands with non-preferred generic equivalents will be updated per the chart below:

Brand Name	Generic Name
Abilify	aripiprazole
Adderall XR	amphetamine salt combo ER
Aldara	imiquimod
Alphagan P	brimonidine
Androgel	testosterone
Avelox	moxifloxacin
Bactroban Cream	mupirocin cream
Baraclude	entecavir
Benzaclin	clindamycin/benzoyl Peroxide
Catapres-TTS	clonidine patches
Cedax	ceftibuten
Celebrex	celecoxib
Cipro Suspension	ciprofloxacin suspension
Derma-Smoothe-FS	fluocinolone 0.01% Oil
Desoxyn	methamphetamine
Dexedrine Spansules	dextroamphetamine spansule
Diastat Accudial/Pedi System	diazepam rectal / system
Differin	adapalene
Diovan	valsartan
Diovan HCT	valsartan / hydrochlorothiazide

Brand Name	Generic Name
Epivir HBV	lamivudine HBV
Epi-Pen	epinephrine
Exforge	amlodipine / valsartan
Exforge HCT	amlodipine / valsartan / HCT
Focalin / Focalin XR	dexmethylphenidate / ER
Gabitril	tiagabine
Hepsera	adefovir
Kadian ER	morphine sulfate ER
Lovenox	enoxaparin
Metadate CD	methylphenidate CD
Methylin Solution	methylphenidate solution
Metrogel Topical	metronidazole gel topical
Natroba	spinosad
Nexium (Rx)	esomeprazole
Orapred ODT	prednisolone ODT
Oxycontin	oxycodone ER
Patanase	olopatadine
Prandin	repaglinide
Provigil	modafinil
Pulmicort 0.25mg/2ml, 0.5mg/2ml	budesonide 0.25mg/2ml, 0.5mg/2ml
Ritalin LA	methylphenidate LA
Rythmol SR	propafenone SR
Symbyax	olanzapine / fluoxetine
Tobradex Drops	tobramycin/dexamethasone drops
Tricor	fenofibrate
Trilipix	fenofibirc acid
Verelan PM	verapamil ER PM
Vivelle-Dot Patch	estradiol patch

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers

Annual Report on Preferred Drug List and Supplemental Rebate Program

The 2014-15 state fiscal year annual public report on the Preferred Drug List (PDL) and Supplemental Rebate Program has been posted to the N.C. Division of Medical Assistance (DMA) PDL web page.

Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Alemtuzumab (Lemtrada™) HCPCS code Q9979: Updated Billing Guidelines to April 2015 Bulletin

Effective with date of service Oct. 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover alemtuzumab (Lemtrada™), for use in the Physician's Drug Program (PDP) when billed with HCPCS code **Q9979** (injection, alemtuzubab, 1 mg). Alemtuzumab (Lemtrada) is commercially available in 12 mg/1.2 ml vials. Alemtuzumab (Lemtrada) is indicated for multiple sclerosis.

For additional billing instructions, see the April 2015 Medicaid Bulletin article, *Alemtuzumab (Lemtrada™) HCPCS code J3590: Billing Guidelines*.

Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Prior Approval for Services Provided Under Medicaid for Pregnant Women

Beneficiaries with eligibility through Medicaid for Pregnant Women (MPW) can only receive services that are related to pregnancy such as prenatal care, delivery, childbirth classes, postpartum care and family planning. Medicaid also provides coverage of services that are medically necessary to treat conditions that may complicate a pregnancy. Some of these services require prior approval (PA) to validate the medical necessity for the service requested.

Effective December 14, 2015, NCTracks will begin accepting PA requests for the authorization of chiropractic and podiatry services for medical necessary pregnancy-related services for beneficiaries with MPW coverage.

Effective with date of service March 1, 2016, claims submitted for chiropractic or podiatry services for beneficiaries with MPW coverage will deny if PA is not on file for the beneficiary.

Note: Other services that may be necessary to treat a pregnancy-related complication already have processes in place to evaluate the medical necessity of the requested service. These services include:

- Durable Medical Equipment,
- Home Health Services,
- Home Infusion Therapy,
- Hospice,
- Personal Care Services,
- Private Duty Nursing, and,
- Optical Services.

Providers are also reminded that dental services are covered only through the day of delivery for beneficiaries with MPW coverage.

All PA requests for chiropractic and podiatry services must submitted via the provider portal. Paper versions of the request submitted by mail or fax will not be accepted. Providers will access NCTracks communications for information related to upcoming training events about this process.

A referral is required from whomever is providing the beneficiary's obstetric care (e.g., family practice physician, OB/GYN, nurse midwife, nurse practitioner, health department, etc.). The referral must document the condition that makes it medically necessary for the beneficiary to see a chiropractor or podiatrist. It must be specific as to how the condition is complicating the pregnancy and include the number of requested visits. The referral may or may not be to a particular chiropractor or podiatrist.

PA is **not** required for the initial visit. Providers may bill for an evaluation using the appropriate procedure codes. PA is required for subsequent visits/treatment. The referral may be submitted as an attachment to the PA request or it may be mailed or faxed to CSC. No medical records, plans of care or other documentation are required to be submitted with the request.

The chiropractic (or podiatry) provider is responsible for entering and submitting the PA request through the NCTracks Provider portal. The provider must indicate the service requested (chiropractic or podiatry) and the request begin and end dates. For chiropractic services, a primary diagnosis must be selected from a drop-down list of diagnosis codes, **and** a secondary diagnosis must be manually entered. For podiatry services, a valid diagnosis code per policy must be entered on the PA request.

PA cannot exceed 60 calendar days. Requests cannot be submitted retroactively (unless the beneficiary is approved for Medicaid retroactively).

If services continue to be needed after the initial approved limits or time period, providers must submit a new PA request. A new referral from the beneficiary's primary obstetric caregiver also must be submitted indicating the medical need for the new time period being requested.

Practitioners and Facilites
DMA, 919-855-4320

Attention: All Providers

Family Planning and Health Check/Screening Services

Claim Reprocessing in October Checkwrite

NCTracks is preparing to reprocess claims affected by the Medicaid Family Planning Waiver, N.C. Be Smart Family Planning State Plan, Health Check and N.C. Health Choice (NCHC) business rule updates.

Family Planning Business Rules Updates

Family planning business rules have been updated to appropriately assign the system-defined family planning indicator on a claim detail (line). This change was implemented in NCTracks on May 3, 2015. NCHC claims will not be impacted.

Health Check for Medicaid and NCHC Wellness Screening Services Business Rules Updates

Business rules affecting Health Check for Medicaid and NCHC Wellness Screening Services have been updated to appropriately assign the indicator for Medicaid Health Check and NCHC screening services on a claim detail (line). This change was implemented in NCTracks on Sept. 8, 2014, for Health Check and on Nov. 3, 2014, for NCHC Screening Services.

Details of Claim Reprocessing

NCTracks is preparing to reprocess all professional, inpatient, outpatient and pharmacy claims impacted by the system-defined family planning indicator setting from July 1, 2013, through May 3, 2015.

NCTracks is preparing to reprocess all professional claims impacted by Health Check for Medicaid from July 1, 2013, through Sept. 8, 2014, and those impacted by NCHC Wellness Screening Services through Nov. 3, 2014.

The affected claims will be reprocessed in an October 2015 checkwrite and appear in a separate section of the paper Remittance Advice (RA) along with EOB 06018 – CLAIM REPROCESSED FOR ADJUSTMENT OF FAMILY PLANNING OR HEALTH CHECK DESIGNATION.

The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

Note: Changes in both situations should **not** impact provider payments for most of the previously paid claims. While some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to reprocessed claims. Therefore, the reprocessed claim could deny. If the reprocessing results in a

recoupment and there are not sufficient funds from claims paid in the Sept. 29, 2015, checkwrite, an accounts receivable will be created.

CSC, 1-800-688-6696

Attention: All Providers

Policy Update: Surgery for Clinically Severe or Morbid Obesity

Clinical coverage policy, 1A-15 *Surgery for Clinically Severe or Morbid Obesity* has been revised and additional CPT codes are included in the policy. **Effective Feb. 1, 2015**, eligible providers can receive reimbursement for the following CPT codes:

- **43775** [Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)]
- **43886** (Gastric restrictive procedure, open; revision of subcutaneous port component only.)
- **43887** (Gastric restrictive procedure, open; removal of subcutaneous port component only)
- **43888** (Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only)

Clinical coverage policy, 1A-15, *Surgery for Clinically Severe or Morbid Obesity* can be found on the Division of Medical Assistance (DMA) Clinical Coverage Policy web page.

CSC, 1-800-688-6696

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

CCNC/CA Referral Authorization Expectations

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers are contractually required to provide or arrange services for the N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries enrolled with their practice and for whom they receive monthly management fees. The coordination of care requirement continues until the effective month that the enrollee is removed from the provider's enrollment panel. Questions arise when the beneficiary has been formally discharged but enrollment panels have not changed, or if the beneficiary has not established care with the assigned CCNC/CA provider.

While the Division of Medical Assistance (DMA) does not require the CCNC/CA primary care provider (PCP) to authorize any service, the CCNC/CA PCP is expected to evaluate every request for Carolina ACCESS referral authorization. This evaluation is not a medical prior approval. The PCP should evaluate each request based on the circumstances and needs of the beneficiary, even if the beneficiary has not yet established care with the practice. If the CCNC/CA referral authorization is refused, the provider who sees the beneficiary will have to take extra steps by submitting a CCNC/CA override request. There is no guarantee that the override request will be approved.

Denying the CCNC/CA referral authorization does **not** correct an incorrect PCP assignment. Providers should remind beneficiaries of the need to contact their local Department of Social Services (DSS) to correct the PCP assignment. Also, providers may contact their local Department of Social Services (DSS) if they are receiving CCNC/CA referral authorization requests for beneficiaries they have not seen. DSS may be able to educate the beneficiary on the importance of establishing care with their assigned PCP or choosing a more appropriate PCP.

Providers may also assist beneficiaries with correcting their PCP assignment by completing a CCNC Enrollment Form for Medicaid Recipients and faxing it to the appropriate DSS office.

With cooperation in the provider community, beneficiaries will be able to access medical services, claims will be adjudicated correctly, and incorrect PCP assignments will be corrected. Regional Managed Care Consultants are available to assist with questions regarding CCNC/CA.

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

Attention: All Dental Providers

New NCTracks Edits to Limit Dental and Orthodontic Services for Medicaid for Pregnant Women (MPW) Beneficiaries

On Aug. 2, 2015, NCTracks began to deny/recoup payment of dental and orthodontic services for beneficiaries covered under the Medicaid for Pregnant Women (MPW) program **if the date of service is after the baby was delivered.** This is a longstanding N.C. Medicaid policy that was previously monitored through post-payment review.

According to N.C. Division of Medical Assistance (DMA) clinical coverage policy 4A, *Dental Services*:

> For pregnant Medicaid-eligible beneficiaries covered under the Medicaid for Pregnant Women program class 'MPW,' dental services as described in this policy are covered through the day of delivery.

Therefore, claims for dental services rendered after the date of delivery for beneficiaries under MPW eligibility are outside the policy limitation and are subject to denial/recoupment.

According to DMA clinical coverage policy 4B, *Orthodontic Services*:

> Pregnant Medicaid-eligible beneficiaries covered under the Medicaid for Pregnant Women program class 'MPW' are not eligible for orthodontic services as described in this policy.

Therefore, claims for orthodontic records (D0150, D0330, D0340, and D0470) or orthodontic banding (D8070 or D8080) rendered for beneficiaries under MPW eligibility are outside of policy limitation and are subject to denial/recoupment.

Periodic orthodontic treatment visits (D8670) and orthodontic retention (D8680) will continue to be reimbursed regardless of the beneficiary's eligibility status at the time of the visit so long as the beneficiary was eligible on the date of banding.

New Explanation of Benefits (EOB) Codes effective Aug. 2, 2015

- EOB 57710: "Recipients covered under the Medicaid for Pregnant Women program (MPW) are not eligible for dental services after the delivery date. Refer to DMA Clinical Coverage Dental Policy 4A."

- EOB 57700: "Recipients covered under the Medicaid for Pregnant Women program (MPW) are not eligible for dental services after the delivery date. Dental claims paid in history are recouped. Refer to DMA Clinical Coverage Dental Policy 4A."

- EOB 01832: "Recipients covered under the Medicaid for Pregnant Women program (MPW) are not eligible for orthodontic services as described in DMA Clinical Coverage Policy 4B."

Medicaid providers are required to verify Medicaid beneficiary eligibility each time a service is rendered. Refer to the *NCMMIS Provider Claims and Billing Assistance Guide* on the NCTracks Provider Policies, Manuals, Guidelines and Forms web page for eligibility verification methods.

DMA clinical coverage policies can be found on the Clinical Coverage Policy web page.

Providers with questions regarding the MPW policy can contact the DMA Dental Program.

Dental Program
DMA, 919-855-4280

Attention: Skilled Nursing Facility Providers

No Reimbursement Rate Change for Skilled Nursing Facilities

- There will be no change in the N.C. Medicaid Skilled Nursing Facility (SNF) rates for the second quarter of the state fiscal year (SFY) 2016, which runs from Oct. 1, 2015, through Dec. 31, 2015. All SNF rates that became effective June 1, 2015, are frozen until further notice.

- The Case Mix Index used to adjust the direct care services component of the SNF per diem rate also is frozen at the rate in effect Dec. 31, 2014. This was mandated by Session Law 2014-100, Section 12H.7.

- Data for the *Case Mix Index Final Point in Time Report* should continue to be maintained and reported.

- Minimum Data Set (MDS) Audit reviews will be conducted as scheduled.

DMA, Provider Reimbursement
919-814-0070

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
November	11/05/15	11/10/15	11/12/15
	11/12/15	11/17/15	11/18/15
	11/19/15	11/24/15	11/25/15
	11/26/15	12/01/15	12/02/15

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

Paul Guthery
Executive Account Director
CSC