N.C. Medicaid Bulletin
December 2017

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Attention to: All Providers

2017 Single Audit

In accordance with 2 CFR part 200, subpart F, the N.C. Office of the State Auditor (OSA) annually selects a sample of N.C. Medicaid and N.C. Health Choice (NCHC) claims to determine the state's accuracy and error rate for claims paid in the prior state fiscal year (July to June). The Office of Compliance & Program Integrity (OCPI) is in the process of sending out record request notifications to providers who have a claim pending and are part of the sample group. To minimize costs and prevent delays, OCPI may contact providers by phone to verify the address where these record requests should be mailed.

The record request contains a list of the documents that need to be submitted to OCPI for the review of the claim. The requested documents **must** be sent as soon as possible, but no later than 30 calendar days from receipt of the letter. OCPI is requesting providers who have more than 25 pages of documentation to send it scanned on an encrypted CD or flash drive, with the password submitted separately via email to Medicaid.sa@dhhs.nc.gov.

During the record request process, OCPI may need to ask for additional documentation to support the claim payment. Failure of the provider to make a timely response to a request for documentation may result in the provider being placed on prepayment claims review.

N.C. Medicaid is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR §431.107 to access patient records for purposes directly related to the administration of Medicaid, the Medicaid Waiver, and the NCHC programs. Also, when applying for Medicaid benefits, beneficiaries sign a release which authorizes access to their Medicaid records by N.C. Medicaid and other appropriate regulatory authorities. Therefore, it is not necessary for providers to require a signed consent for the release of records from any affected Medicaid beneficiary to submit the necessary documentation for this review.

Providers with questions may contact OCPI at Medicaid.sa@dhhs.nc.gov.

Office of Compliance and Program Integrity
DMA, 919-814-0172

Attention: All Providers

Common Pitfalls to Avoid with Medicaid claims

Below are common billing errors providers made when attempting to submit accurate and efficient claims for services provided to both N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries.

Accurate coding continues to be a problem in various specialty areas. Coding mistakes identified in current and past years for desk and on-site audits, post payment reviews, Payment Error Rate Measurement (PERM) and Office of State Auditor (OSA) Single Audit examples are listed below:

- **The description of problem provided is not specific enough to justify the coding or the Diagnostic Related Group (DRG) used.** Provider should be as detailed as possible in their descriptions of the diagnoses involved with the patient. In addition, they should provide details of specific qualifiers that tell of finite problems, rather than just generalities.

- **Coding that is used "unbundles" the procedure or activity being charged, rather than using the correct code which combines activities appropriately.** For example, when submitting a dental claim for filling cavities on three adjoining tooth surfaces, providers must charge for two adjacent surfaces as a "bundled" charge, and the additional one can be charged as a single surface charge. Providers should not submit a claim for three separate, individual charges.

- **Medication units used do not match the written documentation of the service provided for the procedure documented.** For example, the claim submitted for six units of medication used during a procedure; but, in the written procedural summary, only four units were documented as being used. The actual medication usage must match the surgical or anesthesia notes for claims to be accurately paid to the provider.

Submit detailed, accurate documentation for each claim submitted for payment. The following recommendations for document submission can assist in keeping in compliance with regulatory and audit obligations:

- **Sometimes providers must send further, specific information to validate the services submitted in the claim.** For example, if a child has a fractured femur as a primary diagnosis, and this is submitted on the claim along with charges for respiratory therapy treatments and pharmaceutical charges for Albuterol, the provider will be asked for further documentation for these latter charges. This could be avoided with the additional diagnosis of bronchial asthma with severe respiratory distress.

- **Provision of the requested materials earlier than the stated "due date" is highly recommended.** Providers know that the best plans can be delayed at the most inopportune times and other actions may take higher priority in the day-to-day provision of patient care. Avoid these issues by having the requested medical records sent out near the date of request. If additional documents are needed, you will not risk missing the deadline and having the potential for a negative impact on cost reimbursement due to "improper documentation received."

- **Keep all information current within the beneficiary's Medicaid medical record**. Many times, multiple attempts are made to request the additional information from the provider only to find out that the Medicaid beneficiary's Medical Record is not complete and lacks continuity based on the services provided. Thus, the provider may be penalized for non-response or have little time left on a due date timeline.

Office of Compliance and Program Integrity
DMA, 919-814-0154

Attention: All Providers

Hysterectomy Claim Submission

Note to Providers: This article was previously published in the November 2017 Medicaid Bulletin.

Since July 1, 2013, some hysterectomy claims billed without a diagnosis that supports medical necessity have processed in error. The claims have not processed through hysterectomy edits, as they did prior to July 1, 2013. Providers are encouraged to review Clinical Policy 1E-1, *Hysterectomy*, for specific diagnosis that validate medical necessity for a hysterectomy procedure.

All provider types submitting claims for reimbursement, including any associated services following a hysterectomy procedure, **will be denied or recouped** if a diagnosis that supports medical necessity is not submitted on the hysterectomy claim.

A provider notification will be posted when claim reprocessing is required.

For more information, providers should refer to the Clinical Coverage Policy 1E-1, *Hysterectomy, on* DMA's Obstetrics and Gynecology Clinical Coverage Policy web page.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Clarification on Patient Monthly Liability Discrepancies

Patient Monthly Liability (PML) is the amount the beneficiary is responsible for toward their monthly cost of long term care. Upon determination of Medicaid eligibility for long term care services by the county Department of Social Services (DSS), the Medicaid provider will receive notification of the applicant or beneficiary's PML. The DMA-5016, *Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability*, is used to notify providers of the PML amount and any changes to the PML amount. Providers are required to retain the DMA-5016 for audit purposes. The dates and the amounts on the DMA-5016 must match the information on the beneficiary's eligibility detail in NCTracks. If the dates and the amounts do not match, the provider must contact the county DSS that sent the DMA-5016, for corrections.

Providers may experience discrepancies with the beneficiary's current eligibility which prevents them from billing for long term care services. The discrepancies may include but are not limited to:

- No patient monthly liability listed on the beneficiary's file in NCTracks
- No DMA-5016 received by the provider
- Dates or amounts listed on the DMA-5016 do not align with the dates or amounts on the beneficiary's eligibility detail in NCTracks

Providers experiencing any discrepancies must contact the DSS in the beneficiary's county of residence to have the information corrected.

Those with questions about PML should contact the N.C. Medicaid Contact Center at 1-888-245-0179.

Providers experiencing billing issues not related to the DMA-5016 and PML amount should contact NCTracks at 1-800-688-6696.

Recipient Services
DMA, 919-813-5340

Attention: All Providers

NC Medicaid Electronic Health Record Incentive Program Announcement

Program Reminders

There are only five months left to submit an attestation for Program Year 2017.

Providers will have until April 30, 2018, to submit a complete and accurate attestation for Program Year 2017. **After that no changes can be made.** Providers are encouraged to attest as soon as possible to give time to address any problems and discrepancies.

Providers need six years of successful participation to earn the full incentive payment of $63,750. This means providers who started participating in the N.C. Medicaid EHR Incentive Program in Program Year 2016 must successfully attest each remaining year of the program, through Program Year 2021, to receive their full incentive payment. Even if denied in a previous program year, providers who successfully attested at least once by Program Year 2016 are encouraged to return now to have the opportunity to earn the full incentive payment.

As a reminder, if providers were paid for Program Year 2016 using a patient volume reporting period from calendar year 2016, they may use the same patient volume reporting period when attesting in Program Year 2017.

In Program Year 2017, providers have the option to attest to Modified Stage 2 Meaningful Use (MU) or Stage 3 MU. For objective and measure requirements, providers should refer to the CMS Specification Sheets.

- Click here for CMS' Modified Stage 2 MU Specification Sheets
- Click here for CMS' Stage 3 MU Specification Sheets

The attestation guides are updated each year, so providers are encouraged to use the updated attestation guide every year they attest. The attestation guides may be found on the right-hand side of the N.C. Medicaid EHR Incentive Payment System (NC-MIPS). To see the current Modified Stage 2 MU Attestation Guide, click here. To see the current Stage 3 MU Attestation Guide, click here.

Note: Clinical Quality Measures (CQM) have been updated in Program Year 2017. Providers will now select six CQMs from a list of 53. To see the Program Year 2017 CQMs, visit the Electronic Clinical Quality Improvement Resource Center (eCQI) website.

For more information, please visit the N.C. Medicaid EHR Incentive Program web page.

Updates for Program Year 2018

On Aug. 14, 2017, the Centers for Medicare and Medicaid Services (CMS) issued the Inpatient Prospective Payment System (IPPS) Final Rule. The release of this final rule has made the following impacts to the N.C. Medicaid EHR Incentive Program in Program Year 2018:

- Stage 3 Meaningful Use (MU) is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU;
- Providers may choose to use a 2014 Edition Certified EHR Technology (CEHRT), 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT;
- Providers will now be selecting six CQMs from a list of 53 (applicable in Program Year 2017); and,
- Providers will be able to continue using a 90-day MU reporting period.

Visit the N.C. Medicaid EHR Incentive Program website for additional updates as they become available.

N.C. Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers

Increase in Age Coverage for Human Papilloma Virus Vaccines for NC Medicaid

Effective Oct. 1, 2017, N.C. Medicaid will cover the Gardasil and Gardasil 9 vaccines for male and female beneficiaries up through 26 years of age, and the Cervarix vaccine for women up through 25 years of age, as indicated by the Food and Drug Administration (FDA).

The Centers for Disease Control (CDC) recommends that all females and males be vaccinated against HPV starting at 9 years of age. Beneficiaries who did not get vaccinated when they were younger should get vaccinated when possible up through the age of 26 years.

CPT codes are 90651 for Gardasil 9, 90649 for Gardasil, and 90650 for Cervarix. Professional claims for vaccines must now include correct NDC numbers that correspond to the vaccine administered. Providers can use CPT administration codes 90471 and 90472 for vaccines administered to beneficiaries 21 years and older. Providers may bill more than one unit of 90472, as appropriate, if multiple vaccines are administered.

Professional claims for covered vaccinations administered to N.C. Medicaid beneficiaries should be submitted electronically through the NCTracks website using the professional claim format (CMS 1500 form) or an 837P electronic batch transaction.

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

CSRA, 1-800-688-6696

Attention: All Providers

NC HealthConnex Connection Required by June 1, 2018 for Medicaid Hospitals, Physicians and Mid-Level Practitioners

Per Session Law (S.L.) 2015-241, as amended by S.L. 2017-57, North Carolina providers who are reimbursed by the state for providing health care services under Medicaid and N.C. Health Choice (NCHC) programs must join NC HealthConnex, the state-designated Health Information Exchange.

As of June 1, 2018, hospitals, mid-level physicians and nurse practitioners who currently have an electronic health record system are to be connected to NC HealthConnex to continue to receive payments for Medicaid and N.C. Health Choice services. **By June 1, 2019**, all other Medicaid and state-funded providers must be connected, including the State Health Plan, Program for All-Inclusive Care of the Elderly (PACE) and state grants.

The NC Health Information Exchange Authority (HIEA), the N.C. Department of Information Technology agency that manages NC HealthConnex, will host "How to Connect" webinars on the last Monday of each month at noon to educate providers affected by this law, describe the technical and onboarding requirements, and answer questions about the legal Participation Agreement that governs the data connection. In the meantime, providers can learn more at nchealthconnex.gov/how-connect.

To register for the next webinar at noon on Monday, Dec. 18, and to learn more about NC HealthConnex, visit nchealthconnex.gov**.**

NC HealthConnex links disparate systems and existing North Carolina HIE networks to deliver a holistic view of a patient's record. It currently houses 3.9 million unique patient records, allowing providers to access their patients' comprehensive records across multiple providers, and review consolidated lists of items including labs, diagnoses, allergies and medications.

Providers with questions can contact the NC HIEA staff at 919-754-6912 or hiea@nc.gov**.**

NC Health Information Exchange Authority
919-754-6912

Attention: All Providers

Dietary Evaluation and Counseling Policy Revision

Effective Dec. 3, 2017, Clinical Coverage Policy (CCP) 1-I, *Dietary Evaluation and Counseling and Medical Lactation Services* will be updated.

Medical lactation services covered in CCP 1-I include lactation evaluation and breastfeeding counseling when the breastfeeding infant has a chronic, episodic, or acute condition for which medical lactation services are a critical component of medical management.

Beginning Dec. 3, 2017, three new codes (96150, 96151, 96152) will be available when an International Board Certified Lactation Consultant (IBCLC) provides medical lactation support. These codes require modifier SC when billed for Medical Lactation support services and are billed under the infant's MID. The initial lactation assessment (96150-SC) is allowed only once per beneficiary lifetime. Lactation support services (any combination of 96150-96152 with modifier SC) are limited to a total of six units per single date of service, up to a total of 36 units per beneficiary lifetime.

Medical lactation services can be billed by physicians, certified nurse midwives, nurse practitioners, and physician assistants. Health departments who employ one of these providers or an IBCLC may bill for medical lactation services. Rural health centers and federally qualified health centers will bill medical lactation provided by an IBCLC as part of a core service.

For information regarding the use of the CPT codes and the modifier describing the services in CCP 1-I, see Attachment A, Sections C and Section E.

Practitioners, Facilities and Policy Development
DMA, 919-855-4260

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 clinical coverage policy web pages:

- 1-I, *Dietary Evaluation and Counseling and Medical Lactation Services* – Dec. 1, 2017

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Reimbursement of Long Acting Reversible Contraceptives

The Center for Medicare and Medicaid Services (CMS) has approved the N.C. State Plan Amendment NC 17-0010 to add diagnosis related group codes (DRGs) for the payment of long-acting reversible contraception (LARC) services with an effective date of Oct. 1, 2017.

Effective for dates of service on or after Oct. 1, 2017, the following DRG classifications specific to LARCs have been added to the current Grouper 35 version within NCTracks for claims reimbursement.

- 1765 Cesarean section with comorbid condition or major complicating or comorbid condition (CC/MCC) with LARC
- 1766 Cesarean section without CC/MCC with LARC
- 1767 Vaginal delivery with sterilization &/or dilation and curettage (D&C) with LARC
- 1768 Vaginal delivery with operating room procedure except for sterilization &/or D&C with LARC
- 1769 Postpartum & post abortion diagnoses with operating room procedure with LARC
- 1770 Abortion with D&C, aspiration curettage or hysterectomy with LARC
- 1774 Vaginal delivery with complicating diagnoses with LARC
- 1775 Vaginal delivery without complicating diagnoses with LARC
- 1776 Postpartum & post abortion diagnoses without O.R. procedure with LARC
- 1777 Ectopic pregnancy with LARC
- 1779 Abortion without D&C with LARC

A copy of the DRG Grouper Version 35 weights and thresholds in Excel format are posted to the N.C. Division of Medical Assistance (DMA) Fee Schedule web page (see header under "Hospitals") and the Grouper 35 DRG Weight Table.

Inpatient Hospital Services

The payment of LARCs is included in the DRG payment of the delivery. Since this is a covered service, the cost of the LARC is an allowable cost on the cost report, which is used in the calculation of the MRI/GAP supplemental payments.

Outpatient Hospital Services

If the LARC is inserted/implanted during an outpatient encounter, the LARC is billed on the claim, along with the appropriate HCPCS, NDC codes. If the LARC is billed under 340B pricing, the UD modifier must be used. DMA will reimburse the hospital claim at 70 percent of cost. Similar to inpatient services, the cost is allowable and will be considered in the calculation of the MRI/GAP supplemental payments.

Provider Reimbursement
DMA, 919-814-0060

Attention: All Providers

NCTracks Training Available in December 2017

Registration is open for several instructor-led training courses for providers and state operations staff that will be held in December 2017. The duration varies depending on the course. **WebEx** courses are limited to 115 participants. They can be attended remotely from any location with a telephone, computer and internet connection. **On-site** courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. Following are details on the courses, including dates, times and how to enroll.

Provider Trainings

OPR Lite Enrollment (WebEx)

- Monday, Dec. 4, 2017 - 1 - 3 p.m., or,
- Wednesday, Dec. 6, 2017- 1 - 3 p.m.

This course will guide the user through the process of submitting an Ordering, Prescribing and Referring (OPR) provider full and OPR lite enrollment application. At the end of the course, users will be able to:

- Understand the differences between a full provider enrollment and an OPR lite provider enrollment
- Submit an OPR Lite Application
- Upgrade from an OPR lite provider to a fully enrolled provider via a manage change request

Dental Helpful Hints (WebEx)

- Friday, Dec. 8, 2017 - 9:30 am - noon

This course discusses some helpful tips to remember when submitting a request for dental prior approvals (PA)

Note: This course will **not** provide instructions on how to submit a request for dental PA.

The objectives that will be covered are:

- Identifying the three methods of PA submission
- Identifying how to upload documents when submitting a new PA request or adding information to an existing PA request via NCTracks
- Identifying the most common errors when completing an American Dental Association form
- Identifying common errors that require requests for PA additional information
- Identifying the common mistakes when submitting claims

Orthodontics Helpful Hints (WebEx)

- Friday, Dec. 8, 2017 - 1 - 4 p.m.

This course discusses some helpful tips to remember when submitting a request for orthodontic prior approval (PA).

Note: This course will not provide instructions on how to submit an orthodontic PA.

The objectives are:

- Identifying the three methods of PA submission
- Identifying how to upload documents when submitting new PA requests or adding information to an existing PA request via NCTracks
- Identifying the most common errors when completing the American Dental Association form
- Identifying common errors that require requests for PA additional information
- Requesting payment for orthodontic records.
- Submitting a PA request for orthodontic treatment requiring orthognathic surgery
- Using the orthodontic PA attachment forms

Prior Approval Medical (On-Site)

- Monday, Dec. 11, 2017 - 9:30 am - noon

This course shows authorized users how to electronically submit and inquire about prior approvals (PA) for different kinds of medical services and drugs, as well as how to submit managed care referrals and inquire about managed care referrals and overrides. After completing this course, authorized users will be able to:

- Submit PA requests and managed care referrals electronically
- Conduct electronic inquiries about PAs, and managed care referrals and overrides

Submitting a Professional Claim

- Monday, Dec. 11, 2017 - 1 - 4 p.m.

The NCTracks Provider Portal uses a provider's NCID username and password to gain access to a secure online environment for submitting claims. This course will focus on how to submit a professional claim. At the end of training, the authorized user will be able to do the following:

- Submit a professional claim
- Save a draft
- Use Claims Draft Search
- Submit a claim
- View results of a claim submission

State Operations Training

Registration is open for several instructor-led training courses for State Operations users that will be held in December 2017. The duration varies depending on the course. **WebEx** courses are limited to 115 participants. They can be attended remotely from any location with a telephone, computer and internet connection.

Non-Live Interaction Training (WebEx)*

- Wednesday, Dec. 13, 2017 – 10 a.m. - noon

In this training, users are provided with information on how to navigate the system to request or search for a non-live interaction (NLI). The users will also gain an understanding of the call center and functional area Subject Matter Expert (SME) process for NLI requests. At the end of this training, the user will be able to:

- Submit an NLI request
- Identify NCTracks Operation Contact Center's responsibility
- Identify NCTracks functional area SME responsibility
- Search for NLIs within the Operations Portal

**A Non-Live Interaction is a correspondence received via email. The interaction is recorded, logged and forwarded to the appropriate call center workbasket for review and processing.*

Enrollment Instructions for Providers

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

Enrollment Instructions for State Operations Staff

State Operations Users can register for the course in SkillPort. Logon to the secure NCTracks Operations Portal and click the "Other" tab to select "Learning Management System." Once in SkillPort, select "State Operations Training" under "Catalog" and open the folder labeled "ILT Remote via WebEx." The course can be found in the appropriate sub-folder based on the topic. (Refer to the Quick Links on the public Operations Portal home page for detailed instructions on how to use SkillPort.)

CSRA 1-800-688-6696

Attention: All Providers

Claims Pended for Incorrect Billing Location – Update Change in Edit Disposition

Note: This article was previously published in the September 2017 Medicaid Bulletin. It is being republished **with updates**.

Effective Oct. 29, 2017, the N.C. Department of Health and Human Services (DHHS) will validate through NCTracks that the billing provider's address submitted on the claim corresponds to the location listed on the provider record for the dates of service submitted. The billing provider address, city, state, and zip code (first 5 digits) on all N.C. Medicaid and N.C. Health Choice claims must match exactly with the corresponding information on the provider record. (The match is not case sensitive.)

Note: It was previously announced the claim would pend for 60 days. The edit will be implemented with a "pay and report" status. Providers will receive an informational Explanation of Benefits (EOB) 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE.

NCTracks will use the address submitted on the claim (837 D, P, and I - Loop 2010AA / ADA Dental – box 48, CMS-1500 block 33and UB04 – Form Locator 1) to match to a service location address on the provider's record. If NCTracks cannot match the billing provider's address to an active service location in the NCTracks provider's file, the provider will receive on the paper Remittance Advice (RA) the informational EOB code 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE. This EOB indicates that the provider should add or correct the billing provider address on the provider's record in NCTracks or correct the address submitted on the claim.

The edit disposition of pay and report is temporary. Announcement to providers will be made when the edit disposition will change to pend. Claims pended with EOB 04529 will automatically recycle daily, so if the provider adds the correct address to the provider record, the claim will resume processing. If the provider does not add the correct address to the provider record within 60 days, the claim will be denied.

Provider records can be updated with a new billing provider address by submitting a Manage Change Request (MCR) in the secure NCTracks provider portal. Alternatively, providers can correct the billing provider's address on the claim so it matches a service location on the billing provider's record.

Note: MCRs may be subject to credentialing and verification. For guidance on submitting an MCR, refer to the User Guide, *How to Change the Physical Address in NCTracks*, in SkillPort.

Claims with dates of service prior to Oct. 29, 2017, will not be subjected to the edit. Pharmacy and crossover claims also will be excluded from the edit. Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Fingerprinting Process for Providers

Note: This article was originally published in the October 2017 Medicaid Bulletin. This is the final Medicaid Bulletin publication.

'High risk" individual providers and provider organizations, as outlined in NC General Statute 108C-3g, and individual owners with 5 percent or more direct or indirect ownership interest in a "high risk" organization are required to submit fingerprints to the N.C. Medicaid program.

The provider's Office Administrator (OA) will receive two notifications through the NCTracks provider portal, Provider Message Center Inbox, for each person required to submit fingerprints. One notification will be a letter with instructions and the other will be a Fingerprint Submission Release of Information Form. The OA also will receive an email for each party required to submit fingerprints. The email will have the Fingerprint Submission Release of Information Form attached.

The Fingerprint Submission Release of Information form should be printed and completed by the provider prior to taking it to any one of the LiveScan locations. There is also a section on this form that **must be signed by the official taking the fingerprints**.

Once the provider is fingerprinted and the Fingerprint Submission Release of Information form is signed at the LiveScan location, the OA will electronically upload the form to the provider's record in NCTracks by using the following steps:

1. From the Submitted Applications section of the Status and Management page, the OA will see that any NPI that has a status of "In Review" will also have a hyperlink to Upload Documents.

2. Select the Upload Documents link. Once the link is selected, the OA will be able to browse for and attach the form.

3. Select the Upload Documents link found under the Fingerprint Evidence Documents section.

At this point the process is complete, and the provider will be able to go to the Status and Management page for an updated application status.

Note: Individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken. It is recommended that you contact the fingerprinting agency to confirm the fee prior to going.

If the applicant opts to do a Fingerprinting card, rather than a live scan, they must mail the fingerprint card to the SBI for processing at NCSBI/Applicant Unit 3320 Garner Road Raleigh, NC 27626. The Electronic Submission Release of information form is still required to be uploaded to NCTracks.

Note: The Fingerprinting card should not be mailed to the address on the form. Mailing these documents will delay the application processing and could result in a for cause denial or termination.

More information on the Fingerprinting Application Process can be found in the NCTracks Fingerprinting Application Required Job Aid. This link also provides additional resources and information including answers to Frequently Asked Questions (FAQs) and locations for fingerprinting services. Providers can also refer to the Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks article in the August 2017 Medicaid Bulletin.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksProvider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Medicaid Required Enrollment Fees

Note: This article was originally published in the June 2017 Medicaid Bulletin and revised in the November 2017 Medicaid Bulletin. It is being republished with revisions for the month of December 2017.

The N.C. Medicaid and N.C. Health Choice (NCHC) application fee is $100, which covers costs associated with processing enrollment applications. The $100 application fee is required for both in-state and border-area (within 40 miles) providers during initial enrollment and when providers complete the five-year re-verification process.

If an out of state provider chooses to enroll using the full-enrollment application, the $100 fee will apply. Out of state providers using the lite-enrollment application have the option to change from lite to full enrollment by submitting a Manage Change Request (MCR). In that case, they also will also be required to pay the $100 application fee.

If the application is abandoned, withdrawn, or denied, the provider will be required to pay the application fee a second time upon re-submission of the application.

In addition, some providers are required to pay the Affordable Care Act (ACA) application fee. These providers are defined in federal regulation at 42 CFR 455.460, and in N.C. General Statute 108C-3 (e) and (g) as moderate- or high-risk. The ACA application fee is $560 for calendar year 2017, and may be adjusted by the Centers for Medicare and Medicaid Services (CMS) annually. This fee covers the costs associated with provider screening during the enrollment process. The application fee will be collected during initial enrollment, adding a new site location, re-enrollment, and five-year reverification.

Currently the fee collection is a manual process for NCTracks internally. On Jan. 28, 2018, system modifications in NCTracks will be made to automate the fee collection for a more efficient processing time for enrollment, re-enrollment, MCR and reverification applications. Because of the changes, all enrollment, re-enrollment, MCR and re-verification applications currently in "saved draft" status will be deleted on Jan. 28, 2018. To prevent these applications from being deleted, the draft must be completed. Applications created on or after Jan. 29th can once again be saved to draft.

Providers are encouraged to review the Status and Management page on the secure NCTracks Provider Portal for applications that have been initiated by the Enrollment Specialist (ES) or Office Administrator (OA), but not completed. When there is a saved draft application provider's will see "N/A" under the "Select" column of the Records Results. For more information on enrollment fees, refer to in the September 2017 Medicaid Bulletin article, "*Medicaid Required Enrollment Fees.*"

Provider Services
DMA, 919-855-4050

Attention: All Providers

Re-credentialing Due Dates for Calendar Year 2017 and 2018

Note: This article is being republished monthly. It was originally published in the December 2016 Medicaid Bulletin.

List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2017 and the first quarter (January through April) of 2018 is available on the provider enrollment page of the N.C. Medicaid website under the "Re-credentialing" header. Providers can use this resource to determine their re-credentialing/re-validation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

Providers will receive a notification letter 45 days before their re-credentialing due date. Providers are required to pay a $100 application fee for re-credentialing/ reverification. If the provider does not complete the process within the allotted 45 days, payment will be suspended until the process is completed. If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, participation in the N.C. Medicaid and Health Choice programs will be terminated. Providers must submit a reenrollment application to be reinstated.

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. When it is necessary to submit a full Managed Change Request (MCR), the provider must submit the full MCR prior to the 45th day and the MCR application status must be in one of the following statuses to avoid payment suspension:

- In Review
- Returned
- Approved
- Payment Pending

Providers are required to complete the re-credentialing application after the full MCR is completed. Payment will be suspended if the provider does not complete the process by the due date. To lift payment suspension, the provider must submit a re-credentialing application or the full MCR (if required).

When the provider does not submit a reverification application by the reverification due date and the provider has an MCR application in which the status is "In Review, Returned, Approved or Payment Pending," the provider's due date resets to the current date plus 45 calendar days.

Note: Providers must thoroughly review their electronic record in NCTracks to ensure all information is accurate and up-to-date, and take any actions necessary for corrections and updates.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state providers. Out-of-state providers must complete the enrollment process every 365 days.

Providers with questions about the re-credentialing process can contact the NCTracks Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: Durable Medical Equipment Providers

Clinical Coverage Policies 5A-1, 5A-2 and 5A-3: CMS Home Health Final Rule, 42 CFR, Part 440.70

The following updates have been made to the Durable Medical Equipment and Supplies (DME) clinical coverage policies to clarify compliance with Centers for Medicare and Medicaid Services (CMS) Home Health Final Rule, 42 CFR, Part 440.70.

Updates common to 5A-1, 5A-2 & 5A-3

1. **Section 1.2 Categories of Durable Medical Equipment and Supplies,** the last paragraph has been replaced with these three new paragraphs:

   Refer to Attachment A, Section C: Procedure Code(s) for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Medical Supplies.

   For the rates associated with the list of equipment, supplies, and services found in Attachment A, Section C, refer to the Durable Medical Equipment fee schedule at http://dma.ncdhhs.gov/.

   In compliance with the CMS Home Health Final Rule Title 42, §440.70, items not listed in Attachment A, Section C or in the Durable Medical Equipment fee schedule will be considered for coverage if requested by a provider, or a beneficiary through a provider, and submitted for prior authorization (PA) review of medical necessity. For beneficiaries under age 21, request an "EPSDT review" using NCTracks. Refer to section 2.2, *Special Provisions*, for more information about EPSDT. For beneficiaries aged 21 and older, submit the request directly to the Division of Medical Assistance (DMA) per the procedure detailed in Attachment D.

2. **All subsections of Section 5.3 Documenting Medical Necessity,** all occurrences of this statement have been deleted:

   - For a list of the specific HCPCS codes covered, refer to Attachment A, Section C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies.

   And this statement has been added:

   - Refer to Attachment A, Section C: Procedure Code(s) for a list of HCPCS codes, established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see sections 1.2, 2.2 and Attachment D for instructions.

3. **Section 5.4 Amount of Service**, now reads:

   The amount of service is limited to that which is medically necessary as determined by DMA's clinical coverage policies. Refer to Attachment A, Section C: Procedure Code(s), for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see sections 1.2, 2.2 and Attachment D for instructions.

4. **Section 5.5 Durable Medical Equipment and Supplies Limitations**:

   - Sentences two and three now read:

     When the prescribing physician, physician assistant, or nurse practitioner orders equipment or supplies beyond these limits, the provider shall seek authorization for payment for these items through NCTracks. The medical equipment provider shall submit an override request which contains the following information:

   - The last paragraph now reads:

     Refer to Attachment A, Section C: Procedure Code(s) for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies. To request a medical necessity review for an item not listed, see sections 1.2, 2.2 and Attachment D for instructions.

5. **Section 5.8 Servicing and Repairing Medical Equipment,** the second sentence of paragraph two Purchased Equipment Warranty now reads**:**

   If there is no warranty, providers may request prior approval to perform the needed service and repairs by submitting a completed CMN/PA form with a repair estimate to NCTracks.

6. **Section 5.9 Replacing Medical Equipment,** sentence two now reads:

   To request a medical necessity review for an item not listed, see sections 1.2, 2.2 and Attachment D for instructions.

7. **Attachment A: Claims-Related Information, Section C: Procedure Code(s),** paragraph three now reads:

   Refer to the Durable Medical Equipment Fee Schedule for the rates associated with the equipment, supplies, and services listed in the table below. The fee schedules are available on DMA's website: http://dma.ncdhhs.gov/. To request a medical necessity review for an item not listed, see sections 1.2, 2.2 and Attachment D for instructions.

8. The procedure for **Requesting Unlisted DME and Medical Supplies for Adults** has been added to 5A-1 and 5A-2 as Attachment D and to 5A-3 as Attachment E.

Additional Resources

For additional information, please link to the updated policies at Durable Medical Equipment and to the CMS final rule at 42 CFR Part 440.

DMA Clinical Policy and Programs
DMEPOS Section, 919-855-4310

Attention: Home Health Service Providers

Home Health Services: Home Health Final Rule Policy Update

Clinical Coverage Policy 3A, *Home Health Services*, has been updated to reflect the mandatory requirements to support compliance with the Centers for Medicare & Medicaid Services (CMS):

- 42 CFR 440.70 Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health, and,

- 42 CFR Parts 409, 410, 418, 440, 484, 485 and 488 – Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies.

Modified Sections

- **Section 1.0** - Removal of the coverage stipulation that Home Health Services must be provided in the primary private residence (home) of the beneficiary, and that the beneficiary must be homebound to receive services.

  This has been addressed in multiple areas throughout the policy **subsection 3.2.1.1, section 4.2.1, section 5.3.2, attachment A (F)**

- **Section 1.1.1** - Clarification of Skilled Nursing per North Carolina Board of Nursing, NCGS 90-171.20.

- Clarified time frames associated with the assessment type and who can complete an assessment.

- **Section 1.1.2 -** Specialized Therapies regulatory and reference information has been updated to reflect current standards of care.

- **Section 1.1.3 -** Home Health Aide services can be provided **without other skilled services** being ordered, but will require skilled nursing supervision; also, reflected in **Subsection 3.2.1.4**, **Section 6.1.1.**

- **Definitions Added - Sections 1.1.4** Clinical manager, **1.1.5** Representative, **1.1.6** In advance, and **1.1.7** Verbal order

- **Section 1.1.8** - Information clarified regarding items not listed on the fee schedule that may be considered for coverage when submitted by a provider or a beneficiary via their service provider for prior authorization (PA) review of medical necessity. Also, reflected in **Section 5.2.2**, **Attachment B**.

- **Subsection 3.2.1.5 i. -** Information clarified regarding items needed in the provision of physical therapy, occupational therapy, speech language therapy, skilled nursing, or home health aide services can be considered for coverage under the home health policy.

Medical supplies not needed in the provision of these other home health services are available for consideration under Medical Equipment Clinical Coverage Policies. The detailed process for obtaining medical supplies that are on the fee schedule, items not on the fee schedule, and items that exceed the miscellaneous code limits (with and without prior approval). Reference for information related to manual pricing calculations. Also, reflected in **Section 5.3.3.**

- **Section 5.0 -** Updated to include information related to Medicaid for Pregnant Women.
- **Subsection 5.3.1.1 -**Updated to include Telemedicine.
- **Subsection 5.3.1.4 -** Updated to reflect content that must be in the plan of care.
- **Subsection 5.3.1.5 -** Updated process for revision of the plan of care.
- **Section 7.0** - The Home Health Provider (HHP) must develop, implement, evaluate, and maintain an effective, ongoing, HHP-wide, data-driven Quality Assessment and Performance Improvement (QAPI) program in accordance to 42 CFR 484.65 effective July 2018.
- **Section 7.0** - The HHP must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases in accordance with 42 CFR 484.70 effective July 2018.
- **Section 7.4 –** "Beneficiary Rights" section added to reflect the final rule.
- **Section 7.6 –** Updated this section to clarify coordination of services.
- **Subsection 7.6.4.1 -** "Concurrent Care for Children" section was added.
- **Section 7.7.2 -** Clinical records must be retained for five years after the discharge of the patient in accordance with 42 CFR 484.110.
- **Section 7.7.3** – "Discharge or Transfer Documentation" section added to highlight continuity of care.
- **Attachment B** – Attachment added to detail procedure through which Home Health Services Medical Supplies Prior Approval Request for Adults (Medical Supply Items Not Listed on the Fee Schedule or Exceeding the Miscellaneous Procedure Code Limits).

Note: The previous Attachment B was a billing guide that has been removed from the policy. DMA is working with NCTracks to ensure training related to billing is available as needed. Providers are encouraged to refer to computer-based training *CLM 201_How to File an Institutional Claim* in SkillPort on the secure NCTracks provider portal. Refer to the Provider Training page of the portal for specific instructions on how to use SkillPort.

Home Care Services/Community Based Services
DMA, 919-855-4380

Attention: Hospice Providers

Hospice Policy Updates

General Requirements

N.C. Division of Medical Assistance (DMA) clinical review is **not** required for N.C. Medicaid and North Carolina Health Choice (NCHC) hospice service until after the completion of the first and second 90-day benefit period.

- First Benefit Period - The hospice provider must upload, into the NCTracks Provider Portal, the prior approval (PA) request and the election statement within six calendar days of the effective date for hospice election. This notifies DMA of the beneficiary's election of hospice services.
- Second Benefit Period - Only the PA request is entered in NCTracks.
- Third and Subsequent Benefit Periods - The hospice provider shall upload the required documents into the NCTracks provider portal every 60-day benefit period. These documents must be uploaded 10 days prior to the next benefit period.

Effective Nov. 1, 2017, all PA requests regardless of the benefit period will require a one-time upload of the hospice service election statement. In addition, and per policy, documents related to the current benefit period are also required to be uploaded into the NCTracks provider portal at that time.

Providers requesting the beneficiary's current benefit period, shall send requests using secure e-mail, such as ZixMail, to Home Care's secure email address at medicaid.homecareservice@dhhs.nc.gov or fax to 919-717-9025. Providers should indicate "Hospice Benefit Period Inquiring" in the subject line of their inquiry and provide the beneficiary's name, Medicaid ID number (MID), the provider name, and the provider's NPI number.

For dually eligible Medicare and Medicaid beneficiaries in a nursing facility, the agency shall report hospice participation by submitting a PA request. Medicare reimbursement is made for the hospice care, and Medicaid shall reimburse for room and board charges when PA requests have been entered NCTracks prior to service. Hospice claims for room and board are not reimbursed by DMA without prior approval.

Certification PA Requirements

The start of the mandatory clinical review has moved from fifth benefit period to the third benefit period. The movement to the third benefit period requires submission of a hospice face-to-face encounter which must occur no more than 30 calendar days prior to the third benefit period and each subsequent benefit period thereafter. Hospice providers shall upload all required documents via the NCTracks Provider Portal.

The following documents are required for the third and subsequent benefit periods:

- N.C. Medicaid Hospice Prior Approval Authorization Form (NC DMA-3212);
- Hospice Recertification of Terminal Illness;
- Physician Plan of Treatment - Order for care and services;
- Face-To-Face Encounter; and,
- Supporting clinical documentation (e.g., medical history, nurses' notes, interdisciplinary group meeting notes, prognosis)

Following submission of the PA and supporting documents, DMA staff will conduct a Hospice clinical review to confirm PA approval status. Per policy, DMA will change the status from "approved" to "pending" in cases where approval cannot be combined or all required documents are not uploaded into NCTracks. DMA will notify the submitting provider via "read receipt" tracking e-mail to ensure notification has been received. DMA request that all provider correspondence sent via fax or e-mail include the provider contact name, phone number and e-mail address to allow for appropriate notification of any issues that may arise.

Note: All provider e-mail correspondence containing patient health information (PHI) should be sent using secure e-mail such as ZixMail.

With **each PA entry,** providers must fax a copy of the Approval Status Inquiry form or the NCTracks Web Submitted Request for Hospice Prior Approval Confirmation Page to DMA at 919-715-9025. DMA request that providers include their name and e-mail address on the above forms. For PA requests for room and board only, the provider should indicate "Room and Board" on the form.

The hospice provider shall submit a PA request within:

- Six calendar days of the election of the Medicaid, Medicaid-pending or NCHC hospice benefit;
- Six calendar days of the start of the second and each subsequent benefit period; and
- Six calendar days of the start of care, if Medicare is the primary payer and Medicaid is providing coverage for nursing home room and board.

The hospice provider shall report to DMA by faxing the NC DMA Hospice Reporting Form (DMA-0004) for the following situations:

- The beneficiary is discharged from or revokes hospice;
- The time of the beneficiary's death;
- To coordinate reporting a transfer of hospice care from one agency to another. This prevents duplication of dates of service and subsequent denial of payment as only one agency can be paid each day; and,
- To notify DMA of changes in status from *Medicaid-Pending* to *Medicaid-Approved* by providing the MID number.

Patient Monthly Liability

The hospice agency assumes responsibility for collecting the Patient Monthly Liability (PML). The agency must notify the local Department of Social Services (DSS) of the beneficiary's election of hospice, and DSS forwards the hospice agency notification of the PML amount on the Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability Form (DMA-5016). The hospice shall include the collection of PML in the contractual agreement. The nursing facility may act as the hospice agent in collecting the PML if this arrangement is included in the contractual agreement.

Hospice Document Type Designation Within NCTracks

Hospice providers shall upload all required documents in the NCTracks Provider Portal using the attachment type that corresponds with the documents below:

Document Name	Attachment Type
Election Statement	**CONTREAT**
NC Medicaid Hospice Prior Approval Authorization Form (NC DMA-3212)	**ADMINSUMM**
Hospice Recertification of Terminal Illness	**HEALTHCERT**
Physician Plan of Treatment - Order for care and services	**TREATPLAN**
Face-To-Face Encounter	**PHYSICAN**
Supporting clinical documentation (e.g., medical history, nurses' notes, IDG notes, prognosis; Tools such, as but not limited to, Fictional Assessment Scales, Palliative Performance Scales, Hospice Card, New York Heart Association Functional Classification Tool, Palmetto Eligibility Scale Tool, and Local Coverage Determination. Ensure all health and other records that support the beneficiary have met the specific criteria in **Subsection 2.0** of this policy.	**MEDREC**
NC DMA Hospice Reporting Form (DMA-0004)	**DISCHREP**

The

NCTracks Provider User Guides for *How to Submit Prior Approval Attachments in NCTracks* and a step-by-step instructions training guide can be found on the NCTracks Provider User Guides and Training web page.

Home Care Services/Community Based Services
DMA, 919-855-4380

Attention: Hospice Providers

Hospice Payment Reform

As previously communicated in the January 2016 Medicaid Special Bulletin, *CBSA Codes and Hospice Payment Reform*, the Centers for Medicare and Medicaid Service (CMS) issued guidance in 42 CFR 418, Hospice Payment Reform, The Core Based Statistical Area (CBSA).

With the implementation of Hospice Payment Reform, N.C. Medicaid made policy and system changes to allow the use of two-tier hospice fee schedules for Jan. 1, 2016, Oct. 1, 2016, and Oct. 1, 2017. Hospice Payment Reform implemented the use of two Routine Home Care (RHC) rates based on days on hospice service and a Service Intensity Add-on (SIA) payment for services provided during the last seven days of life.

On Oct. 29, 2017, CSRA released the NCTracks system update that coincides with the implementation of the payment reform components. Beginning, Nov. 1, 2017, all claims for hospice service are reimbursed in accordance with the requirements of Hospice Payment Reform.

N.C. Medicaid continues to work with hospice stakeholders to finalize the details of the phase-in approach that will be used to reprocess claims for services provided from Jan. 1, 2016 to Oct. 31, 2017.

Routine Home Care Rates Policy

N.C. Medicaid has implemented the FY 2016 Medicare Hospice Payment Reform which replaces the single routine home care per diem rate with a two-tier RHC payment rate system:

- A higher payment rate for the first 60 days of hospice care; and
- A lesser payment rate for day 61 and beyond.

If a beneficiary is readmitted into hospice, a 60-day gap in hospice service is required to reset the counter that determines if a beneficiary is qualified for the 1-60 days' payment tier.

Note: Hospice providers that submitted a claim between Oct. 29, 2017 and Nov. 3, 2017, which were incorrectly paid $0.00, will need to submit adjustment claims.

Service Intensity Add-On

The SIA payment is reimbursed in addition to the per diem RHC rate when all the following criteria are met:

- The service day is an RHC level of care day
- The service day occurs during the last seven days of the beneficiary's life
- The beneficiary is discharged expired, and,
- Direct patient care is furnished by a registered nurse (RN) or social worker (SW) on the qualifying day.

The SIA payment is based on the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct care provided by an RN or SW during the last seven days of life in increments of 15 minutes, up to four hours per day.

New G-codes will be used to identify the SIA provider (RN or SW) in conjunction with Revenue Code 0235.

HCPCS Code(s)	Description
G0299	Direct skilled nursing services of an RN in the home health or hospice setting, each 15-minute increment up to four hours per day.
G0300	Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting, each 15-minute increment up to four hours per

As previously announced in the November 2017 Medicaid Bulletin, status code 20 is no longer accepted. Providers must use status code 40 (Expired at home), 41 (Expired at medical facility) and 42 (Expired place unknown) to report the death.

Date of Death information must be provided to end date a PA due to beneficiary expiration and to ensure timely reimbursement for SIA claims. Required information includes:

- Beneficiary name
- Beneficiary Medicaid ID number
- Providers contact information
- Provider NPI
- Date of Death

This information is to be submitted on the NC DMA Hospice Reporting Form (DMA-0004). Hospice providers should submit DMA-0004 forms via fax to 919-715-9025.

If providers receive an "error message" indicating missing or incorrect date of death, they should submit the DMA-0004 form to N.C. Medicaid via fax (as indicated above) and an N.C. Division of Medical Assistance (DMA) hospice nurse consultant will update the information in the system. This will allow continued processing of previously pended claims.

Note: Be sure you use a secure email when corresponding with DMA.

Home Care Services/Community Based Services
DMA, 919-855-4380

Attention: Nurse Practitioners, Physicians and Physicians Assistants

Copanlisib injection, for intravenous use (Aliqopa) HCPCS code J9999: Billing Guidelines

Effective with date of service Sept. 18, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover copanlisib injection, for intravenous use (Aliqopa) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs. Aliqopa is available as 60 mg of lyophilized solid in single-dose vial for reconstitution.

Aliqopa is indicated for the treatment of adult patients with relapsed follicular lymphoma (FL) who have received at least two prior systemic therapies. Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Recommended dose is 60 mg administered as a one-hour intravenous infusion on days one, eight and 15 of a 28-day treatment cycle on an intermittent schedule (three weeks on and one week off). Modify dosage for toxicity. Continue treatment until disease progression or unacceptable toxicity.
See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are:
    - C82.00 Follicular lymphoma grade I, unspecified site;
    - C82.01 Follicular lymphoma grade I, lymph nodes of head, face, and neck;
    - C82.02 Follicular lymphoma grade I, intrathoracic lymph nodes;
    - C82.03 Follicular lymphoma grade I, intra-abdominal lymph nodes;
    - C82.04 Follicular lymphoma grade I, lymph nodes of axilla and upper limb;
    - C82.05 Follicular lymph grade I, lymph nodes of inguinal region & lower limb;
    - C82.06 Follicular lymphoma grade I, intrapelvic lymph nodes;
    - C82.07 Follicular lymphoma grade I, spleen;
    - C82.08 Follicular lymphoma grade I, lymph nodes of multiple sites;
    - C82.09 Follicular lymphoma grade I, extranodal and solid organ sites;
    - C82.10 Follicular lymphoma grade II, unspecified site;
    - C82.11 Follicular lymphoma grade II, lymph nodes of head, face, and neck;
    - C82.12 Follicular lymphoma grade II, intrathoracic lymph nodes;
    - C82.13 Follicular lymphoma grade II, intra-abdominal lymph nodes;
    - C82.14 Follicular lymphoma grade II, lymph nodes of axilla and upper limb;
    - C82.15 Follicular lymph grade II, lymph nodes of inguinal region & lower limb;
    - C82.16 Follicular lymphoma grade II, intrapelvic lymph nodes;
    - C82.17 Follicular lymphoma grade II, spleen;
    - C82.18 Follicular lymphoma grade II, lymph nodes of multiple sites;
    - C82.19 Follicular lymphoma grade II, extranodal and solid organ sites; C82.20 Follicular lymphoma grade III, unspecified site;

- C82.21 Follicular lymphoma grade III, lymph nodes of head, face, and neck;
- C82.22 Follicular lymphoma grade III, intrathoracic lymph nodes;
- C82.23 Follicular lymphoma grade III, intra-abdominal lymph nodes;
- C82.24 Follicular lymphoma grade III, lymph nodes of axilla and upper limb;
- C82.25 Follicular lymph grade III, lymph nodes of inguinal region & lower limb;
- C82.26 Follicular lymphoma grade III, intrapelvic lymph nodes;
- C82.27 Follicular lymphoma grade III, spleen;
- C82.28 Follicular lymphoma grade III, lymph nodes of multiple sites;
- C82.29 Follicular lymphoma grade III, extranodal and solid organ sites;
- C82.30 Follicular lymphoma grade IIIA, unspecified site;
- C82.31 Follicular lymphoma grade IIIA, lymph nodes of head, face, and neck;
- C82.32 Follicular lymphoma grade IIIA, intrathoracic lymph nodes;
- C82.33 Follicular lymphoma grade IIIA, intra-abdominal lymph nodes;
- C82.34 Follicular lymphoma grade IIIA, lymph nodes of axilla and upper limb;
- C82.35 Follicular lymphoma grade IIIA, lymph nodes of inguinal region and lower limb;
- C82.36 Follicular lymphoma grade IIIA, intrapelvic lymph nodes;
- C82.37 Follicular lymphoma grade IIIA, spleen;
- C82.38 Follicular lymphoma grade IIIA, lymph nodes of multiple sites;
- C82.39 Follicular lymphoma grade IIIA, extranodal and solid organ sites;
- C82.40 Follicular lymphoma grade IIIB, unspecified site;
- C82.41 Follicular lymphoma grade IIIB, lymph nodes of head, face, and neck;
- C82.42 Follicular lymphoma grade IIIB, intrathoracic lymph nodes;
- C82.43 Follicular lymphoma grade IIIB, intra-abdominal lymph nodes;
- C82.44 Follicular lymphoma grade IIIB, lymph nodes of axilla and upper limb;
- C82.45 Follicular lymphoma grade IIIB, lymph nodes of inguinal region and lower limb;
- C82.46 Follicular lymphoma grade IIIB, intrapelvic lymph nodes;
- C82.47 Follicular lymphoma grade IIIB, spleen;
- C82.48 Follicular lymphoma grade IIIB, lymph nodes of multiple sites;
- C82.49 Follicular lymphoma grade IIIB, extranodal and solid organ sites;
- C82.50 Diffuse follicle center lymphoma, unspecified site;
- C82.51 Diffuse follicle center lymphoma, lymph nodes of head, face, and neck;
- C82.52 Diffuse follicle center lymphoma, intrathoracic lymph nodes;
- C82.53 Diffuse follicle center lymphoma, intra-abdominal lymph nodes;
- C82.54 Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb;
- C82.55 Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb;
- C82.56 Diffuse follicle center lymphoma, intrapelvic lymph nodes;
- C82.57 Diffuse follicle center lymphoma, spleen;
- C82.58 Diffuse follicle center lymphoma, lymph nodes of multiple sites;
- C82.59 Diffuse follicle center lymphoma, extranodal and solid organ sites;
- C82.60 Cutaneous follicle center lymphoma, unspecified site;
- C82.61 Cutaneous follicle center lymphoma, lymph nodes of head, face, & neck;
- C82.62 Cutaneous follicle center lymphoma, intrathoracic lymph nodes;
- C82.63 Cutaneous follicle center lymphoma, intra-abdominal lymph nodes;

- C82.64 Cutaneous follicle center lymph, lymph nodes of axilla & upper limb;
- C82.65 Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb;
- C82.66 Cutaneous follicle center lymphoma, intrapelvic lymph nodes;
- C82.67 Cutaneous follicle center lymphoma, spleen;
- C82.68 Cutaneous follicle center lymphoma, lymph nodes of multiple sites;
- C82.69 Cutaneous follicle center lymphoma, extranodal and solid organ sites;
- C82.80 Other types of follicular lymphoma, unspecified site;
- C82.81 Other types of follicular lymphoma, lymph nodes of head, face, and neck;
- C82.82 Other types of follicular lymphoma, intrathoracic lymph nodes;
- C82.83 Other types of follicular lymphoma, intra-abdominal lymph nodes;
- C82.84 Other types of follicular lymphoma, lymph nodes of axilla & upper limb;
- C82.85 Other types of follicular lymph, lymph nodes of inguinal region and lower limb;
- C82.86 Other types of follicular lymphoma, intrapelvic lymph nodes;
- C82.87 Other types of follicular lymphoma, spleen;
- C82.88 Other types of follicular lymphoma, lymph nodes of multiple sites;
- C82.89 Other types of follicular lymphoma, extranodal and solid organ sites;
- C82.90 Follicular lymphoma, unspecified, unspecified site;
- C82.91 Follicular lymphoma, unspecified, lymph nodes of head, face, and neck;
- C82.92 Follicular lymphoma, unspecified, intrathoracic lymph nodes;
- C82.93 Follicular lymphoma, unspecified, intra-abdominal lymph nodes;
- C82.94 Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb;
- C82.95 Follicular lymph, unspecified, lymph nodes of inguinal region & lower limb;
- C82.96 Follicular lymphoma, unspecified, intrapelvic lymph nodes;
- C82.97 Follicular lymphoma, unspecified, spleen;
- C82.98 Follicular lymphoma, unspecified, lymph nodes of multiple sites;
- C82.99 Follicular lymphoma, unspecified, extranodal and solid organ sites

- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs

- One Medicaid unit of coverage is: 1 mg

- The maximum reimbursement rate per unit is: $75.60 per 1 mg

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 50419-0385-01

- The NDC units should be reported as “UN1.”

- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.

- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on N.C. Medicaid's website.

- Providers shall bill their usual and customary charge for non-340B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on N.C. Medicaid's PDP web page.

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians and Physicians Assistants

Gemtuzumab ozogamicin injection, for intravenous use (Mylotarg) HCPCS code J9999: Billing Guidelines

Effective with date of service Sept. 6, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover gemtuzumab ozogamicin injection, for intravenous use (Mylotarg) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs. Mylotarg is currently commercially available as 4.5 mg lyophilized cake or powder in a single-dose vial for reconstitution and dilution.

Mylotarg is indicated for the treatment of newly-diagnosed CD33-positive acute myeloid leukemia (AML) in adults and the treatment of relapsed or refractory CD33-positive AML in adults and in pediatric patients 2 years of age and older.

Recommended dose for newly-diagnosed, de novo AML (combination regimen): Induction is 3 mg/m squared (up to one 4.5 mg vial) on Days one, four and seven in combination with daunorubicin and cytarabine. Dose for consolidation is 3 mg/m squared on Day 1 (up to one 4.5 mg vial) in combination with daunorubicin and cytarabine.

For use in newly-diagnosed AML (single-agent regimen): Induction dose is 6 mg/m squared on day one and three and 3 mg/m squared on day eight. Dose for continuation for patients without evidence of disease progression, for up to eight continuation courses of Mylotarg, is 2 mg/m squared on day one every four weeks.

For relapsed or refractory AML (single-agent regimen), dose is 3 mg/m squared on days one, four and seven.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are:
    - C92.00 - Acute myeloblastic leukemia, not having achieved remission
    - C92.01 - Acute myeloblastic leukemia, in remission
    - C92.02 - Acute myeloblastic leukemia, in relapse
- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
- One Medicaid unit of coverage is: 1 mg (NC Health Choice bills according to Medicaid units)
- The maximum reimbursement rate per unit is: $1,968.00 per 1 mg

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 00008-4510-01

- The NDC units should be reported as "UN1."

- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.

- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on the N.C. Medicaid website.

- Providers shall bill their usual and customary charge for non-340B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on N.C. Medicaid's PDP web page.

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians and Physicians Assistants

Triptorelin extended-release injectable suspension, for intramuscular use (Triptodur) HCPCS code J3490: Billing Guidelines

Effective with date of service Sept. 25, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover triptorelin extended-release injectable suspension, for intramuscular use (Triptodur) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified Drugs. Triptodur is commercially available as 22.5 mg powder cake for reconstitution with the co-packaged 2 mL of diluent sterile water for injection.

Triptodur is indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty. Triptodur is administered as a single intramuscular injection of 22.5 mg once every 24 weeks.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is E22.8 - Other hyperfunction of pituitary gland
- Providers must bill with HCPCS code: J3490 - Unclassified Drugs
- One Medicaid unit of coverage is: 1 kit
- The maximum reimbursement rate per unit is: $17,280.00 per kit
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is 24338-0150-20
- The NDC units should be reported as “UN1.”
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.
- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on N.C. Medicaid’s website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the “UD” modifier

on the drug detail.

- The fee schedule for the Physician's Drug Program is available on N.C. Medicaid's PDP web page.

CSRA 1-800-688-6696

Attention: Nurse Practitioners, and Physician Assistants and Physicians

Cerliponase alfa injection, for intraventricular use (Brineura) HCPCS code J3590: Billing Guidelines

Effective with date of service June 1, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs covers cerliponase alfa injection, for intraventricular use (Brineura) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified biologics. Brineura is currently commercially available as a 150 mg/5 mL (30 mg/mL) solution, two single-dose vials per carton co-packaged with Intraventricular Electrolytes Injection 5 mL in a single-dose vial as a kit.

Brineura is indicated to slow the loss of ambulation in symptomatic pediatric patients 3 years of age and older with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency.

The recommended dose is 300 mg administered once every other week as an intraventricular infusion followed by infusion of Intraventricular Electrolytes. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are: E75.4 - Neuronal ceroid lipofuscinosis
- Providers must bill with HCPCS code: J3590 - Unclassified Biologics
- One Medicaid unit of coverage is: 1 kit
- The maximum reimbursement rate per unit is: $29,160.00 per kit
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 68135-0500-00 and 68135-0811-02
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.
- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on N.C. Medicaid's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate

that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the Physician's Drug Program is available on the N.C. Medicaid PDP web page.

CSRA 1-800-688-6696

Attention: Prescribers

Prior Approval Criteria for Opioid Analgesics Updated to Comply with the STOP Act

Effective Jan. 2, 2018, the clinical coverage criteria for opioid analgesics will be updated to comply with the quantity limits mandated by the Strengthen Opioid Misuse Prevention (STOP) Act, S.L. 2017-74. Prior approval will be required for short-acting opioids for greater than a five-day supply for acute pain and seven-day supply for post-operative acute pain. Prior approval will be required for long-acting opioids for greater than a seven-day supply. This is a change from current criteria which requires prior approvals for greater than a 14-day supply for long- and short-acting opioid analgesics.

The prescribing provider may submit prior approval requests to NCTracks through the NCTracks portal or by fax. New opioid analgesic prior approval forms and revised clinical coverage criteria will be available on the NCTracks website.

Beneficiaries with diagnosis of pain secondary to cancer will continue to be exempt from prior approval requirements.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: Private Duty Nursing Providers

Private Duty Nursing Program: Prior Authorization Time Frames

Documentation Requirements

Private Duty Nursing (PDN) service providers are reminded of the Prior Authorization (PA) documentation requirements found in Clinical Coverage Policies 3G-1, *Private Duty Nursing for Beneficiaries Age 21 and Older*, and 3G-2, *Private Duty Nursing for Beneficiaries Under 21 years of Age*. PA requirements for both policies are found in Section 5.2.2.7 (*Documentation Required for PDN Service Reauthorization*).

PDN PA Approval Time Frame – Traditional PDN Beneficiaries

Effective Nov. 1, 2017, Clinical Coverage Policies 3G-1 and 3G-2 allows for a PA approval for a maximum of six months. The six-month PA must contain the following documentation:

- DMA 3061 Form: PDN Medical Update-Beneficiary Information Form
- Hourly Nursing Review Criteria Form
- Home Health Certification and Plan of Care Form (CMS-485) for each 60-day certification period

  (**Note:** the physician signed CMS-485 shall be uploaded to the PA every 60 days, for a total of three CMS-485s per six-month PA).

- Verification of School Nursing Form (if applicable)

  Note: The physician signed CMS-485 shall be uploaded to the PA every 60 days, for a total of three CMS-485 per six-month PA).

Beneficiaries will be provided an extended PA when their next PA is ready for renewal in NCTracks. Beneficiaries will eventually be placed on a six-month cycle that aligns with their birth month. See the example below:

- PA approval end: Oct. 15, 2017
- Beneficiary's birth month: February
- New PA approvals:
  - Oct. 16, 2017 – Feb. 12, 2018 (four-month PA – takes beneficiary to birth month)
  - Feb. 13 – Aug. 11, 2018 (six-month PA)
  - Aug. 12, 2018 – Feb. 7, 2019 (six-month PA)

PDN PA Approval Time Frame – Community Alternatives Program for Children to PDN Transition Beneficiaries

After March 2018, PAs for the Community Alternatives Program for Children (CAP/C) to PDN transition beneficiaries will be extended to the month of their CAP/C Continued Need Review (CNR) date. Extensions will be completed starting with those CAP/C to PDN transition beneficiaries who have a PA expiring in October 2017. Providers shall continue to upload the physician signed CMS-485 every 60 days to the approved, extended PA.

Note: For providers who have entered a new PA for PDN clinical review, the new PA will be extended into 2018. See the example below:

- PDN PA approval end date: Oct. 5, 2017
- Beneficiary's CAP/C CNR month: June 2018
- New PDN approval: Oct. 6, 2017 – June 5, 2018

Home Care Services/Community Based Services
DMA, 919-855-4380

Proposed Clinical Coverage Policies

Per NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the N.C. Division of Medical Assistance's website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies web page. 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 because 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 periods will instead be 30- and 10-day periods.

As of Dec. 1, 2017, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
PA Criteria Treatment for Movement Disorders	11/01/17	12/16/17
PA Criteria Systemic Immunomodulators	11/01/17	12/16/17
3B, Program of All-Inclusive Care for the Elderly (PACE)	11/01/17	12/16/17
1A-4, Cochlear and Auditory Brainstem Implants	10/25/17	12/09/17
PA Criteria Nuplazid	10/23/17	12/07/17

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
December 2017	12/01/17	12/05/17	12/06/17
	12/08/17	12/12/17	12/13/17
	12/15/17	12/19/17	12/20/17
	No checkwrite week of Dec. 25 – 29		
January 2018	01/04/18	01/09/18	01/10/18
	01/11/18	01/17/18	01/18/18
	01/18/18	01/23/18	01/24/18
	01/25/18	01/30/18	01/31/18

* Batch cutoff date is previous day

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

Paul Guthery
Executive Account Director
CSRA