November 2014 Medicaid Bulletin

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Providers are responsible for informing their billing agency of information in this bulletin.

Attention: All Providers

NCTracks Updates

Update to Institutional Provider Billing re: Admission Date and From Date

A change was made in NCTracks to align institutional providers billing with the National Uniform Billing Committee (NUBC) specifications for UB-04 claims.

Previously, claim adjudication required that the Admission Date (FL 12) be equal to the "From" Service Date (FL 6) on the initial provider claim. To avoid claim denials, providers may have taken steps to ensure that the two dates matched.

As of September 1, 2014, the system edits that compared the Admission Date to the "From" Service Date have been changed to comply with the NUBC specifications – which note that the two dates are "distinctly different." This change does not adversely impact claim processing, but providers may need to change their systems to ensure their billing practices are aligned with the new specifications.

For further information on the definition and usage of Admission Date and Statement Covers Period (From-Through Dates), see the UB-04 Official Data Specifications Manual on the NUBC website at www.nubc.org.

Posting of Additional Prior Approval (PA) Letters to Provider Inbox

Previously, the only prior approval (PA) letters posted to the Message Center Inbox on the secure NCTracks Provider Portal were letters granting approval. **Effective September 15, 2014,** two additional types of PA letters are posted to the Inbox:

- PA Adverse Decision Letters
- PA Request for Additional Information Letters

Only the requesting provider receives copies of PA letters. Once logged into the secure Provider Portal, only individuals with access to the National Provider Identifier (NPI) of the requesting provider can view letters in the NCTracks Message Center Inbox. Other supporting providers will need to contact the requesting provider to determine the status of a PA request.

This functionality allows providers requesting PA from NCTracks to know about adverse decisions and request for additional information faster, which should expedite whatever actions need to be taken. Hardcopy versions of the adverse decision letters and requests for additional information will continue to be delivered by the U.S. Postal Service.

This feature only applies to PA requests submitted to NCTracks. However, providers can continue to view the status of all adjudicated PAs, including those dispositioned by other vendors, in the secure Provider Portal. For more information on PA and NCTracks, visit the PA page of the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.

PA Fact Sheet Updated

The Fact Sheet related to PA has been updated on the NCTracks Provider Portal to provide additional and current contact information for several PA vendors. For more information regarding PA and NCTracks, see the updated PA Fact Sheet. A list of other available topics is on the Fact Sheet page on the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html.

Update on Obstetrical Ultrasounds Denied for Edit 23420

Some providers have reported denials of Obstetrical Ultrasounds when billed with the U2 modifier. The denials are for Edit 23420 - RVW OB ULTRASND MED NECESSITY. This situation has been resolved. Providers who have denied claims for Obstetrical Ultrasound services when using modifier U2 should resubmit the claims for review. For more information, see Clinical Policy No: 1K-7, *Prior Approval for Imaging Services*, Sections 5.1.1(a), which states:

> **5.1.1 Exemptions**
>
> a. Imaging procedures performed in the following situations are exempt from the prior approval requirement:
>
> 1. During an inpatient hospitalization.
> 2. During an observation stay (this includes labor and delivery observation stay).
> 3. During an emergency room visit.
> 4. During an urgent care visit (only for urgent care, not primary care).
> 5. As a referral from a hospital emergency department or an urgent care facility.
>
> **Note:** Procedures that are exempt from the prior approval requirement must meet current North Carolina Medicaid policies that define medical necessity criteria and unit limitations for claims payment. Bypassing PA by having the procedures performed in the emergency room is not a guarantee of payment.

Clinical Coverage Policies can be found on the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy Web page at www.ncdhhs.gov/dma/mp/.

Reminder to Include Claim and Completed Form with Override Request

When submitting an override request, three pieces of information are necessary:

1. Medicaid Resolution Inquiry Form
2. Supporting Documentation
3. Claim Form

A significant number of override requests have been received without the claim form and cannot be processed. In addition, the Medicaid Resolution Inquiry Form must be completely filled out. *Providers must indicate the reason for the override or it will delay the time to process and may not produce the desired results.* **Note:** Claim overrides are only done for the reasons listed on the form.

A User Guide titled *How to Submit Claim Adjustment and Time Limit and Medicare Overrides,* which provides step-by-step instructions for submitting override requests, can be found under the heading "Claim Submission" on the Provider User Guide and Training Page of NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html.

The Medicaid Resolution Inquiry Form can be found under the heading "Provider Forms" on the Provider Policies, Manuals, and Guidelines page of the Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html. The inquiry form must include the claim, Remittance Advices (RAs) and all related documents.

Additional FAQs for PCS Claim Reprocessing Posted

Additional Frequently Asked Questions (FAQ) related to Personal Care Services (PCS) claim reprocessing have been added to the NCTracks Provider Portal. For the latest questions and answers, see the PCS Claim Reprocessing FAQs page at https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-PCS-Claim-Reprocessing.html.

For links to all of the topic areas, see the FAQ Main Page at https://www.nctracks.nc.gov/content/public/providers/faq-main-page.html.

Access to Consent Form Information

DMA requires that consent forms for sterilizations and hysterectomy statements be submitted to NCTracks by the rendering provider (e.g., surgeon). Only the rendering provider has access to information regarding the disposition of the Sterilization Consent form and Hysterectomy Statement. Therefore, only the rendering provider can view the status of these forms on the secure NCTracks Provider Portal. Moreover, denial letters are mailed to the rendering provider for consent forms and statements that are not approved.

The NCTracks Call Center cannot disclose consent form or statement information to anyone other than the rendering provider. Ancillary providers should contact the rendering provider (surgeon) for information regarding the status of Sterilization Consent forms and Hysterectomy Statements.

For a list of common errors associated with Sterilization Consent forms and Hysterectomy Statements, read the June 5, 2014 announcement titled *Common Errors on Consent Forms*, posted on the NCTracks Provider Portal.

CSC, 1-800-688-6696

Attention: All Providers

Outpatient Specialized Therapies Providers

No increase in frequency of services may be implemented without first obtaining prior approval (PA) from The Carolinas Center for Medical Excellence (CCME), which is the N.C. Division of Medical Assistance (DMA) PA Review Vendor. Any units/visits billed in excess of the PA frequency or the frequency stipulated on the Plan of Care (POC) are subject to recoupment. For further information on requesting PA for an increase in service frequency, refer to CCME's website at https://www.medicaidprograms.org/NC/ChoicePA/Account/Login.aspx.

Outpatient Specialized Therapy
DMA, 919-855-4260

All Providers

BRANDS Program Suspended

Effective November 1, 2014, the Brand Request-Adverse event Needs Documentation (BRANDS) process – found at www.documentforsafety.org – will be suspended. BRANDS is a prior authorization process that allows providers to request brand-name medications for patients who experienced adverse effects with generic equivalents, as well as document those adverse effects.

Information about the continuation or permanent discontinuation of BRANDS will be communicated through the Medicaid Bulletin as it becomes available.

Outpatient Pharmacy
DMA, 919-855-4300

All Providers

Skyla and ParaGard are available via Point-of Sale Pharmacy

Skyla and ParaGard intrauterine devices (IUDs) are now available by prescription from retail pharmacies. Not all pharmacies carry these products. Contact the manufacturers for availability information.

ParaGard is manufactured by Teva Women's Health, Inc., a Subsidiary of Teva Pharmaceuticals USA, Inc. The website is www.paragard.com. Questions should be directed to 1-877-Paragard (727-2427).

Skyla is manufactured by Bayer Pharmaceuticals. The website is www.skyla-us.com/. Questions should be directed to 1-888-84-Bayer (1-888-842-2937).

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) website at www.ncdhhs.gov/dma/mp/:

- 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 (11/1/14)
- 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older (11/1/14)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

All Providers

Preferred Drug List (PDL) Review Panel Scheduled

The next Preferred Drug List (PDL) review panel will be held Tuesday, November 4, 2014 from 1 to 5 p.m. at the State Library Building, 109 E. Jones Street, Raleigh, N.C. 27601. Details are posted at the Division of Medical Assistance (DMA) PDL Web page at www.ncdhhs.gov/dma/pharmacy/pdl.htm.

The PDL changes for 2014-2015 are open for public comment through Monday, November 3, 2014. Comments may be submitted at www.ncdhhs.gov/dma/mpproposed/.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers

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

Notice to Providers: This is an update of an article which 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. It is anticipated the provider enrollment will be mandated in March 2015.

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 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."

Effective November 16, 2014, both original prescriptions and refill claims that are written by prescribers not enrolled in N.C. Medicaid or NCHC will be denied.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: CAP/DA Providers

DMA is Accepting Applications for Financial Management Providers

Both the Community Alternatives Program for Children (CAP/C) and the Community Alternatives Program for Disabled Adults (CAP/DA) allow beneficiaries to self-direct their care under the CAP/Choice option.

The N.C. Division of Medical Assistance (DMA) is seeking qualified vendor(s) to administer funds and manage payrolls for beneficiaries who opt to self-direct the services they receive. Qualified vendor(s) will provide statewide Financial Management (FM) services and serve as Financial Intermediaries (FI) for these CAP beneficiaries.

FM is an approved waiver service. The reimbursement rate can be found on DMA's CAP/Choice fee schedule page at www.ncdhhs.gov/dma/fee/CAP/CAP_Choice_120701.pdf. FM is billed in units of 15 minutes with a maximum limit of four units for the start-up month, and up to four units per month thereafter. The start-up fee is used for services planning in the month prior to the effective date of the CAP/Choice beneficiary's Plan of Care (POC).

Requirements

Provider Type: Fiscal Management Agency

Provider Qualifications:

- Enrolled Medicaid provider
- Two years of experience in payroll activities, including issuing paychecks to employees and paying the necessary state/federal taxes and insurance
- Approved employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6

All prospective vendor(s) must meet all the requirements set forth in the N.C. Department of Health and Human Services' approved application for a 1915(c) Home and Community-Based Services Waiver (NCDHHS 1915(c) HCBS Waiver). A copy of the approved NCDHHS 1915 (c) HCBS Waiver can be found on DMA's CAP web page at www.ncdhhs.gov/dma/cap/CAPDA_Waiver_2013.pdf.

Interested providers shall send DMA's CAP Manager the following documents:

1. Operation Manual
2. Financial Management Services employment history

3. Mail the documents to the address below by **November 21, 2014**:

   CAP Manager
   N.C. Division of Medical Assistance
   2501 Mail Service Center
   Raleigh, NC 27699-2501

Home and Community Care Section – CAP/DA Unit
DMA, 919-855-4371

Attention: Nurse Practitioners, Physicians and Physician Assistants

Alglucosidase alfa (Lumizyme®) HCPCS code J0221: Updated Billing Guidelines

The FDA recently approved the label expansion of **Alglucosidase alfa (Lumizyme®).** Lumizyme® was initially indicated for patients 8 years and older with Pompe disease. **Effective with date of service August 1, 2014**, N.C. Medicaid will cover beneficiaries aged 0-8 years through the Physician Drug Program when billed with J0221. N.C. Health Choice (NCHC) beneficiaries will be covered from ages 6-18 years,

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Nurse Practitioners, Physicians and Physician Assistants

Belinostat (Beleodaq®), HCPCS code J9999: Billing Guidelines

Effective with date of service August 1, 2014, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover belinostat (Beleodaq®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 not otherwise classified, antineoplastic drugs. Beleodaq® is currently commercially available in 500 mg vials.

Belinostat (Beleodaq®) is indicated for relapsed or refractory peripheral T-cell lymphoma (PTCL). The recommended dosage for belinostat (Beleodaq®) is 1,000 mg/m^2 administered over 30 minutes by intravenous infusion once daily on days 1-5 of a 21-day cycle. Cycles may be repeated every 21 days until disease progression or unacceptable toxicity.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing belinostat (Beleodaq®) is 202.7 Peripheral T-Cell Lymphoma.
- Providers must bill Beleodaq® with HCPCS code J9999 not otherwise classified, antineoplastic drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid or NCHC unit of coverage for Beleodaq® is 1 mg. The maximum reimbursement rate per mg is $3.2400. One 500 mg vial contains 500 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Beleodaq® 500 mg vials is 68152-0108-09.
- The NDC units for belinostat (Beleodaq®) 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 instructions, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on DMA's website 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 website at: www.ncdhhs.gov/dma/fee/.

CSC, 800-688-6696

Attention: Nurse Practitioners, Physicians and Physician Assistants

Aflibercept (Eylea®) HCPCS code J0178: Updated Billing Guidelines

Eylea received an expanded FDA indication for Diabetic Macular Edema (DME). **Effective with date of service August 1, 2014**, N.C. Medicaid and N.C. Health Choice (NCHC) will cover this indication through the Physician Drug Program when billed with J0178 and the following ICD-9 diagnosis codes:

- **362.07** Diabetic Macular Edema (DME). In accordance with ICD-9 CM 2014 coding guidance, DME must be coded with:
    - **250.50** Diabetes with ophthalmic manifestations, type 2 or unspecified type not stated as uncontrolled
    - **250.51** Diabetes with ophthalmic manifestations, type 1 (juvenile type), not stated as uncontrolled
    - **250.52** Diabetes with ophthalmic manifestations, type 2 or unspecified type not stated as uncontrolled
    - **250.53** Diabetes with ophthalmic manifestations, type 1 (juvenile type), uncontrolled
    - **362.01** Background diabetic retinopathy
    - **362.02** Proliferative diabetic retinopathy
    - **362.03** Nonproliferative diabetic retinopathy NOS
    - **362.04** Mild nonproliferative diabetic retinopathy
    - **362.05** Moderate nonproliferative diabetic retinopathy
    - **362.06** Severe nonproliferative diabetic retinopathy

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Nurse Practitioners, Physicians and Physician Assistants

IVIG (Privigen®) HCPCS code J1459: Updated Billing Guidelines

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

Providers should bill for Privigen with HCPCS code **J1459.** Privigen is covered for the following ICD-9 diagnosis codes:

- **279.00** Hypogammaglobulinemia, unspecified
- **279.01** Selective IgA immunodeficiency
- **279.02** Selective IgM immunodeficiency
- **279.03** Other selective immunoglobulin deficiencies
- **279.04** Congenital hypogammaglobulinemia
- **279.05** Immunodeficiency with increased IgM
- **279.06** Common variable immunodeficiency
- **279.12** Wiskott-Aldrich syndrome
- **279.2** Combined immunity deficiency
- **287.31** Chronic immune thrombocytopenic purpura

Providers should select the most appropriate ICD-9 diagnosis codes with the highest level of specificity to describe a patient's condition. All codes must be supported with adequate documentation in the medical record.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: PCS Providers (In-Home Care & Residential Care)

Update: Delayed Implementation of the Personal Care Services (PCS) On-Line Service Plan

Note: This is an update of an article published in the October 2014 Medicaid Bulletin titled *Personal Care Services (PCS) On-Line Plan of Care*.

The implementation of the Personal Care Services (PCS) Service Plan is delayed until further notice. Additional information will be forthcoming and available regarding the status of online service plan via the N.C. Division of Medical Assistance (DMA) PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html.

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

Attention: Physicians

3% Rate Reduction Update for Physicians Services Providers Only

Note: This Special Bulletin is an update to a September 2014 Special Medicaid Bulletin article titled *3% Rate Reduction Update for Physicians ONLY* which can be found at www.ncdhhs.gov/dma/bulletin/pdfbulletin/0914_Special_Bulletin_RateReduction.pdf**.**

It was previously communicated that beginning October 26, 2014, NCTracks would process all claims for Non-ACA physicians at the new reimbursement rate, which is equal to 97 percent (97%) of the previous reimbursement rates. However, the October 26 date is being revised to a future date. The N.C. Division of Medical Assistance (DMA) will provide updates when a new date is determined. Claims with dates of service January 1, 2014 through rate implementation date will also be reprocessed at a later date. DMA will provide updates and additional details in upcoming Medicaid bulletins, stakeholder meetings and via webinars.

Rate Setting
DMA, 919-814-0070

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 the Division of Medical Assistance (DMA) 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
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
December	12/04/14	12/09/14	12/10/14
	12/11/14	12/16/14	12/17/14
	12/25/14	12/30/14	12/31/14

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
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CSC