



## November 2015 Medicaid Bulletin

### ***In This Issue* .....Page**

#### **All Providers**

NCTracks Updates.....	2
NCTracks ICD-10 Updates.....	6
N.C. Health Choice Extended Coverage Benefit Eliminated.....	7
Occupational Therapy, Physical Therapy and Speech/Language Therapy Providers.....	8
CPT Code 90460: Code for Immunization Administration That Includes Physician Counseling for Beneficiaries through 18 Years of Age.....	10
One Percent (1%) Rate Reduction.....	13
Limits on New Participation in NC Electronic Health Records Incentive Program.....	14
Update on Enrollment Criteria for Ordering, Prescribing and Referring Providers.....	15

#### **Behavioral Health Services Providers**

Out of Network Contract Requirements.....	16
---	----

#### **Community Alternatives Program (CAP) Providers**

Request for a Lead Case Management Agency for the Community Alternatives Program for Disabled Adults in Pasquotank, Perquimans, Currituck and Camden Counties.....	17
---	----

#### **Dental Providers**

Billing for Partial and Complete Dentures.....	20
--	----

#### **Home Health Providers**

Updated Bill Type for Home Health Providers.....	21
--	----

#### **LME/MCO**

Out of Network Contract Requirements.....	16
---	----

### ***In This Issue*.....Page**

#### **Nurse Practitioners and Physician Assistants**

Diclofenac Vial (Dyloject™) HCPCS Code J3490: Billing Guidelines .....	22
Dinutuximab Vial (Unituxin™) HCPCS Code J9999: Billing Guidelines.....	24
Filgrastim-sndz (G-CSF), Biosimilar Pre-filled Syringes (Zarxio™) HCPCS Code Q5101: Billing Guidelines.....	26

#### **Nursing Facility Providers**

Change in Delivery of Nursing Facility Rate Letter and Patient Roster.....	28
---	----

#### **Pharmacists and Prescribers**

NC Medicaid and N.C. Health Choice Preferred Drug List Changes.....	29
--	----

#### **Physicians**

Diclofenac Vial (Dyloject™) HCPCS Code J3490: Billing Guidelines .....	22
Dinutuximab Vial (Unituxin™) HCPCS Code J9999: Billing Guidelines.....	24
Filgrastim-sndz (G-CSF), Biosimilar Pre-filled Syringes (Zarxio™) HCPCS Code Q5101: Billing Guidelines.....	26
Phenylephrine and Ketorolac Injection 1% / 0.3% Vial (Omidria™) HCPCS Code J3490: Billing Guidelines.....	31

*Providers are responsible for informing their billing agency of information in this bulletin.  
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## Attention: All Providers

# NCTracks Updates

### Chrome Browser Support for Electronic Document Viewer

Google announced that **effective Sept. 1, 2015**, the Chrome web browser no longer supports Netscape Plugin Application Programming Interface (NPAPI) based plugins. This change prevents Chrome from displaying the Electronic Document Viewer, which is used by NCTracks providers who have a very large Remittance Advice (RA) and hospital providers who view their Provider Statistical and Reimbursement (PS&R) reports online.

While NCTracks investigates the implications of this change, providers who use the Electronic Document Viewer are encouraged to use a different browser if they encounter problems. Supported browsers include Firefox (v.10 and higher) and Internet Explorer (v.8 and higher). More information will be posted on the NCTracks Provider Communication web page as available.

### Remittance Advice Enhancement - Phase I

One of the common provider requests for improvement to NCTracks pertains to the Remittance Advice (RA). The current RA format was the result of a concerted effort to address concerns expressed about the previous RA format. However, the current format results in a longer RA that providers have often found cumbersome to read.

A joint task force was organized with representatives from the N.C. Department of Health and Human Services (DHHS), CSC, and the provider community to consider enhancements to the RA. It was determined that the project would best be approached in phases. The first phase of enhancements increased the size and density (darkness) of the font used in printing the RA to improve its readability. Phase I was implemented with the RA generated in the Sept. 29, 2015, checkwrite. Planning for subsequent phases of RA enhancements will begin shortly. Additional information will be forthcoming.

### NCTracks Implementing 256-bit Encryption

**Friday evening, Sept. 18, 2015**, CSC implemented mandatory 256-bit level encryption on the NCTracks website. This enhancement aligns with the N.C. Statewide Information Security Manual, which outlines technology policies and standards intended to protect the privacy of North Carolinians.

There should have been no impact on providers who currently use the Internet browsers supported by NCTracks. If a provider is using an older unsupported browser, such as IE 6, it may be necessary to upgrade to a supported browser. A list of the Internet browsers supported by NCTracks can be found in the [System Requirements](#) link in the footer of every NCTracks web page.

## **Chiropractic Claim Denials Resolved**

Some claims for chiropractic services had previously denied with EOB 01171 - DIAGNOSIS REQUIRES SUPPORTING DOCUMENTATION. RESUBMIT AS A ADJUSTMENT WITH MEDICAL RECORDS. Claims submitted based on Division of Medical Assistance (DMA) policy should now be processing correctly. Providers may resubmit claims that previously denied through their regular claim submission method and not as a paper adjustment.

## **NCTracks Contact Center Cannot Disclose PA Info to Recipients**

Some providers have been encouraging recipient to contact the NCTracks Contact Center regarding prior approval (PA) requests not yet approved. The Contact Center is **not** allowed to discuss information regarding PA with a recipient. The only information that the Contact Center may disclose to recipients pertains to their own eligibility, as reflected in NCTracks. PA information may only be discussed with the provider who submitted the PA request.

## **Reminder: Requesting Additional Information - Non Pharmacy PA**

If the necessary information to adjudicate a PA request is missing or needs clarification, a Request for Additional Information letter will be sent. The PA request will be placed in PEND AL 1 status. A letter will be mailed to the requesting provider's service location address and posted to the Message Center Inbox on the secure provider portal. The Request for Additional Information letter states what information is needed to complete the review and the date the requested information must be received.

If the information that was requested is not received by the date in the letter, the PA request will be denied. In that case, a denial letter will be sent to both the recipient beneficiary and the provider. Providers are encouraged to respond promptly to the Request for Additional Information letter to avoid PA denials.

## **Error Submitting Application or Manage Change Requests**

Some providers have reported an error occurred when trying to submit an application or Manage Change Request (MCR) on the secure Provider Portal. This issue is intermittent.

Providers are encouraged to submit a screen shot of the error, along with the date the issue occurred, their NCID and NPI to [NCTracksProvider@nctracks.com](mailto:NCTracksProvider@nctracks.com). This will help us research the issue. An update will be posted when more information is available.

## **Diagnosis Codes on Ambulance Claims**

In the past, ambulance providers have been instructed to use V719 as the required diagnosis code on straight Medicaid claims. This is no longer a requirement. Ambulance providers should use the appropriate ICD-9 or ICD-10 code in effect for the date the service was provided.

## N.C. Health Choice Claim Denials for Age Edit Resolved

It was previously reported that N.C. Health Choice (NCHC) claims for recipients under the age of 6 who lost their Medicaid coverage due to changes in income were denying with Edit 00149 PROCEDURE INVALID FOR AGE, even though the recipients are eligible. This issue was resolved Sept. 6, 2015. Providers who had claims that denied for Edit 00149 PROCEDURE INVALID FOR AGE for recipients with program MICJ when age was less than 6 years old can now resubmit their denied claims as original claims.

## New PA Attachment for Xolair®

There are several methods by which PA requests for Xolair® can be submitted to NCTracks, including the secure provider portal, fax and mail. A new attachment for Xolair has been posted to the NCTracks website to allow PA for the indication of Chronic Idiopathic Urticaria. This attachment is on the [Drug Request Forms web page](#).

The recommended method for submitting a PA request is to key it directly into the secure NCTracks Provider Portal, which is the fastest and most efficient method for obtaining PA. To enter a PA for Xolair for Chronic Idiopathic Urticaria on the portal, complete the PA for Xolair and add the **Xolair Attachment** as an upload.

Providers who must mail or fax a PA request must use the Standard Xolair Request Form as the first page, followed by the attachment.

- [Standard Xolair Form](#)
- [Xolair Attachment for Chronic Idiopathic Urticaria](#)

## Pharmacy Providers Calling NCTracks

Some pharmacy providers have been calling NCTracks to request recipient copay information. **The NCTracks Contact Center is not allowed to provide that information.**

## New Physician Drug Program Edits Implemented October 1

Two new Physician Drug Program (PDP) edits were implemented in NCTracks on Oct. 1, 2015:

- Edit 02672 compares the J code billed with the Generic Code Number (GCN) to ensure it is a valid combination. If the claim fails the edit, it will deny and post with EOB 02672 - SERVICE DENIED. J CODE + NDC/GCN COMBINATION IS NOT VALID.
- Edit 02673 compares the National Drug Code/Generic Code Number (NDC/GCN) with the diagnosis code (ICD-9 or ICD-10) billed to ensure it is a valid combination. If the claim fails this edit, it will deny and post EOB 02673 - SERVICE DENIED. NDC/GCN + ICD DIAGNOSIS COMBINATION IS NOT VALID.

Providers will continue to bill with the NDC. These edits take the place of a manual review process, so claims will process more efficiently. The edits apply to Medicaid and NCHC benefit

plans. Both edits were effective **Jan. 1, 2015**, but will be applied based on date of processing of the claim, not date of service.

### **Updates to NCTracks 837 Companion Guides**

The 837 Companion Guides (D/I/P) on the [Trading Partner Information page](#) of the NCTracks Provider Portal were updated Sept. 16, 2015. The formatting of the transactions has not changed, but additional guidance has been added in the “Comments” area to assist with billing ICD-10 claims.

**CSC, 1-800-688-6696**

**Attention: All Providers****NCTracks ICD-10 Updates****ICD-10 Help Kit**

An [ICD-10 Help Kit](#) is posted under the Quick Links on the ICD-10 page of the NCTracks provider portal. The kit consolidates key information regarding ICD-10 that has been published on NCTracks over the last several months. Included is guidance regarding claim submission (batch submission of electronic claims and provider portal entry), prior approval (PA), frequently asked questions, how to get assistance and a section outlining the Edits and EOBs that providers are likely to encounter with the implementation of ICD-10.

**Remember the ICD-9 or ICD-10 Button When Keying in Claims**

NCTracks has received several calls about claims keyed into the portal denying. Those keying claims into the NCTracks Provider Portal have to click the radio button to select either ICD-9 or ICD-10. Those submitting claims with dates of service **before Oct. 1, 2015**, should click ICD-9. Those submitting claims for services rendered **on or after October 1** should click ICD-10. Claims keyed into the portal that do not have the right ICD version selected will be denied.

[Example of ICD Version Radio Button on Provider Portal Claim](#)

**Note:** The ICD version radio button on provider portal claims defaults to ICD-10.

**ICD-10 Q&As**

The following are answers to additional questions sent by providers to the ICD-10 Inbox:

**Q: How will the voided claims work after October 1 if the original date of service is before ICD-10 implementation?**

**A:** No matter when the claim is submitted, the code to use is based on date of service. Services provided before Oct. 1 require ICD-9 codes.

**Q: Will the codes automatically convert from ICD-9 to ICD-10 when I submit the professional claims?**

**A:** No, it won't automatically convert. You must pick the most accurate code. See what your most used ICD-9 codes correspond to in ICD-10 using the [NCTracks ICD-10 Crosswalk](#).

**Q: If we have an existing PA, and need to submit the claim, can we use the existing PA or must we create a brand new one with ICD-10 codes?**

**A:** If you already have an approved PA request with ICD-9 codes, you do **not** need a new prior approval with ICD-10 codes to submit the claim.

**Q: Where can I find out more information about using the proper ICD qualifier?**

**A:** Look under Quick Links on the right side of the [Trading Partner web page](#).

**Q: Do we have to key all the fields in for new ICD-10 claims or can we just change certain fields in the batch files?**

**A:** For most providers, the only claim fields that are changing with the implementation of ICD-10 are diagnosis codes. Claims for inpatient hospital charges will also use ICD-10 procedure codes.

**Q: How do the crossover claims work?**

**A:** Crossover claims process the same way they did before October 1. All health care claims are affected by the implementation of ICD-10, based on the date of service (or date of discharge for inpatient hospital claims).

**CSC, 1-800-688-6696**

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## **Attention: All Providers**

### **N**C Health Choice Extended Coverage Benefit Eliminated

On Sept. 18, 2015, the law authorizing the N.C. Health Choice (NCHC) Extended Coverage benefit was repealed.

Session Law 2015-241, Appropriations Act of 2015 (State budget), Section 12H.14(a) repealed N.C. General Statute §108A-70.21(g) and (h), which authorized the purchase of Extended Coverage for NCHC beneficiaries who become ineligible for insurance because of a family income increase. Since the repeal of the law was effective upon signing, the extended coverage benefit is no longer available.

Individuals and their families or guardians are encouraged to obtain health insurance coverage through an employer-based insurance plan or North Carolina's Federally Facilitated Marketplace at [www.healthcare.gov](http://www.healthcare.gov).

**N.C. Health Choice,  
DMA, 919-855-4113**

**Attention: All Providers**

**O**ccupational Therapy, Physical Therapy and Speech/Language Therapy Providers

N.C. Division of Medical Assistance (DMA) Outpatient Specialized Therapies provides **guidelines** for the frequency of services to beneficiaries under 21 years of age, and identifies factors that warrant a tapering or discontinuation of services. The guidelines are most applicable for the provider types that are required to request and receive prior authorization for services.

The expected range for the frequency of services shown below considers factors such as **age, diagnosis, prognosis, motivation and potential for medical regression**. “Frequency of Service” is the combined frequency of services for each therapy discipline from all provider types in all clinical settings (outpatient clinic, office, home, school and daycare).

FACTORS TO CONSIDER	FREQUENCY OF SERVICE (maximum frequency for all provider types in all clinical settings combined)			
	<i>TWO VISITS/WEEK</i>	<i>ONE VISIT/WEEK</i>	<i>ONE TO TWO VISITS/MONTH</i>	<i>EPISODIC/AS NEEDED</i>
Potential to participate and benefit from the therapy process	Beneficiary has potential for rapid progress, or potential for rapid decline or loss of functional skills, due to medical condition	Beneficiary demonstrates continuous meaningful progress toward established functional goals	Beneficiary demonstrates slow rate of attainment of goals and/or does not regress	Therapist uses clinical decision making and problem-solving skills to recommend solutions to specific newly identified issues
Critical period* for skill acquisition or for potential regression related to medical condition	Extremely critical period	Critical period	Not a critical period, or episodically critical period, related to change in life stage or medical condition	Specific challenges identified by beneficiary or parent that requires specific adaptations



FACTORS TO CONSIDER	FREQUENCY OF SERVICE (maximum frequency for all provider types in all clinical settings combined)			
	TWO VISITS/WEEK	ONE VISIT/WEEK	ONE TO TWO VISITS/MONTH	EPISODIC/AS NEEDED
Amount of clinical decision making and problem solving needed from licensed therapist	Requires the clinical skills and problem solving of a licensed therapist; only a limited part of the therapy program can be safely performed by beneficiary or parent	Requires the clinical skills and problem solving of a licensed therapist for a significant part of the therapy program; some activities can be safely performed by the beneficiary or parent	Requires the clinical skills and problem solving of a licensed therapist to periodically reassess condition and update home program; beneficiary or parent can safely perform home program	Home program can be carried out safely by beneficiary and/or caregiver. Clinical skills and problem solving of a licensed therapist needed for specific challenges identified by the family or beneficiary.

\* A critical period is an important life-stage for beneficiaries to:

- Acquire a particular developmental skill that is indispensable in their life span and which can influence future development; or,
- Lose skills, or develop an additional disability, from medical regression or intervention.

The following factors indicate a tapering or discontinuation of services:

- Behaviors are present that interfere with progress or participation in therapy, or there is a change in the beneficiary’s medical condition limiting the benefits of therapy at the time.
- Poor attendance, the beneficiary refuses to cooperate, or the beneficiary's motivation is so low as to preclude therapeutic intervention.
- Maximum benefit from services has been reached or functional skills have been achieved.
- There is a plateau in the progress achieved with intervention services (beneficiary has not demonstrated any significant measurable progress over a 90-day time frame), and parent education has been provided to optimize and preserve the skills obtained.

**Outpatient Specialized Therapies**  
**DMA, 919-855-4260**

## Attention All Providers

### **CPT Code 90460: Code for Immunization Administration That Includes Physician Counseling for Beneficiaries through 18 Years of Age**

Effective with date of service **Jan. 1, 2015**, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover the CPT code for immunization administration with counseling, 90460.

Per *CPT 2015*, the descriptor for CPT code 90460 is as follows:

<b>Procedure Code</b>	<b>Description</b>	<b>Billing Instructions</b>
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional	Append EP or TJ modifier to the CPT code.

**CPT guidance states that code 90460 should be used:**

**“Only when the physician or qualified healthcare professional provides face-to-face counseling of the patient and family during the administration of a vaccine.”**

A qualified health care professional is defined as physician assistant, nurse practitioner or certified nurse midwife. According to the Centers for Medicare & Medicaid Services (CMS), the N.C. Division of Medical Assistance (DMA) must reimburse for CPT code 90460 for the administration of the vaccine product, not per antigen or vaccine component, while CPT code 90461 is not covered per CMS.

**Note:** CPT code 90460 can be used for eligible beneficiaries up until the 19<sup>th</sup> birthday. When billing for CPT code 90460:

1. The beneficiary must be under 19 years of age on the date of service.
2. Modifier EP must be appended to CPT code 90460 for Medicaid, while TJ modifier must be appended for NCHC billing.
3. Do **NOT** append the EP or TJ modifier to the vaccine product CPT codes.
4. As is the case with the current codes, CPT code 90460 is an immunization administration code, which includes counseling. It is not an add-on “counseling” code. Therefore, 90460 **cannot** be mixed with other codes for the same vaccine product.

For example, 90460 EP (primary code involving counseling for a vaccine) plus 90472 EP (add-on code for a vaccine **not** involving counseling) cannot be reported for

the **same** vaccine, such as Measles, Mumps and Rubella vaccine (MMR vaccine). The billing of CPT code 90460 is for the total reimbursement of the one vaccine administration.

5. The physician or qualified health care professional must perform **face-to-face vaccine counseling** associated with the administration and must document that they have done so. If the physician or qualified health care professional provides only a vaccine information statement (VIS), this does not constitute face-to-face counseling for the purposes of billing CPT code 90460 EP. The physician or qualified health care professional is not required to administer the vaccine.
6. All units billed for each CPT code (90460 EP, 90471 EP, 90472 EP, 90473 EP, and 90474 EP) must be billed on **one** detail to avoid duplicate audit denials. Currently, 90474 EP cannot be billed with 90473 EP because there are no two oral/intranasal vaccines that would be given to a beneficiary. Billing only one unit of either 90473 EP or 90474 EP is allowed.

**Note:** The “EP” modifier pertains to Medicaid; the “TJ” modifier to NCHC. The same rule applies. For example, 90474 TJ cannot be billed with 90473 TJ.

7. For those beneficiaries through 18 years of age, codes involving counseling (90460 EP) can be billed on the same encounter as codes not involving counseling (90471 EP through 90474 EP) for **separate** vaccines.

According to *CPT 2015*,

“For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471 through 90474.”

CPT codes 90471 through 90474, used for immunization administration without counseling for children, and for all persons 19 and older, have not changed. Their descriptors are listed in the table below:

<b>Procedure Code</b>	<b>Description</b>	<b>Billing Instructions</b>
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)	No additional instructions.

Procedure Code	Description	Billing Instructions
90472+ (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid); <b>each additional vaccine</b> (single or combination vaccine/toxoid)	List separately in addition to code for primary procedure, 90471 or 90460.
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	Do not report 90473 in conjunction with 90471.
90474+* (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 Use 90474 in conjunction with 90471 or 90473.**

**\*Note:** Currently, CPT code 90474 cannot be billed with code 90473 because there are no two oral and/or intranasal vaccines that would be given to a beneficiary.

**\*\*For beneficiaries who are 19 years of age and older, the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 with no modifier.**

**Outpatient Pharmacy  
DMA, 919-855-4300**

## **Attention: All Providers One Percent (1%) Rate Reduction**

A one percent (1%) rate reduction was enacted by the N.C. General Assembly, Session Law 2014-100, Section 12H.14A. Pending Centers for Medicare & Medicaid Services (CMS) approval, most providers will be subject to a 1% fee schedule reduction effective Jan. 1, 2015.

The impacted services/providers are:

- Ambulatory Surgical Centers
- Behavioral Health Enhanced
- Chiropractor, Podiatry, and Optometry
- Dental
- Dialysis
- Durable Medical Equipment
- Extended Services for Pregnant Women
- Hearing Aids
- Home Infusion Therapy
- HIV Case Management
- Independent Practitioner Services
- Labs & X-Rays
- Nurse Midwives, Certified Registered Nurse Anesthesiologist, Anesthesiology Assistants
- Nurse Practitioners
- Orthotics and Prosthetics
- Optical Supplies
- Other Licensed Practitioner Services
- Personal Care Services
- Psychiatric Residential Treatment Facilities
- Physician Assistant Services
- Physician Drug Program\*
- Physician Services
- Targeted Case Management - Intellectual/Developmental Disabilities
- Targeted Case Management - Mental Health/Substance Abuse

As the N.C. Division of Medical Assistance (DMA) receives approval from CMS for these rate reductions, the following will take place:

1. The new reimbursement rates will be updated in NCTracks, so that providers are reimbursed with the new rate from that date forward.
2. Updated fee schedules will be posted to [DMA's Fee Schedule web page](#).
3. DMA will also do a systematic re-processing of all claims with a date of service of January 1, 2015 through the date the new rates are implemented in NCTracks. The date

of the systematic adjustment will be communicated to provider groups prior to implementation.

\*As reported in the August 2015 Medicaid Bulletin, article, [Physician Drugs: 1 Percent Rate Reduction](#), CMS approved SPA14-021 for 1% for the Physician Drug Program on Dec. 12, 2014 and the rates were implemented in NCTracks in August 2015.

**Provider Reimbursement**  
**DMA, 919-814-0060**

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## **Attention: All Providers**

### **Limits on New Participation in NC Medicaid Electronic Health Record Incentive Program**

Program Year 2016 is the last year an eligible professional (EP) may begin participating in the NC Medicaid Electronic Health Record (EHR) Incentive Program. Program Year 2016 also is the last year an EP may attest for adopt, implement and upgrade (AIU).

If EPs do **not** receive a first-year incentive payment by Program Year 2016, they will not have the opportunity to participate in the NC Medicaid EHR Incentive Program. The first day EPs may begin attesting for Program Year 2016 is Jan. 1, 2016.

Participation years do not need to be consecutive, but EPs need to have six years of participation to receive the full EHR incentive payment of \$63,750. The last year an EP may submit an attestation for the NC Medicaid EHR Incentive Program is Program Year 2021.

The last year an eligible hospital may attest and receive payment for the NC Medicaid EHR Incentive Program is Program Year 2016.

For more information, visit the [NC Medicaid EHR Incentive Program website](#).

**N.C. Medicaid Health Information Technology (HIT)**  
**DMA, [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)**

**Attention: All Providers\*****Update on Enrollment Criteria for Ordering, Prescribing and Referring Providers**

**Notice to Providers:** This article updates the [August 2014 Medicaid Bulletin](#) article *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. Physician or non-physician practitioners who write orders, prescriptions or referrals must be enrolled in the N.C. Medicaid or NCHC and their **individual NPI (not organizational NPI)** must be included on the claim.

**Beginning Feb. 1, 2016**, failure of an OPR provider to enroll in N.C. Medicaid or NCHC will result in claim denials. The billing provider will receive a denial with an EOB stating that the OPR provider is not enrolled.

Institutional, clinical and professional claims will deny if **any** of the NPIs on the claim are found to be providers who are not enrolled in N.C. Medicaid or NCHC. Providers should ensure that all ordering, prescribing and referring providers of the services for which they submit Medicaid or NCHC claims are enrolled in those programs.

As a reminder, effective July 1, 2015, all Institutional (UB-04/837-I) claims for Psychiatric Residential Treatment Facility (PRTF) services must include the name and NPI of the beneficiary's attending psychiatrist and billing provider for reimbursement. If the attending psychiatrist's NPI is not entered on the claim, the claim will deny with EOB Code 03101, "THE TAXONOMY CODE FOR THE ATTENDING PROVIDER IS MISSING OR INVALID." Please refer to the [April 2015 Medicaid Bulletin](#).

If services are furnished to beneficiaries in another state, the out-of-state providers are required to enroll with N.C. Medicaid or NCHC. Enrollment in another state's Medicaid program does **not** exempt an OPR provider from enrolling with N.C. Medicaid or NCHC. More information for OPR professionals can be found on the N.C. Division of Medical Assistance (DMA) [Provider Enrollment web page](#).

Providers with questions about the NCTracks [online enrollment application](#) can contact the CSC Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com) (email).

\* This also includes providers directly contracted with the LME/MCOs.

**Provider Relations  
DMA, 919-855-4050**

## **Attention: LME/MCOs, Behavioral Health Providers**

### **O**ut-of-Network Contract Requirements

Recent session law specifies when Local Management Entities/Managed Care Organizations (LME/MCOs) are required to use out-of-network contracts with individual providers.

Session Law 2015-241 (2015 Appropriations Act), Section 12H.3 requires LME/MCOs to use out-of-network contracts with individual behavioral health or intellectual/developmental disability (IDD) services providers when:

1. The services requested are medically necessary and cannot be provided by an in-network provider.
2. The behavioral health or IDD provider's site of service delivery is located outside of the geographical catchment area of the LME/MCO, and the LME/MCO is not accepting applications or the provider does not wish to apply for membership in the LME/MCO closed network.
3. The behavioral health or IDD provider is not excluded from participation in the Medicaid program, the N.C. Health Choice program, or other State or federal health care program.
4. The behavioral health or IDD provider is serving no more than two enrollees of the LME/MCO, unless the agreement is for inpatient hospitalization, in which case the LME/MCO may, but shall not be required to, enter into more than five such out-of-network agreements with a single hospital or health system in any 12-month period.

The Business Practices Standardization Committee is currently working on standardized contract language for use with out-of-network providers.

LME-MCOs are required to be in compliance by **Nov. 1, 2015**, the effective date of this legislation.

**Behavioral Health Policy Section**  
**DMA, 919-855-4290**



## **Attention: Medicaid Enrolled Home and Community-Based Services Providers for CAP/C and CAP/DA**

### **Request for a Lead Case Management Agency for the Community Alternatives Program for Disabled Adults in Pasquotank, Perquimans, Currituck and Camden Counties**

The Community Alternatives Program for Disabled Adults (CAP/DA) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under § 1915(c) of the Social Security Act, found in 42 CFR 440.180. Federal regulations for HCBS waivers may be found in 42 CFR Part 441 Subpart G.

The CAP/DA program waives certain N.C. Medicaid requirements to furnish an array of HCBS to **adults with disabilities 18 years of age and older** who are at risk of institutionalization. The services are designed to provide an alternative to institutionalization for beneficiaries in this target population who prefer to remain in their primary private residences and would be at risk of institutionalization without these services.

#### **Functions and Qualified Providers**

The N.C. Department of Health and Human Services (NCDHHS) Division of Medical Assistance (DMA) appoints local lead agencies to be responsible for the day-to-day case management functions for eligible CAP/DA beneficiaries. Case management functions include:

- Assessing
- Care planning
- Referral and linkage
- Monitoring
- Follow-up

DMA seeks a qualified lead agency for Pasquotank, Perquimans, and Currituck and Camden counties. Eligible providers may include:

- Area aging programs
- Local health departments
- Departments of social services
- Hospitals
- Home care agencies licensed by N.C. Division of Health Services Regulations (DHSR) under 10A NCAC 13J
- Established home and community-based case management providers

Pasquotank, Perquimans, Currituck and Camden counties are approved to serve 95 CAP/DA participants per year. There are 78 participants currently being served by the appointed lead agency.

## Lead Agency Requirements

The selected lead agency must be **currently enrolled as a Medicaid provider and approved to provide services under in-home services and supports**. The agency must be capable of providing case management by both nursing and social work staff.

The agency also must have **demonstrated**:

1. Experience with disabled and aging population
2. Experience in HCBS case management.
3. Capacity of web-based automation.
4. Experienced staff to assure case mix and caseload management.
5. Fiscal soundness, on-hand and reserve resources

The selected agency must be able to:

1. Process a service request to determine basic eligibility criteria for waiver participation
2. Complete comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation
3. Coordinate and collaborate in an interdisciplinary team approach for the provision of waiver services that prevent institutionalization
4. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration and frequency
5. Conduct monthly monitoring of the service plan with beneficiaries and quarterly monitoring with all approved service providers

Other Provider Qualifications:

1. Two or more years of experience in case management and HCBS
2. Direct community connection to Pasquotank, Perquimans, Currituck and Camden counties

All prospective agencies must meet all other requirements set forth in [NCDHHS 1915\(c\) Community Alternatives Program for Disabled Adults HCBS Waiver](#). Information about the CAP/DA program can be found on the [DMA CAP/DA web page](#).

## Submission Requirements

Interested providers must send to the DMA's CAP Manager the following documents **by Nov. 30, 2015**.

1. Letter of Interest
2. Current Operation Manual
3. Case Management and HCBS
4. Resume of all personnel

Send all information to:

CAP Manager  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**Home and Community Care Section, CAP/DA  
DMA, 919-855-4360**

## Attention: Dental Providers

### Billing for Partial and Complete Dentures

**Notice to Providers:** This article was previously published in the *June 2014 Medicaid Bulletin*. Providers must use the date of delivery as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed and delivered. N.C. Medicaid or N.C. Health Choice (NCHC) payment may be recouped for claims filed using a date other than the delivery date.

**Note:** If the beneficiary's Medicaid or NCHC eligibility expires *between* the final impression date and delivery date, the provider will use the final impression date as the date of service. This exception is allowed *only* when the dentist has completed the final impression on a date for which the beneficiary is eligible *and* has actually delivered the denture(s). The delivery date *must* be recorded in the beneficiary's chart.

### Billing for Non-deliverable Partial and Complete Dentures

Dentists will make every effort to schedule partial and complete denture delivery *before* requesting payment for a non-deliverable denture. This must include contact with the beneficiary's county social worker, who must be allowed at least two weeks to assist in scheduling an appointment for denture delivery. If a reasonable time has elapsed and circumstances beyond the dentist's control prevent denture delivery, a claim for payment of non-deliverable dentures may be filed. The dentist will submit the following:

1. A completed claim form clearly marked "Non-deliverable dentures"
2. Any supporting material documenting the reason for non-delivery
3. A copy of the lab bill indicating a charge for the dentures
4. A copy of the dental record indicating dates and methods by which the beneficiary was notified and dates of any appointments for impressions or try-ins

These claims must be sent to the address listed below.

**DMA Dental Program – 20  
2501 Mail Service Center  
Raleigh, N.C. 27699-2501**

Reimbursement is determined on a case-by-case basis. The dentist will retain the dentures, lab work orders, lab bills and record documentation for six years as proof that dentures were constructed. Dentures *must not* be mailed to DMA.

**Dental Program  
DMA, 919-855-4280**

**Attention: Home Health Providers****Updated Bill Type for Home Health Providers**

**Notice to Providers:** This was originally published as a Special Bulletin in October 2015.

**Effective Nov. 1, 2015**, providers should no longer submit original claims for home health services using Bill Type 33X. Providers should use Bill Type 32X or 34X instead. Bill Type 33X will be discontinued per the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee.

**Service Limit Information Accessible via NCTracks and AVRS**

Effective with date of service **Nov. 1, 2015**, home health providers will be able to obtain service limit information via the NCTracks Provider Portal or the Automatic Voice Response System (AVRS).

To access service limit information via the Provider Portal go to the “Eligibility” tab, input the required information and review the Medicaid Service Limits section of the screen.

The AVRS allows enrolled providers to access detailed information pertaining to the N.C. Medicaid program. Using a touch-tone telephone, providers may access service limit information by calling 1-800-723-4337.

**Implementation of Prior Approval Requirement for the Miscellaneous Supply Procedure Code (T1999)**

Effective with date of service **Nov. 1, 2015**, home health providers must submit prior approval requests for use of the T1999 procedure code through the NCTracks Provider Portal. Limits and prior approval of requirements for use of the T1999 code include the following:

- Total maximum miscellaneous billing limit of \$250 per patient per year without prior approval required.
- Prior approval is required for total miscellaneous billing greater than \$250.
- Total maximum miscellaneous billing limit of \$1,500 per patient per year.

Verification of limits will be made available through the AVRS and via NCTracks in the Provider Portal.

**Home Health Services**  
**DMA, 919-855-4380**

## **Attention: Nurse Practitioners, Physicians and Physicians Assistants**

### **Diclofenac Vial (Dyloject™) HCPCS Code J3490: Billing Guidelines**

**Effective with date of service Aug. 1, 2015**, the N.C. and N.C. Health Choice (NCHC) programs cover diclofenac vials for injection (Dyloject™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 Unclassified drugs. Dyloject is currently commercially available in a 37.5mg/mL single use vial.

Diclofenac vial for injection (Dyloject) is an NSAID indicated for use in adults for the management of mild to moderate pain and management of moderate to severe pain alone or in combination with opioid analgesics.

The recommended dosage for diclofenac vial for injection (Dyloject) is 37.5 mg administered by intravenous bolus injection over 15 seconds every 6 hours as needed, not to exceed 150 mg/day.

#### **For Medicaid and NCHC Billing**

- The ICD-9-CM diagnosis codes required for billing diclofenac vial for injection (Dyloject) are:
  - 780.96 generalized pain
  - 338.1X acute pain
  - 338.2X chronic pain, or,
  - 338.3 neoplasm related pain (acute)(chronic).
  
- The ICD-10-CM diagnosis codes required for billing diclofenac vial for injection (Dyloject) are:
  - R52 pain, unspecified
  - G89.1X acute pain, not elsewhere classified
  - G89.2X chronic pain, not elsewhere classified, and,
  - G89.3 neoplasm related pain, (acute)(chronic).
  
- Providers must bill Dyloject with HCPCS code J3490 unclassified drugs.
  
- One Medicaid unit of coverage for Dyloject is one single use vial of 37.5mg/mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per one vial is \$17.01000.
  
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Dyloject 37.5mg/1mL vial is 00409-1068-01.
  
- The NDC units for diclofenac vial for injection (Dyloject) should be reported as "UN1."
  
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).

- Providers will bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs will bill the cost that is reflective of their acquisition cost. Providers will indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on [DMA’s fee schedule web page](#).

**CSC, 1-800-688-6696**

## Attention: Nurse Practitioners, Physicians and Physicians Assistants

# Dinutuximab Vial (Unituxin™) HCPCS Code J9999: Billing Guidelines

Effective with date of service Aug. 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover dinutuximab vials for injection (Unituxin™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999, Not otherwise classified, antineoplastic drugs. Unituxin is currently commercially available in a 17.5 mg/5 mL (3.5 mg/mL) single-use vial.

Dinutuximab vial for injection (Unituxin) is indicated for the treatment of high-risk neuroblastoma in pediatric patients who achieve at least a partial response to first-line multiagent, multimodality therapy in combination with 13-cis-retinoic acid (isotretinoin), granulocyte-macrophage colony-stimulating factor (sargramostim), and interleukin-2 (aldesleukin).

The recommended dosage for dinutuximab vials for injection (Unituxin) is 17.5mg/m<sup>2</sup>/day administered as an intravenous infusion over 10 to 20 hours for four consecutive days for a maximum of 5 cycles.<sup>1</sup>

### For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing dinutuximab vial for injection (Unituxin) are 194.0-Malignant neoplasm of other endocrine glands and related structures-adrenal gland (neuroblastoma); if specified site, see Neoplasm, by site, malignant in ICD reference neoplasm table
- The ICD-10-CM diagnosis code required for billing dinutuximab vial for injection (Unituxin) is C74.90 malignant neoplasm of unspecified part of unspecified adrenal gland.
- Providers must bill Unituxin with HCPCS code J9999 not otherwise classified, antineoplastic drugs.
- One Medicaid unit of coverage for Unituxin is one single use vial of 17.5 mg/5 mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per one vial is \$1,620.00000.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Unituxin 17.5 mg/5 mL vial is 66302-0014-01.
- The NDC units for dinutuximab vial for injection (Unituxin) should be reported as "UN1".
- For additional information, refer to the January 2012 Special Bulletin, [National Drug Code Implementation Update](#).



- Providers will bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs will bill the cost that is reflective of their acquisition cost. Providers will indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on [DMA’s fee schedule web page](#).

**CSC, 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Filgrastim-sndz (G-CSF), Biosimilar Pre-filled Syringes (Zarxio™)  
HCPCS Code Q5101: Billing Guidelines**

**Effective with date of service Sept. 1, 2015**, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover filgrastim-sndz (G-CSF), biosimilar (Zarxio™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code Q5101 Injection, filgrastim (G-CSF), biosimilar, 1 microgram. Zarxio is currently commercially available in 300mcg/0.5 mL and 480mcg/0.8 mL single-dose, preservative-free, prefilled syringes.

**For Medicaid and NCHC Billing**

- The ICD-9-CM diagnosis codes required for billing filgrastim-sndz (G-CSF), biosimilar (Zarxio) for cancer therapy and related ICD-9 codes may include:
  - 140.0-239.9 (Neoplasms); 996.85 - Complications of transplanted organ-transplant failure or rejection-bone marrow
  - 996.88 - Complications of transplanted organ-transplant failure or rejection-stem cell-complications from stem cells from: peripheral blood, umbilical cord
  - 288.00 - Neutropenia, unspecified;
  - 288.01 - Congenital neutropenia;
  - 288.02 - Cyclic neutropenia
  - 288.03 - Drug induced neutropenia (ICD-9 Tip: Assign 288.03 for neutropenic fever due to chemotherapy drugs, along with codes for the fever, adverse effect, and the underlying malignancy.)
  - 288.04 - Neutropenia due to infection
  - 288.09 - Other neutropenia
- The ICD-10-CM diagnosis codes required for billing filgrastim-sndz (G-CSF), biosimilar (Zarxio) are:
  - C00 - D49;T86.5 Complications of stem cell transplant (complications from stem cells from peripheral blood, umbilical blood)
  - T86.00 – Unspecified complication of bone marrow transplant
  - T86.01 - bone marrow transplant rejection
  - T86.02 - bone marrow transplant failure
  - T86.03 - bone marrow transplant infection
  - T86.09 – other complications of bone marrow transplant
  - D70.0 - congenital agranulocytosis
  - D70.1 - agranulocytosis secondary to cancer chemotherapy
  - D70.2 - other drug-induced agranulocytosis; D70.3 - Neutropenia due to infection
  - D70.4 - cyclic neutropenia
  - D70.8 - Other neutropenia
  - D70.9 - Neutropenia, unspecified

- Providers must bill Zarxio with HCPCS code Q5101 - Injection, filgrastim (G-CSF), biosimilar, 1 microgram (mcg)
- One Medicaid unit of coverage for Zarxio is 1 microgram. NCHC bills according to Medicaid units. The maximum reimbursement amount rate per unit is \$0.969
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units.

See table below:

NDC	Strength	Package Size
61314-0304-01	300mcg/0.5mL	1 pre-filled syringe
61314-0304-10	300mcg/0.5mL	10 pre-filled syringes
61314-0312-01	480 mcg/0.8 mL	1 pre-filled syringe
61314-0312-10	480 mcg/0.8 mL	10 pre-filled syringes

- The NDC units for filgrastim-sndz (G-CSF), biosimilar (Zarxio) should be reported as “UN1”.
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- Providers will bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs will bill the cost that is reflective of their acquisition cost. Providers will indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on [DMA’s fee schedule web page](#).

**CSC, 1-800-688-6696**

**Attention: Nursing Facility Providers****C**hange in Delivery of Nursing Facility Rate Letter and Patient Roster

**Effective Jan. 1, 2016**, nursing facility providers will receive their nursing facility rate letters and Final Point in Time Reports (patient rosters) from CSC via the secure NCTracks provider portal. Previously this information was mailed to providers from the N.C. Division of Medical Assistance (DMA).

The nursing facility rate letter and patient roster will be posted to the provider's Message Center Inbox each quarter. This approach provides quick accessibility to review, download, and print letters and patient rosters. This is the same method used to retrieve the paper Remittance Advice (RA). The letters and rosters will remain available for up to eight quarters.

Nursing facility providers may see a slight difference in the format of the facility rate letter and patient roster, but the content will be the same. Access is restricted to those people who have permission to view the corresponding NPI on the secure NCTracks provider portal. To obtain permission, contact the Office Administrator for the NPI.

Training information will be made available for nursing facility providers shortly.

**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:

<b>Brand Name</b>	<b>Generic Name</b>
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

<b>Brand Name</b>	<b>Generic Name</b>
Diovan HCT	valsartan / hydrochlorothiazide
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	fenofibric acid
Verelan PM	verapamil ER PM
Vivelle-Dot Patch	estradiol patch

**Outpatient Pharmacy  
DMA, 919-855-4300**

**Attention: Physicians****Phenylephrine and Ketorolac Injection 1% / 0.3% Vial (Omidria™)  
HCPCS Code J3490: Billing Guidelines**

**Effective with date of service Aug. 1, 2015**, the N.C. Medicaid and N.C. Health Choice (NCHC) covers phenylephrine and ketorolac injection 1% / 0.3% vials (Omidria™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 Unclassified drugs. Omidria is currently commercially available as a sterile solution concentrate in a single-patient-use vial containing 4mL of sterile solution.

Phenylephrine and ketorolac injection 1% / 0.3% vial (Omidria) is added to an ophthalmic irrigation solution used during cataract surgery or intraocular lens replacement and is indicated for maintaining pupil size by preventing intraoperative miosis and reducing postoperative ocular pain.

Omidria must be diluted prior to use. For administration to patients undergoing cataract surgery or intraocular lens replacement, 4 mL of Omidria is diluted in 500 mL of ophthalmic irrigating solution. Irrigation solution is to be used as needed for the surgical procedure.

**For Medicaid and NCHC Billing**

- The ICD-9-CM diagnosis codes required for billing phenylephrine and ketorolac injection 1% / 0.3% vial (Omidria) are:
  - 366.1X - Senile cataract
  - 366.2X - Traumatic cataract
  - 366.3X - Cataract secondary to ocular disorders
  - 366.4X - Cataract associated with other disorders
  - 366.5X - After-cataract
  - 366.8 - Other cataract
  - 366.9 - Unspecified cataract.
  
- The ICD-10-CM diagnosis codes required for billing phenylephrine and ketorolac injection 1% / 0.3% vial (Omidria) are:
  - E08.36 Diabetes mellitus due to underlying condition with diabetic cataract
  - E09.36 Drug or chemical induced diabetes mellitus with diabetic cataract
  - E10.36 Type 1 diabetes mellitus with diabetic cataract
  - E11.36 Type 2 diabetes mellitus with diabetic cataract
  - H25.01X Cortical age-related cataract
  - H25.03X Anterior subcapsular polar age-related cataract
  - H25.04X Posterior subcapsular polar age-related cataract
  - H25.09X Other age-related incipient cataract
  - H25.1X Age-related nuclear cataract
  - H25.2X Age-related cataract, Morgagnian type
  - H25.81X Combined forms of age-related cataract

- H25.89 Other age-related cataract
  - H25.9 Unspecified age-related cataract
  - H26.10X Unspecified traumatic cataract
  - H26.11X Localized traumatic opacities
  - H26.12X Partially resolved traumatic cataract
  - H26.13X Total traumatic cataract
  - H26.20 Unspecified complicated cataract
  - H26.21X Cataract with neovascularization
  - H26.22X Cataract secondary to ocular disorders (degenerative)(inflammatory)
  - H26.23X Glaucomatous flecks (subcapsular)
  - H26.3X Drug-induced cataract
  - H26.40 Unspecified secondary cataract
  - H26.41X Soemmering's Ring
  - H26.49X Other secondary cataract
  - H26.8 Other specified cataract
  - H26.9 Unspecified cataract
  - H28 Cataract in diseases classified elsewhere
  - H27.0X Aphakia, H27.1X Dislocation of lens
- Providers must bill Omidria with HCPCS code J3490 unclassified drugs.
  - One Medicaid unit of coverage for Omidria is one 5mL single-patient-use vial per surgical procedure. NCHC bills according to Medicaid units. The maximum reimbursement rate per one vial is \$502.20.
  - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Omidria are 62225-0600-00, 62225-0600-04, 62225-0600-10, and 62225-0600-99.
  - The NDC units for phenylephrine and ketorolac injection 1% / 0.3% vial (Omidria) should be reported as “UN1”.
  - For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
  - Providers will bill their usual and customary charge for non-340-B drugs.
  - PDP reimburses for drugs billed for Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs will bill the cost that is reflective of their acquisition cost. Providers will indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
  - The fee schedule for the PDP is available on [DMA’s fee schedule web page](#).

**CSC, 1-800-688-6696**



### 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/](http://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
<b>November</b>	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
<b>December</b>	12/03/15	12/08/15	12/09/15
	12/10/15	12/15/15	12/16/15
	12/24/15	12/29/15	12/30/15

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

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**Paul Guthery**  
 Executive Account Director  
 CSC