December 2014 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates

2015 Checkwrite Schedules Posted

The 2015 checkwrite schedules for the N.C. Divisions of Medical Assistance (DMA), Mental Health (DMH), Public Health (DPH) and the Office of Rural Health and Community Care (ORHCC) have been posted to the NCTracks website. They can be found under Quick Links on the right side of the Provider Portal home page at https://www.nctracks.nc.gov/content/public/providers.html.

In addition, the 2015 DMA checkwrite schedule and the 2015 N.C. state employee holiday schedule can be found on DMA's calendar web page at www.ncdhhs.gov/dma/provider/calendar.htm.

Important Reminder When Sending Information to CSC or DHHS

Recipient information containing Protected Health Information (PHI) should be encrypted when it is sent to CSC or the N.C. Department of Health and Human Services (DHHS). PHI includes recipient name, ID, date of birth, and other information that could be used to identify individuals and their health status.

Note: Screen shots from the secure Provider Portal and the Remittance Advice often contain PHI.

Note: Provider names, addresses and National Provider Identifiers (NPIs) are **not** considered PHI.

Before emailing PHI, encrypt and password-protect the information using a file compression software program such as WinZip. The password should be sent in a separate email. For more information about safeguarding PHI, see the U.S. Department of Health and Human Services website at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html#standard.

Common Error with Transplant Prior Approval (PA) Requests

When submitting a Prior Approval (PA) request for transplants on the secure NCTracks Provider Portal, make sure to select the PA Type of "Transplant" in the drop down list, rather than "Medical" or "Surgical." This will expedite the review of transplant requests.

Time Limit Override and Adjustment Requests for Dental Claims

When dental providers submit Medicaid Resolution Inquiry Forms (for Time Limit Override requests) or Medicaid Claim Adjustment Request Forms, the ADA paper claim submitted with the form **must** have the Billing Provider taxonomy code entered into Field 35 ("Remarks") **or it will**

be denied. Requests previously denied because of a missing taxonomy code in Field 35 should be corrected and resubmitted, along with any supporting documentation.
Medicaid Resolution Inquiry Forms and Medicaid Claim Adjustment Request Forms can be found under the heading "Forms" on the Provider Policies, Manuals, and Guidelines page of the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

Orthodontic Providers: Models and records held when additional information is needed

Effective October 27, 2014, CSC will hold orthodontic records (photos, X-rays, and models) when additional information is requested. Since additional information can be uploaded to the existing prior approval in NCTracks or mailed/faxed with the provided cover sheet, this will eliminate the need for providers to resubmit the orthodontic records and models to CSC. This will result in a cost savings for providers by reducing shipping charges.

There may be situations where the orthodontic records are returned to the provider if the original models cannot be used for case review. Examples include if the models are not trimmed and marked for centric occlusion; models are broken; or models are moldy because they were packaged while still wet or damp. All orthodontic records (X-rays and models) must be diagnostic.

Durable Medical Equipment Retroactive PA Review

Initial Durable Medical Equipment (DME) PA requests with a "submit date" outside of the "requested begin date" and "requested end date" will be considered retroactive requests and will be denied. For a PA request to be considered timely, the submit date must fall within or prior to the "requested begin date" and "requested end date" on the PA. In addition, any DME PA request with a begin date greater than 365 days in the past will be denied.

There is no retroactive PA for DME except as noted under the heading "Retroactive DME Exceptions." A denied retroactive request will include directions if a provider plans to appeal the decision.

Examples of retroactive requests that will be denied:

> **Example A.** Submit date of September 14, 2014, with a service request period of October 14, 2013, through September 1, 2014.
>
> **Example B.** Submit date of September 22, 2014, with a service request period of January 12, 2014, through May 10, 2014.
>
> **Example C.** Submit date of October 8, 2014, with a service request period of October 1, 2013, through October 2, 2014.

Retroactive DME Exceptions

There is no retroactive PA for DME **unless** PA requests are submitted specifically for services that exceed the lifetime expectancies or quantity limitations allowed in Clinical Coverage Policy (CCP) 5A - *Durable Medical Equipment and Supplies* and CCP 5B - *Orthotics & Prosthetics*. (See CCP 5A – Attachments A and C, and CCP 5B – Attachment B.)

If the service being requested exceeds the limitations allowed in those policies:

- A PA must be submitted (regardless of whether the service requires PA), and
- It must be noted on the PA that it is a request to exceed the polity coverage limitations

This PA will be the request to override the policy limitation in NCTracks. The request must include the Certificate of Medical Necessity (CMN) and supporting documentation for exceeding the coverage limitations. Otherwise the PA decision will be delayed until the documents arrive. *(*See CCP 5A - Section 5.5 and CCP 5B - Section 5.6*.)*

Clinical Coverage Policies can be found on DMA's Clinical Coverage Policy web page at www.ncdhhs.gov/dma/mp/.

> **Quantity Example:** One manual wheelchair is approved every three years. Mr. Smith received approval for a wheelchair on August 1, 2012. On October 1, 2014, a request was submitted to NCTracks for a second wheelchair for Mr. Smith. The request included a CMN and a report substantiating that the chair had irreparable damage from a house fire. The request was approved for a second wheelchair.

For more information about retroactive PA for DME, contact NCTracks at 800-688-6696.

Place of Service Billing for Core Services in FQHCs and RHCs

As announced in *Place of Service Billing for Core Services* in the May 2014 Medicaid Bulletin, core services provided by a Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) must be billed with a Place of Service (POS) code 50 for the FQHC and POS code 72 for the RHC.

Effective November 2, 2014, claims for payment of core services that do not reflect a POS code 50 for the FQHC and POS code 72 for the RHC will be denied with Explanation of Benefit (EOB) Code 2689.

Expanded Recipient Eligibility Information

Beginning November 2, 2014, NCTracks is returning the Recipient's Category of Eligibility code (COE) and County Code for each enrollment span included in the eligibility verification response. (The County Code will be returned with the recipient's primary benefit plan only).

The COE and County Code are reflected in the response to all forms of recipient eligibility inquiry, including the Automated Voice Response System (AVRS), the secure Provider Portal, and the 270/271 X12 transaction. The following response will be provided for each channel of recipient eligibility inquiry:

- The **AVRS** conveys "The eligibility coverage code is…" and "The county is…"

- The secure **Provider Portal** displays the County Code above the list of benefit plans and the COE is displayed with its associated benefit plan.

- For Trading Partners that receive an X12 response, the COE and County codes are returned in the **271 Eligibility Response**, Loop 2110C, MSG segment, with the headers "COE" and "COUNTY" followed by the codes.

For more information, read the *270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide (updated in November 2, 2014)* on the Trading Partner Information page on the NCTracks Provider Portal.

Some Mental and Behavioral Health Providers Will Need to Enroll in NCTracks

Beginning November 3, 2014, providers who serve N.C. Health Choice (NCHC) recipients or Medicaid recipients who are documented aliens or younger than age 3 will be reimbursed in a fee-for-service model, not the capitated rates of the LME-MCOs.

Mental and behavioral health providers who are:

- Enrolled through their Local Management Entity-Managed Care Organization (LME-MCO) will be automatically enrolled in NCTracks; no action is required

- Not enrolled in their LME-MCO must enroll in NCTracks at https://nctracks.nc.gov/content/public/providers/provider-enrollment.html

These provider types can now enroll:

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Psychiatric Residential Treatment Facility
- Community Based Residential Treatment Facility, Mental Illness

Also enrolling are the following Community Intervention Services (CIS) services:

- Ambulatory Detoxification
- Assertive Community Treatment Team (ACTT)
- Community Support Team
- Diagnostic Assessment

- Early Intervention Services
- Intensive In Home Services
- Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification/Crisis Stabilization
- Mobile Crisis Management
- Multi-Systemic Therapy (MST)
- Non-Hospital Detoxification
- Opioid Treatment
- Partial Hospitalization
- Peer Support Services
- Professional Treatment Services in Facility Based Crisis Program – Adult
- Professional Treatment Services in Facility Based Crisis Program – Child
- Psychosocial Rehabilitation
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medical Community Residential

Bypass of PA/Preferred Drug List when Medicaid is billed as Secondary for Certain Pharmacy Claims

A change was implemented in NCTracks regarding PA requirements for pharmacy claims when primarily paid by a third party. **As of November 2, 2014**, when third-party insurance has paid 60% or more of the calculated Medicaid allowed amount for a pharmacy claim – point-of-sale (POS) or paper – then the PA requirement will be bypassed, whether the PA is for preferred or non-preferred drugs. This change is based on date of processing. Providers may rebill previously denied claims.

Recipient Lock-in

Beginning November 2, 2014, the "Pharmacy Opt-in" section of the Provider Eligibility Response page of the NCTracks Provider Portal has been renamed "Pharmacy Lock-in" and additional fields have been added. These changes are part of the preparations for the updated Recipient Lock-in program, being implemented February 1, 2015. At that time, the NCTracks Provider Portal will display information about prescribers and pharmacies associated with recipients in the Lock-in program. Lock-in information also will be available through the AVRS and 270/271 X12 transactions.

More information will be available closer to the implementation date, including an updated version of the *270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide*, which will be posted to the Trading Partner Information page on the NCTracks Provider Portal.

Reminder About Access to Consent Form Information

Sterilization Consent Forms and Hysterectomy Statements must be submitted to NCTracks by the rendering provider (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 information about Sterilization Consent Forms or Hysterectomy Statements to anyone other than the rendering provider. Ancillary providers should contact the rendering provider (surgeon) for information regarding Sterilization Consent Form and Hysterectomy Statements Status.

For a list of common errors associated with Sterilization Consent Forms and Hysterectomy Statements, refer to "Common Errors in Consent Forms," posted June 5, 2014, on the NCTracks Provider Portal.

A Note about Unsubscribing from NCTracks Email Listserv

NCTracks uses Constant Contact as a listserv for email communication with providers, associations, and trading partners. Anyone can sign up for the listserv by going to the NCTracks Provider Communications page clicking on the link in the upper right corner to "Sign Up for NCTracks Communications."

Those who do not wish to receive email communication from NCTracks, can click on the "SafeUnsubscribe" link in the footer of any NCTracks email. Once unsubscribed, NCTracks will no longer send any email communication.

Note: Email is a key means of communicating with the provider community about important topics regarding NCTracks, such as outstanding issues, claims reprocessing, upcoming system changes, etc. A concerted effort is made to limit the number of emails sent. Providers are encouraged to remain subscribed to NCTracks email communication. Those who unsubscribe can re-subscribe at any time.

CSC, 1-800-688-6696

Attention: All Providers

CMS 2014 Certified Electronic Health Record Technology (CEHRT) Flexibility Final Rule

This information from the Centers for Medicare and Medicaid Services (CMS) explains the new CMS 2014 Certified Electronic Health Record Technology (CEHRT) Flexibility Final Rule published August 29, 2014.

The CMS Flexibility Final Rule became effective October 1, 2014, giving flexibility to certain providers participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. To qualify:

- Providers must be unable to fully implement a 2014 Edition CEHRT for a 2014 EHR reporting period due to delays in 2014 Edition CEHRT availability, and
- The delay must relate to software development, certification, implementation, testing, or release of the product by the EHR vendor that resulted in a provider being unable to fully implement 2014 Edition CEHRT.

Note: A provider's participation in the EHR Incentive Program for 2015 and subsequent years <u>is not</u> altered under this rule.

The Flexibility Rule:

- Allows providers to meet Meaningful Use (MU) for Program Year 2014 if the EHR software is certified to meet either the 2011 or 2014 Edition criteria, or a combination of criteria from both editions

- Requires providers to report using 2014 Edition CEHRT for an EHR Reporting Period in 2015

- Extends Stage 2 through 2016, and pushes Stage 3 out to 2017

- Requires providers in their first year of participation, who are attesting to Adopt, Implement or Upgrade (AIU) criteria, to use 2014 Edition CEHRT

- Does not allow objectives and Clinical Quality Measures (CQMs) to be mixed and matched from different years (e.g., 2013 and 2014 definitions)

- CQMs cannot be separated from MU objectives and measures, but providers can use the updated electronic specifications of the CQMs.

The Rule defines that a provider's inability to *fully implement* a 2014 Edition CEHRT **must** be based on:

- Delayed software development
- Delayed or missing software updates
- Not being able to implement 2014 CEHRT for part of the reporting period (not the full reporting period)
- Inability to train staff, test the updates system, or put new workflows in place due to delay with installation of 2014 CEHRT
- Inability for a referring provider to meet Stage 2 Summary of Care measures because the receiving provider was impacted by 2014 CEHRT issues. (Referring providers may experience significant difficulty meeting the 10% threshold for electronic transmissions, despite their ability to send the electronic document, if the receiving provider couldn't fully implement 2014 Edition CEHRT.)

The Flexibility Rule lists the following **unacceptable** reasons for NOT fully implementing CEHRT:

- Financial issues
- Inability to meet one or more measures
- Staff turnover and change
- Waiting too long to engage a vendor
- Refusal to purchase the requisite software
- Ability to fully implement 2014 Edition CEHRT and report in 2014 but not doing so

By January 2015, the NC Medicaid EHR Incentive Program plans to accept the CMS 2014 CEHRT Flexibility Rule criteria into the North Carolina Medicaid Incentive Payment System (NC-MIPS) website. An Eligible Professional (EP) Flexibility Final Rule Attestation Guide will be available to help providers navigate through the new reporting options in NC-MIPS. For specific dates and details, visit the N.C. Division of Medical Assistance (DMA) NC Medicaid EHR Incentive Program website at www.ncdhhs.gov/dma/provider/ehr.htm.

The Flexibility Final Rule is applicable only for Program Year 2014 attestations. The NC Medicaid EHR Incentive Program will be accepting Program Year 2014 attestations until the end of Program Year 2014's attestation tail period on April 30, 2015 pm EST.

Providers should submit their attestations before the deadline so attestation discrepancies can be addressed.

Attestations cannot be altered after the close of the attestation tail period. If EPs are denied for Program Year 2014 and the attestation tail period has ended, the EPs will not be able to re-attest for Program Year 2014. Providers may re-attest for Program Year 2015 with no penalty and still have the opportunity to earn the full incentive payment of $63,750 over six years of participation.

N.C. Medicaid Health Information Technology (HIT)
DMA, NCMedicaid.HIT@dhhs.nc.gov (preferred contact method), 919-814-0180

Attention: All Providers

New DMA Pharmacy Director – John Stancil

John C. Stancil, Jr., R.Ph., joined the N.C. Division of Medical Assistance (DMA) as the new Pharmacy Director October 20, 2014.

Stancil holds a Bachelor of Pharmacy degree from the UNC Eschelman School of Pharmacy and has more than 30 years of experience in hospital, long-term care, and retail pharmacy management. For many years, he served as a Senior Account Manager for a national firm which provided pharmacy benefits management to Medicaid agencies. As such, Stancil led various pharmacy services and accounts for Medicaid agencies across the United States.

Stancil's background in prior authorizations, medication management programs, and Preferred Drug Lists (PDLs) aligns with DMA's initiatives.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on DMA's website at http://www.ncdhhs.gov/dma/mp/:

- 10A, Outpatient Specialized Therapies
- 10B, Independent Practitioners (IP)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Behavioral Health Providers, Pharmacists and Prescribers

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

Effective with an estimated date of service of **January 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). Below are highlights of some of the changes that will occur.

- The prior authorization criteria will be removed from the leukotriene class

- New classes are being added:
  - Under TOPICAL, Imidazoquinolinamines
  - Under MISCELLANEOUS, Epinephrine, Self-Injected; Estrogen Agents, Vaginal Preparations; Glucocorticoid Steroids, Oral

- Some mental health pharmaceuticals will have non-preferred options for the first time. Below is what the PDL will look like January 1, 2015

ANTIDEPRESSANTS- Other	
Preferred	**Non-Preferred**
bupropion (generic for Wellbutrin®)	Aplenzin®
bupropion SR (generic for Wellbutrin SR®)	Brintellix®
bupropion XL (generic for Wellbutrin XL®)	desvenlafaxine ER (generic for Pristiq®)
Cymbalta®	duloxetine (generic for Cymbalta®)
maprotiline (generic for Ludiomil®)	Effexor XR® Capsules
mirtazapine (generic for Remeron®)	Emsam®
Nardil®	Fetzima®
Parnate®	Forfivo XL®
phenelzine (generic for Nardil®)	Khedezla®
Savella®	nefazodone (generic for Serzone®)
tranylcypromine (generic for Parnate®)	Oleptro ER®
trazodone (generic for Desyrel®)	Pristiq®
venlafaxine (generic for Effexor®)	Remeron®
venlafaxine ER capsules (generic for Effexor XR Capsules®)	Remeron® ODT
	venlafaxine ER tablets (generic for Effexor XR Tablets®)
	Viibryd®

ANTIDEPRESSANTS- Other (continued)	
Preferred	**Non-Preferred**
	Wellbutrin®
	Wellbutrin SR®
	Wellbutrin XL®

ANTIDEPRESSANTS -Selective Serotonin Reuptake Inhibitor (SSRI)	
Preferred	**Non-Preferred**
citalopram (generic for Celexa®)	Brisdell®
escitalopram tablet (generic for Lexapro® Tablet)	Celexa®
fluoxetine capsule (generic for Prozac® Capsule)	escitalopram solution (generic for Lexapro® Solution)
fluoxetine solution (generic for Prozac® Solution)	fluoxetine DR 90mg Caps (generic for Prozac Weekly®)
fluvoxamine (generic for Luvox®)	fluvoxamine ER (generic for Luvox CR®)
paroxetine (generic for Paxil®)	Lexapro®
sertraline (generic for Zoloft®)	Luvox CR®
	paroxetine CR (generic for Paxil CR®)
	Paxil®
	Paxil CR®
	Pexeva®
	Prozac®
	Prozac Weekly®
	Sarafem®
	Zoloft®

ANTIHYPERKINESIS	
Preferred	**Non-Preferred**
Adderall XR®	amphetamine salt combo XR capsules (generic for Adderall XR)
Adderall®	Concerta®
amphetamine salt combo tablets (generic for Adderall)	dexmethylphenidate (generic for Focalin®)
clonidine ER (Kapvay®)	dexmethylphenidate XR (generic for Focalin® XR)
Daytrana®	dextroamphetamine ER (generic for Dexedrine Spansules®)
Desoxyn®	dextroamphetamine solution (generic for ProCentra®)
Dexedrine Spansules®	Intuniv®
dextroamphetamine (generic for DextroStat®)	methamphetamine (generic for Desoxyn®)
Focalin®	Methylin Chewable Tablet®
Focalin XR®	methylphenidate CD capsules (generic for Metadate® CD)
Kapvay®	methylphenidate LA capsules (generic for Ritalin® LA)
Metadate CD®	methylphenidate solution (generic for Methylin® Soluton)
Metadate ER®	ProCentra®
Methylin Solution®	Ritalin® SR
methylphenidate ER tablets (generic for Concerta®)	Zenzedi®
methylphenidate ER tablets (generic for Ritalin® SR)	
methylphenidate tablets (generic for Methylin®/Ritalin®)	
Quillivant XR®	
Ritalin®	
Ritalin® LA	
Strattera®	
Vyvanse®	

ATYPICAL ANTIPSYCHOTICS	
Injectable Long Acting	
(Trial and Failure of only 1 preferred required)	
Preferred	**Non-Preferred**
Abilify Maintena®	
fluphenazine decanoate (generic for Prolixin decanoate®)	
Haldol decanoate®	
haloperidol decanoate (generic for Haldol decanoate®)	
Invega Sustenna®	
Risperdal Consta®	
Zyprexa Relprevv®	

ATYPICAL ANTIPSYCHOTICS	
Oral	
(Trial and Failure of only 1 preferred required)	
Preferred	**Non-Preferred**
Abilify®	Clozaril®
clozapine (generic for Clozaril®)	Fanapt® Titration Pack
clozapine ODT (generic for FazaClo®)	FazaClo®
Fanapt®	Geodon®
Invega®	olanzapine/fluoxetine (generic for Symbyax®)
Latuda®	Risperdal®
olanzapine (generic for Zyprexa®)	Risperdal M®
olanzapine ODT (generic for Zyprexa® Zydis)	Seroquel®
quetiapine (generic for Seroquel®)	Versacloz®
risperidone (generic for Risperdal®)	Zyprexa®
risperidone ODT (generic for Risperdal M®)	Zyprexa Zydis®
Saphris®	
Seroquel® XR	
Symbyax®	
ziprasidone (generic for Geodon®)	

If you have a patient who is stable on a non-preferred product, and want them to continue on it, you may fill out a standard drug request prior authorization form found at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

These forms will be accepted beginning December 1, 2014. Forms must be submitted by December 30, 2014 to have approved prior authorizations active in the system by January 1, 2015.

1. Update on preferred brands with non-preferred generic equivalents

In addition to the changes above, preferred brands with non-preferred generic equivalents will be updated and are listed in the chart below:

Brand Name	Generic Name
Accolate	Zafirlukast
Adderall XR	Amphetamine Salt Combo ER
Aldara	Imiquimod
Alphagan P	Brimonidine
Astelin/Astepro	Azelastine Hydrochloride
Bactroban	Mupirocin
Benzaclin	Clindamycin/Benzoyl Peroxide
Cardizem LA	Matzim LA
Catapress-TTS	Clonidine Patches
Cedax	Ceftibuten
Cymbalta	Duloxetine
Derma-Smoothe-FS	Fluocinolone 0.01% Oil
Desoxyn	Methamphetamine
Dexedrine Spansules	Dextroamphetamine
Diastat/Diastat Accudial	Diazepam Rectal
Differin	Adapalene
Diovan	Valsartan
Diovan HCT	Valsartan / Hydrochlorothiazide
Duetact	Pioglitazone / Glimepiride
Epivir HBV	Lamivudine HBV
Entocort EC	Budesonide
Epi-Pen	Epinephrine
Exforge	Amlodipine / Valsartan
Exelon	Rivastigmine
Focalin / Focalin XR	Dexmethylphenidate
Gabitril	Tiagabine
Gris-Peg	Griseofulvin Ultramicrosize
Hepsera	Adefovir

Brand Name	Generic Name
Kadian ER	Morphine Sulfate ER
Lovenox	Enoxaparin
Metadate CD	Methylphenidate CD
Methylin Solution	Methylphenidate Solution
Metrogel Vaginal	Metronidazole Gel Vaginal
Natroba	Spinosad
Niaspan ER	Niacin ER
Opana ER	Oxymorphone ER
Prandin	Repaglinide
PrevPac	Lansoprazole / Amoxicillin / Clarithromycin
Provigil	Modafinil
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Budesonide 0.25mg/2ml, 0.5mg/2ml
Ritalin LA	Methylphenidate ER
Symbyax	Olanzapine / Fluoxetine
Tobradex Suspension	Tobramycin/Dexamethasone Susp
Toprol XL	Metoprolol Succinate
Travatan	Travoprost
Verelan PM	Verapamil ER PM
Zovirax Ointment	Acyclovir Ointment

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Hospitals, LME-MCOs

Medical Detoxification Billing

Many claims for hospital admission due to medical detoxification are currently being denied at the Local Management Entity–Managed Care Organization (LME-MCO) level. These denied claims are being sent to the N.C. Division of Medical Assistance (DMA) for fee-for-service payments.

"Medical detoxification" is encompassed in a psychiatric Diagnosis-Related Group (DRG) that was included in LME-MCO capitation rate development. Therefore, "medical detoxification" must be part of the benefit plan offered by LME-MCOs. **Effective with dates of service December 1, 2014, and on, all claims included in a psychiatric DRG – including "medical detoxification" – must be paid by the LME-MCO.**

Note: LME-MCOs also are responsible for follow-up and aftercare of these beneficiaries, which is more effectively done if LMEs-MCOs follow beneficiaries throughout their course of treatment.

Behavioral Health Services
DMA, 919-855-4290

Attention: Nurse Practitioners, Physician Assistants and Physicians

Recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®), HCPCS code J3590: Billing Guidelines

Effective with date of service September 1, 2014, N.C. Medicaid and N.C. Health Choice (NCHC) programs cover recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 unclassified biologics. Ruconest® is currently commercially available in 2,100 IU vials.

Recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®) is indicated for acute attacks in adult and adolescent patients with hereditary angioedema (HAE).

The recommended dosage for recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®) is < 84 kg 50 IU per kg; >= 84 kg 4,200 IU (2 vials).

Medicaid Billing and NCHC Billing

- The ICD-9-CM diagnosis code required for billing recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®) is 277.6 Other deficiencies of circulating enzymes.
- Providers must bill Ruconest® with HCPCS code J3590 unclassified biologics.
- Providers must indicate the number of HCPCS units.
- One Medicaid or NCHC unit of coverage for Ruconest® is 1 IU. The maximum reimbursement rate per mg is $2.4390. One 2,100 IU vial contains 2,100 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Ruconest® 2,100 IU vials are 68012-0350-01 and 68012-0350-02.
- The NDC units for recombinant human C1 esterase inhibitor (rhC1INH) (Ruconest®) 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* at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers must bill their usual and customary charge.
- The new fee schedule for the PDP 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

Methotrexate (Rasuvo™), HCPCS code J3490: Billing Guidelines

Effective with date of service September 1, 2014, the N.C. Medicaid program covers methotrexate (Rasuvo™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 unclassified drugs.

Methotrexate (Rasuvo™) is indicated for severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA) for patients who are intolerant of or had an inadequate response to first-line therapy. It is used for symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy.

The recommended starting dosage for methotrexate (Rasuvo™) is:

- RA: 7.5 mg once weekly of an oral or subcutaneous formulation.
- pJIA: 10 mg/m2 once weekly.
- Psoriasis: 10 to 25 mg once weekly of an oral, intramuscular, subcutaneous, or intravenous formulation.

Adjust dose gradually to achieve an optimal response. Use another formulation of methotrexate for patients requiring oral, intramuscular, intravenous, intra-arterial, or intrathecal dosing, doses less than 7.5 mg per week, doses above 30 mg per week, high-dose regimens, or dose adjustments of less than 2.5 mg increments.

Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing methotrexate (Rasuvo™) are 714.0 Rheumatoid arthritis; 714.3 Polyarticular juvenile idiopathic arthritis, chronic or unspecified; and 696.1 Other psoriasis.
- Providers must bill Rasuvo™ with HCPCS code J3490 unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Rasuvo™ is 1 mg.
- Dosage, reimbursement and National Drug Code (NDC) information is:

Commercially Available Dosages	Reimbursement Rate	NDC
7.5 mg/0.15 mL	$16.1280	59137-0505-04
10 mg/0.20 mL	$12.0960	59137-0510-04
12.5 mg/0.25 mL	$9.6768	59137-0515-04
15 mg/0.30 mL	$8.0640	59137-0520-04
17.5 mg/0.35 mL	$6.9120	59137-0525-04
20 mg/0.40 mL	$6.0480	59137-0530-04
22.5 mg/0.45mL	$5.3760	59137-0535-04

Commercially Available Dosages	Reimbursement Rate	NDC
25 mg/0.50 mL	$4.8384	59137-0540-04
27.5 mg/0.55 mL	$4.3985	59137-0545-04
30 mg/0.60 mL	$4.0320	59137-0550-04

For example, one 7.5 mg/0.15 mL injectable contains 7.5 billable units.

- The NDC units for methotrexate (Rasuvo™) 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 must bill their usual and customary charge.
- The new fee schedule for the PDP 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

Oritavancin diphosphate (Orbactiv™), HCPCS code J3490: Billing Guidelines

Effective with date of service September 1, 2014, the N.C. Medicaid program cover oritavancin diphosphate (Orbactiv™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 unclassified drugs. Orbactiv™ became commercially available in 400 mg vials in October 2014.

Oritavancin diphosphate (Orbactiv™) is indicated for acute bacterial skin and skin structure infections (ABSSSI).

The recommended dosage for oritavancin diphosphate (Orbactiv™) is a 1,200 mg single dose administered by intravenous infusion over three hours.

Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing oritavancin diphosphate (Orbactiv™) are 680 - 686 Infections of Skin and Subcutaneous Tissue.
- Providers must bill Orbactiv™ with HCPCS code J3490 unclassified drugs.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Orbactiv™ is 1 mg .The maximum reimbursement rate per mg is $2.6100. One 400 mg vial contains 400 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Orbactiv™ 400 mg vials are 65293-0004-01 and 65293-0004-03.
- The NDC units for oritavancin diphosphate (Orbactiv™) 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* at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers must 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, 1-800-688-6696

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 will instead be 30- and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
December 2014	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
January 2015	1/01/15	1/06/15	1/07/15
	1/08/15	1/13/15	1/14/15
	1/15/15	1/21/15	1/22/15
	1/22/15	1/27/15	1/28/15
	1/29/15	2/03/15	2/04/15

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