



N.C. Medicaid Bulletin

March 2018

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*Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**C**hange in Age Requirement for Chiropractic Services

Effective March 1, 2018, all North Carolina Medicaid and NC Health Choice beneficiaries must be **12 years of age or older** to receive chiropractic services.

Beneficiaries with Medicaid for Pregnant Women coverage are eligible for chiropractic services, but **prior approval is required**.

Chiropractic services are billed with the following procedure codes:

- 98940, Chiropractic manipulation treatment (CMT); spinal, 1-2 regions
- 98941, Chiropractic manipulation treatment (CMT); spinal, 3-4 regions
- 98942, Chiropractic manipulation treatment (CMT); spinal, 5 regions

For more information, refer to Clinical Coverage Policy 1F, [Chiropractic Services](#).

CSRA, 1-800-688-6696

Attention: All Providers**U**ppdate to Clinical Coverage Policy 3B, Program of All-Inclusive Care for the Elderly (PACE)

Following a 45-day public comment period, Clinical Coverage Policy 3B, *Program of All-Inclusive Care for the Elderly (PACE)*, was amended and posted on North Carolina Medicaid [Community-Based Services Clinical Coverage Policy web page](#).

The amendment contains updates to areas involving involuntary disenrollment of PACE participants and specific timeframes for participant assessments (30 calendar days) and care plan development (45 calendar days).

**Long-Term Services and Supports Section, PACE
DMA, 919-855-4360**

Attention: All Providers**Update to Clinical Coverage Policy 11C, Ventricular Assist Devices**

Effective March 1, 2018, North Carolina Medicaid has revised Clinical Policy 11C, *Ventricular Assist Devices*, as follows:

- Prior authorization is removed for CPT codes 33975, 33976, 33977, 33978, 33979, and 33980
- PA requirements are removed for ICD 10 codes 02HA0QZ, 02HA0RS, 02HA3QZ, 02HA3RS, 02HA3RZ, 02HA4QZ, 02HA4RZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02UA0JZ, 02UA3JZ, 02UA4JZ, 5A02116 and 5A02216.
- Coverage criteria under Section 3.0 and non-coverage criteria under Section 4.0 are updated
- Limitations listed under Section 5.3 are added to provide criteria when a replacement VAD or a component of the VAD is considered medically necessary.

The revised policy is available on Medicaid's [Ventricular Assist Devices Clinical Coverage Policy](#) web page.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**NCTracks Update: Accurate Provider Email Crucial**

In a recent attempt to send an email helping providers with a common error, CSRA noticed that 12.5 percent of the provider email addresses were invalid or unsubscribed. To provide providers with the accurate information they need, it is crucial that NCTracks has a valid email address that is subscribed to the NCTracks Communications email list. This is especially important for targeted emails that apply to specific providers (such as a claim reprocessing notice).

NCTracks encourages providers to:

- Check the email address on their provider record today to make sure it is accurate
- Subscribe or re-subscribe to the [NCTracks communications email list](#) (the "Sign Up for NCTracks Communications" link can also be found on the Provider Communications tab of the Provider Home page)

CSRA, 1-800-688-6696

Attention: All Providers**Update to NC Medicaid Electronic Health Record Incentive Program****Program Reminders**

Providers have until April 30, 2018, to submit a complete and accurate attestation for Program Year 2017 of the NC Electronic Health Record (EHR) Incentive Program. **After that no changes can be made.** Attestations submitted within 30 days of the deadline are not guaranteed to be reviewed prior to April 30, 2018. **Providers are advised to submit their attestation no later than March 30, 2018,** so discrepancies may be addressed.

Eligible professionals (EPs) can receive a maximum of \$63,750 for six years of successful participation in the NC Medicaid EHR Incentive Program. Program Year 2021 is the last year to participate; therefore, EPs who received only one incentive payment prior to Program Year 2017 must successfully attest in Program Year 2017 and each remaining year through Program Year 2021 to receive all six payments. EPs who successfully attested at least once in program years 2011 through 2016 can return in Program Year 2017 even if they were previously denied.

If the provider was 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 Centers for Medicare and Medicaid Services (CMS) [Modified Stage 2 MU](#) or the CMS [Stage 3 MU](#) specification sheets.

The attestation guides are updated each year. Providers should use the most current [Modified Stage 2 MU](#) or [Stage 3 MU](#) attestation guide. Attestation guides can also be accessed from the menu on the right-hand side of the NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)).

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, visit the [NC Medicaid EHR Incentive Program web page](#).

Updates for Program Year 2018

On Aug. 14, 2017, CMS issued the [Inpatient Prospective Payment System \(IPPS\) Final Rule](#). The final rule made the following changes to the NC Medicaid EHR Incentive Program in Program Year 2018:

- Stage 3 MU is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU.
- Providers may use a 2014 Edition Certified EHR Technology (CEHRT), 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT.

- Providers will select six CQMs from a list of 53 (applicable in Program Year 2017).
- Providers may continue using a 90-day MU reporting period.

NC Medicaid EHR Incentive Program

NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers**NCTracks Provider Training Available in March 2018**

Registration is open for the March 2018 instructor-led provider training courses listed below. Slots are limited.

WebEx courses: Participants can be attended remotely from any location with a telephone, computer and internet connection.

On-site courses: Courses are held at CSRA, 2610 Wycliff Road in Raleigh.

Following are details on the courses, including dates, times and how to enroll.

**Submitting Institutional Prior Approvals (On-Site)
Thursday, March 1 - 9:30 a.m. to noon**

How to submit prior approval (PA) requests, with a focus on nursing facilities, to ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiries to check on the status of a PA request.

**Submitting an Institutional Claim (On-Site)
Thursday, March 1 – 1 to 4 p.m.**

How to submit an institutional claim through the NCTracks Provider Portal, with a focus on long-term care and secondary claims. At the end of training authorized users will be able to:

- Enter an institutional claim
- Save a draft
- Use the claims draft search tool
- Submit a claim
- View results of a claim submission

**Prior Approval Pharmacy (WebEx)
Monday, March 5 - 10 a.m. to noon**

How to submit prior approval (PA) requests to ensure compliance with Medicaid clinical coverage policy and medical necessity. At the end of training, providers will be able to:

- Navigate the NCTracks portal to enter a PA
- Search and review PA information
- Identify whether a PA is approved or denied determined by set criteria from business rules

Submitting Medical Prior Approvals (On-Site)
Tuesday, March 6 - 9:30 a.m. to noon

This course shows authorized users how to electronically submit and inquire about prior approvals for different kinds of medical services. After completing this course, authorized users will be able to:

- Submit PA and Managed Care Referrals electronically
- Conduct electronic inquiries about PAs

How to file a Professional Claim (On-Site)
Tuesday, March 6 – 1 p.m. to 4 p.m.

How to submit a professional claim using the secure NCTracks Provider Portal. (Providers will need an NCID username and password to gain access to a secure online environment for submitting claims.) After completing this course, authorized users will be able to:

- Enter a professional claim
- Save a draft
- Use claims draft search
- Submit a claim
- View results of a claim submission

Provider Re-Credentialing/Re-Verification (WebEx)
Thursday, March 8 – 1 p.m. to 2:30 p.m.

How to complete the re-verification process through NCTracks, including how to complete and submit a Manage Change Request (MCR) in the event the user is prompted to complete an MCR during re-verification/re-credentialing. (The terms re-credentialing and re-verification are used interchangeably in NCTracks.) At the end of training, providers will be able to:

- Understand provider re-verification and why it is required
- Understand each phase of re-verification
- Complete the re-verification process in NCTracks
- Complete an MCR for invalid or missing provider data

Annual Seminar (New Bern, NC)
Tuesday, March 27 - 9 a.m. to 4 p.m.

Annual seminars run from 9 a.m. to 4 p.m. at different dates and locations across the state. The first is scheduled for New Bern on March 27. Others will be announced in future Medicaid Bulletins.

Training Enrollment Instructions

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 about downloading Java, which is required for the use of SkillPort.

CSRA, 1-800-688-6696

Attention: All Providers**Avoid Delays in the Processing of Provider Enrollment Applications**

Note: This article was previously published in the [February 2018 Medicaid Bulletin](#).

If a provider's enrollment application or Manage Change Request (MCR) is clean and does not contain errors, it will process more quickly. The NCTracks Enrollment Team identified common errors that cause delays in processing applications and MCRs. Common errors include:

- **Supporting documentation not attached** – If supporting documentation is required, it must be uploaded and attached prior to submission (including license/certification/accreditation). For guidance on how to attach supporting documentation, refer to section 3.30.1 of Participant User Guide PRV111 Provider Web Portal Applications on the secure NCTracks provider portal.
- **Name on application** – Name on application should match National Plan and Provider Enumeration System (NPES) National Provider Identifier (NPI).
- **Incomplete Exclusion Sanction information** – The Exclusion Sanction questions must be answered. On question K, **all** convictions (misdemeanors and felonies) must be disclosed regardless of how old the conviction is. (The only exception to this requirement is minor traffic offenses, such as a speeding ticket, expired registration, etc.) The questions must be answered for the enrolling provider, its owners, and agents in accordance with 42 CFR 455.100; 101; 104; 106 and 42 CFR 1002.3.

If the answer to the Exclusion Sanction questions is “yes,” then documentation regarding the disposition of the action must be attached to the application. If a provider submits a written attestation, it must be on company letterhead and signed and dated by the person to whom the attestation applies. For a complete list of questions, go to the [Provider User Guides and Training page](#) of the NCTracks Provider Portal and open either the “How to Enroll in North Carolina Medicaid as an Individual Practitioner” or “How to Enroll in North Carolina Medicaid as an Organization” user guides, which are located in the **Enrollment and Re-Verification** section. These documents contain the list of sanction questions.

- **Failure to upload Electronic Fingerprinting Submission Release of Information Form (Evidence)** – The form must be signed and dated by each person required to submit fingerprints. It must also be signed and dated by the law enforcement agency collecting the fingerprints. Providers must upload the Release of Information Form into NCTracks by the deadline on the notification letter.
- **Fingerprinting Card should not be mailed to address on the evidence form** – If the applicant opts to do a Fingerprint Card, it must be mailed to the State Bureau of Investigation (SBI) for processing at NCSBI/Applicant Unit, 3320 Garner Road, Raleigh, NC 27626.
- **Choosing the incorrect taxonomy code** – The taxonomy code selected must accurately reflect the type of provider. The provider must meet the enrollment qualifications for the taxonomy code selected and possess the required licensure and/or credentials. Providers who are uncertain which taxonomy code to select should consult the “Provider Permission Matrix” (and instruction sheet) on the [Provider Enrollment page](#) of the NCTracks provider portal. For additional guidance, refer to “How to View and

Update Taxonomy on the Provider Profile in NCTracks” on the [Provider User Guides and Training page](#) of the NCTracks provider portal.

- **NCID misuse** – This continues to be an issue on applications and may result in adverse action on the provider’s application and record. Refer to the article, *Using NCIDs Properly in NCTracks*, in the [December 2016 Medicaid Bulletin](#).
- **Inaccurate entry of names, Social Security numbers (SSN) and date of birth (DOB) on applications** – This continues to be an issue which impacts the integrity of the application and Participation Agreement and may result in adverse action on the application.

For assistance with NCID and/or PIN, refer to the [Getting Started web page](#) on NCTracks and the NCTracks [NCID Fact Sheet](#).

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

CSRA, 1-800-688-6696

Attention: All Providers**Re-credentialing and Ongoing Verification Updates****List of Providers Due for Re-credentialing**

A list of providers scheduled for re-credentialing January through April 2018 is available on the [provider enrollment page](#) of the North Carolina 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.

Note: The terms re-credentialing, re-verification, and re-validation are synonymous.

Changes to Re-credentialing Process

Beginning April 30, 2018, the re-credentialing notification and suspension will be modified to the following:

1. The notification, suspension, and termination timeline will be modified to the following:
 - First notification will now be sent 70 days prior to the provider re-credentialing due date.
 - If re-credentialing is not submitted, reminders will be sent at 30 days, 15 days, and 5 days prior to the provider re-credentialing due date.
 - Providers will be suspended if the re-credentialing application is not submitted by their re-credentialing due date.
 - The provider will be terminated from the North Carolina Medicaid and NC Health Choice programs at the end of the month following 30 days of suspension.
2. Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process.
3. Providers are required to pay a \$100 application fee for re-credentialing.
4. The existing rules to extend the re-credentialing due date if a Manage Change Request (MCR) Application is “In Review” will be removed. Therefore, if a change is required via a MCR, the MCR process must be completed before the re-credentialing due date.
5. The Re-credentialing Application on the NCTracks Provider Portal will be modified to display the existing owners and managing employees and allow the provider to edit, end-date, or add to the Re-credentialing Application.

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.

If terminated, the provider must submit a re-enrollment application to be reinstated.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state (OOS) lite providers. OOS providers who enroll using the OOS-lite application must complete the enrollment process every 365 days. OOS providers who are fully enrolled must re-credential every five years.

Because of the system changes, all enrollment, re-enrollment, MCR and re-verification applications currently in “saved draft” status will be deleted on April 28, 2018. To prevent these applications from being deleted, the draft must be submitted. Applications created on or after April 29, 2018, can once again be saved to draft.

Changes to Ongoing Verification Process

Providers must also update their expiring licenses, certifications and accreditations. The system currently suspends and terminates providers who fail to respond within the specified time limits.

With system modifications, the notification, suspension, and termination timeline will be modified to the following:

1. First notification will be sent 60 days prior to expiration
2. If the expired item has not been updated, a reminder will be sent on days 30, 14, and the final reminder on day 7 prior to expiration
3. The provider will be suspended if the expired item has not been updated by the due date. The suspension will remain for 60 days, and can be removed at any time if the expired item is updated.
4. The provider’s participation in the North Carolina Medicaid and NC Health Choice programs will be terminated if the item has not been updated by day 61 after suspension.

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: All Providers**Billing Errors identified in FY 2016 Payment Error Rate Measurement (PERM) Audit in North Carolina**

The Payment Error Rate Measurement (PERM) audit calculates error rates for Medicaid, Children's Health Insurance Programs (CHIP) and Managed Care on a three-year cycle for the Centers for Medicare & Medicaid Services (CMS). The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of those three programs in the fiscal year under review.

Note: NC Health Choice (NCHC) is the state's CHIP program.

The PERM audit for Federal Fiscal Year (FFY) 2016 reviewed claims for service dates between Oct. 1, 2015 – Sept. 30, 2016.

Most of North Carolina's FFY 2016 errors were due to the following provider billing errors:

- Missing or insufficient documentation to support the service billed
- Required document missing from the medical record
- Procedure Coding Error
- Incorrect date of service (DOS) billed
- Attending, rendering or ordering provider not enrolled in Medicaid, CHIP or Managed Care
- Duplicate claim submissions

Providers can reduce the likelihood of future billing errors by:

- Using the NCTracks Provider Portal to access web-based tutorials, classes and training materials to educate themselves and their billing personnel on all aspects of claims submission
- Implementing an internal quality assurance program which includes regular review for the billing errors listed above
- Incorporating review of claims submissions as a component of any internal quality assurance program
- Identifying overpayments as part of a [voluntary self-audit](#)
- Reviewing Medicaid's [monthly Medicaid Bulletin](#) to stay abreast of changes that may impact billing.

**Office of Compliance and Program Integrity
DMA, 919-814-0000**

Attention: All Providers**Reporting Suspected Medicaid Fraud, Waste, and Abuse**

This article assists providers to identify and report potential report fraud, waste, or abuse.

The Office of Compliance and Program Integrity's mission is:

To protect the resources of the Division of Medical Assistance by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program.

The terms fraud, waste and abuse are defined as follows:

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefits to himself or some other person.
- **Waste:** Costs that could have been avoided without a negative impact on quality.
- **Abuse:** Occurs when provider practices are inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health.

Any matters involving potential or suspected Medicaid fraud, waste, or abuse shall be reported to the Office of Compliance and Program Integrity. Individuals may remain anonymous; however, sometimes to conduct an effective investigation, staff may need to contact individuals. Individual name will not be shared with anyone investigated except in some rare cases involving legal proceedings.

Examples of Medicaid fraud and abuse:

- A provider's credentials are not accurate
- A provider bills for services that were not rendered
- A provider performs and bills for services not medically necessary
- A provider upcodes procedures to receive higher reimbursement
- An individual does not report all income when applying for Medicaid
- An individual does not report other insurance when applying for Medicaid
- A non-beneficiary uses a beneficiary's card with or without the recipient's knowledge

People may report a complaint by calling Medicaid Fraud, Waste and Program Abuse Tip-Line at 919-814-0181, or completing an [Online Confidential Complaint Form](#).

Office of Compliance and Program Integrity
DMA, 919-814-0000

Attention: All Providers**NPI Exemption List Extension to April 30, 2018 - Update**

Note: This article was originally published as a Special Bulletin in January 2018.

In response to provider feedback, the use of the NPI Exemption List for residents and interns enrolled in graduate dental and medical programs, and area health education centers **will be extended from Jan. 31, 2018 to April 30, 2018.**

Clinical pharmacist practitioners will continue to use the NPI Exemption List until further notice.

Residents and interns licensed through the NC Medical Board and NC Dental Board with a resident in training license (RTL) may enroll as ordering, prescribing and referring (OPR) lite providers via the abbreviated application in NCTracks. These practitioners will use the taxonomy 390200000X, Student Health Care, when enrolling as an OPR lite provider.

The services of residents or interns in a Graduate Medical Education teaching setting are **not** billable to Medicaid. Therefore, residents and interns who order services, prescribe medications or services, or make referrals **must** provide their NPI (if enrolled) or their supervising physician's NPI to the provider submitting claims for service reimbursement. The supervising physician may bill for the services they personally provided during the patient encounter.

The following enrollment requirements will apply to OPR lite providers:

- \$100 application fee
- Credentialing and criminal background checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- Revalidate every five years, and,
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they meet the full enrollment criteria and are to be reimbursed for claims.

Note: OPR lite providers may request a retroactive effective date up to 365 days preceding the date of application.

Provider Services
DMA, 919-855-4050

Attention: All Providers**North Carolina Medicaid and NC Health Choice Preferred Drug List Changes**

Effective **April 1, 2018**, North Carolina Medicaid will make the following changes to the [Medicaid and NC Health Choice Preferred Drug List \(PDL\)](#):

Analgesics

Opioids

Long-Acting

- Kadian moved to preferred
- Morphine sulfate ER (generic for Kadian) remains non-preferred

Anticonvulsants

Second Generation

- Sabril Powder Pack moved to preferred
- vigabatrin (generic for Sabril) powder pack non-preferred

Anti-infectives

Systemic Antivirals

Herpes Treatment

- Zovirax Ointment moved to preferred

Hepatitis B

- Epivir HBV moved to preferred
- lamivudine HBV (generic for Epivir HBV) remains preferred

Antibiotics

Quinolones

- Avelox moved to non-preferred.
- moxifloxacin (generic for Avelox) moved to preferred

Behavioral Health

Antidepressants

Other

- Desvenlafaxine ER (generic for Pristiq) moved to preferred
- Pristiq remains non-preferred

Antipsychotics

Atypical oral

- Invega moved to non-preferred
- Paliperidone (generic for Invega) moved to preferred
- FazaClo moved to preferred
- Clozapine ODT (generic for FazaClo) moved to non-preferred

Cardiovascular

Platelet Inhibitors

- Effient moved to non-preferred
- prasugrel tablet (generic for Effient Tablet) moved to preferred

Niacin Derivatives

- Niaspan ER moved to preferred
- niacin ER (generic for Niaspan ER) moved to non- preferred

Hematologic

Anticoagulant

Injectable

- Lovenox syringe/vial moved to non-preferred
- enoxaparin (generic for Lovenox) syringe/vial moved to preferred

Gastrointestinal

Ulcerative Colitis

- Lialda moved to preferred
- mesalamine (generic for Lialda) moved to non-preferred

Ophthalmic

Allergic Conjunctivitis

- Pataday ophthalmic drops moved to preferred
- olopatadine (generic for Pataday) ophthalmic drops moved to non-preferred

Respiratory

Intranasal Rhinitis Agents

- Astepro nasal spray moved to preferred
- azelastine (generic for Astepro) nasal spray moved to non-preferred

Topical

Acne Agents

- Epiduo gel moved to preferred
- Benzaclin gel moved to non-preferred
- Clindamycin-benzoyl peroxide (generic for Benzaclin) gel moved to preferred

Psoriasis

- Dovonex Cream moved to preferred
- calcipotriene cream (generic for Dovonex) moved to non-preferred

Steroids

Very High Potency

- Clobex shampoo moved to preferred
- clobetasol (generic for Clobex) shampoo moved to non-preferred

Low Potency

- Derma-Smoothe FS Scalp and Body Oil moved to non-preferred
- Fluocinolone (generic for Derma-Smoothe FS) body/scalp oil moved to preferred

Miscellaneous Topicals

- Vivelle-Dot moved to non-preferred
- Estradiol patch (generic for Vivelle-Dot) moved to preferred

CSRA 1-800-688-6696

Attention: All Providers

Update to Medicaid Required Enrollment Fees

Note: This article was originally published in the [January 2018 Medicaid Bulletin](#).

The North Carolina Medicaid and NC 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 reverification process.

If an out-of-state provider chooses to enroll using the full-enrollment application, the \$100 fee will apply. Out-of-state (OOS) 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 resubmission of the application.

In addition, some providers are required to pay the federal application fee. These providers are defined in federal regulation at [42 CFR 455.460](#), and in [NC General Statute 108C-3 \(e\) and \(g\)](#) as moderate- or high-risk. The Federal application fee is \$569 for calendar year 2018, 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. Refer to the [Provider Permission Matrix](#) on the Provider Enrollment page of NCTracks for more details.

System modifications in NCTracks automated fee collection for more efficient processing of enrollment, reenrollment, MCR and reverification applications. The site visit no longer occurs post enrollment. The federal fee collection and site visit now occur during processing of the re-enrollment, MCR or re-verification application.

Previously, only the site visit for initial enrollment applications occurred during processing.

Due to the changes, all enrollment, re-enrollment, MCR and reverification applications that were in “saved draft” status were deleted on Jan. 28, 2018. Applications created on or after Jan. 29, 2018, can once again be saved to draft.

Providers are encouraged to review the Status and Management web page on the secure NCTracks Provider Portal for applications initiated by the Enrollment Specialist (ES) or Office Administrator (OA), but not completed. If a draft application was deleted, providers will see “N/A” under the “Select” column of the Records Results.

A Job Aid for Updated Requirements for MCR, Re-verification, Re-enrollment, and Enrollment is also available in SkillPort.

Application Type	NC Fee \$100	Federal Fee (currently \$569)	Federal Site Visit	Provider Training
Enrollment	Always required when provider applies for Medicaid and/or NCHC Exclusion: OOS Lite	Federal fee is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Federal site visit is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Always required when provider applies for Medicaid and/or NCHC
Re-enrollment	Never required	Federal fee is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Federal site visit is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Never required
Manage Change Request	Only required when an OOS lite provider upgrades to OOS full provider	Federal fee is required per newly added/reinstated location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Federal site visit is required per newly added/reinstated location when one or more federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Never required
Re-verification	Always required when provider is active in Medicaid and/or NCHC	Federal fee is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are active. Note: Medicaid/NCHC plans only	Federal site visit is required per location when one or more federal taxonomy codes (as identified on the Permission Matrix) are active. Note: Medicaid/NCHC plans only	Never required
Abbreviated MCR	Never required	Never required	Never required	Never required
Change Office Administrator	Never required	Never required	Never required	Never required
Maintain Eligibility	Never required	Never required	Never required	Never required
Fingerprinting	Never required	Never required	Never required	Never required

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 North Carolina 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 for fingerprinting services](#). 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 with 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 access 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 NC 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**C**hange in Edit Disposition: Claims Pended for Incorrect Billing Location

Note: This article was previously published in the [September 2017 Medicaid Bulletin](#). It is being republished with updates regarding edit disposition.

Effective Oct. 29, 2017, the NC Department of Health and Human Services (DHHS) validates 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 five digits) on all North Carolina Medicaid and NC 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 that the claim would pend for 60 days. The edit was implemented with a "pay and report" status. Providers receive an informational Explanation of Benefits (EOB) 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE.

NCTracks uses the address submitted on the claim (837 D, P, and I - Loop 2010AA / ADA Dental – box 48, CMS-1500 block 33 and 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 receives the informational EOB code 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE on the paper Remittance Advice (RA).

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.

Providers identified with EOB 04529 will be sent a notification via email. 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 and then refile the claim.

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.

The edit disposition of pay and report is temporary. Providers will be notified when the edit disposition will change to pend. Once the disposition change to pend occurs, the 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.

Claims with dates of service prior to Oct. 29, 2017, are not subjected to the edit. Pharmacy and crossover claims are also 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: Durable Medical Equipment (DME) Providers

Upcoming DME Changes to the Roche Rebate Program for Preferred Roche Diabetic Supplies

Beginning **April 1, 2018**, diabetic testing supplies will be transitioned to the [North Carolina Medicaid and NC Health Choice Preferred Drug List \(PDL\)](#) and Roche diabetic testing supplies will remain preferred. DME providers will no longer receive two separate payments for claims for Roche diabetic testing supplies. Instead, providers will receive one payment based on a State Maximum Allowable Cost (SMAC).

The DME fee schedule will be updated to reflect the NDC-associated rates shown in the table below. Non-preferred brand diabetic testing supplies will continue to require prior authorization (PA) and will be reimbursed at the current SMAC rates.

The following chart outlines the Roche diabetic testing supplies with their corresponding preferred NDC number and CPT code, specific reimbursement amounts and current rates for non-preferred brand diabetic testing supplies.

Product	NDC Number	CPT Code	NC Medicaid SMAC Rate
ACCU-CHEK AVIVA PLUS 50 ct Test Strips	65702-0407-10	A4253	\$79.63/box of 50
ACCU-CHEK SMARTVIEW 50 ct Test Strips	65702-0492-10	A4253	\$79.63/box of 50
ACCU-CHEK COMPACT 51 ct Test Strips	50924-0988-50	A4253	\$81.67/box of 51
ACCU-CHEK GUIDE 50 ct Test Strips	65702-0711-10	A4253	\$21.56/box of 50
Non-preferred Brand 50 ct Test Strips	N/A	A4253	\$29.46/box of 50
ACCU-CHEK SOFTCLIX Lancing Device Kit (Black)	65702-0400-10	A4258	\$22.63 each
ACCU-CHEK FASTCLIX Lancing Device Kit	65702-0481-10	A4258	\$17.55 each
Non-preferred Brand Spring-powered Device for Lancet, Each	N/A	A4258	\$17.55 each
ACCU-CHEK MULTICLIX 102 ct Lancets	50924-0450-01	A4259	\$15.68/box of 102
ACCU-CHEK SOFTCLIX 100 ct Lancets	50924-0971-10	A4259	\$13.93/box of 100
ACCU-CHEK FASTCLIX 102 ct Lancets	65702-0288-10	A4259	\$13.68/box of 102
Non-preferred Brand Lancets, 100 per Box	N/A	A4259	\$10.69/box of 100
ACCU-CHEK AVIVA Glucose Control Solution (2 levels)	65702-0107-10	A4256	\$11.13/bottle
ACCU-CHEK COMPACT PLUS CLEAR Glucose Control Solution (2 levels)	65702-0468-10	A4256	\$11.13/bottle
ACCU-CHEK GUIDE Glucose Control Solution (2 levels)	65702-0713-10	A4256	\$11.13/bottle
ACCU-CHEK® SMARTVIEW Glucose Control Solution (2 levels)	65702-0488-10	A4256	\$11.13/bottle
Non-preferred Brand Calibrator Solution/Chips, Each	N/A	A4256	\$11.13/bottle

Attention: Home Health Providers**Removal of Diabetic Testing Supplies from the Home Health Fee Schedule**

Effective April 1, 2018, the following CPT codes for diabetic testing supplies will be removed from the Home Health fee schedule.

CPT Code	Code Description
A4253	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR
A4258	SPRING-POWERED DEVICE FOR LANCET
A4259	LANCETS

These supplies can be obtained through a pharmacy or Durable Medical Equipment (DME) provider with a physician's order.

Providers with questions may contact the DME program at 919-855-4310.

Home Care Services
DMA, 919-855-4380

Attention: Nurse Practitioners and Physician Assistants**Billing Code Update for Nurse Practitioners and Physician Assistants**

Medicaid provided instructions to NCTracks to update the claims processing system to address claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

The following procedure codes are updated to include additional NP and PA taxonomies.

27360 (A)	99231 (D)	99232 (D)	99233 (D)
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***Codes marked with an (A) were updated for modifiers 80 and 82**

***Codes marked with a (D) were updated for modifier 57**

The Medicaid website has a complete list of [previously denied billing codes for NP, PAs and Certified Nurse Midwives](#).

Note: Codes currently in process for system updates will be published once system modifications are completed. Additional code problems will be addressed as DMA Clinical Policy becomes aware of them.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Billing Guidelines: Emicizumab-kxwh injection, for subcutaneous use (Hemlibra) HCPCS code J3590**

Effective with date of service Nov. 27, 2017, the North Carolina Medicaid and NC Health Choice (NCHC) Program covers emicizumab-kxwh injection (Hemlibra), for subcutaneous use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 - Unclassified biologics. Hemlibra is available as a single-dose vial for injection: 30 mg/mL, 60 mg/0.4 mL, 105 mg/0.7 mL, 150 mg/mL.

Hemlibra is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients with hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors. The recommended dose is 3 mg/kg by subcutaneous injection once weekly for the first four weeks, followed by 1.5 mg/kg once weekly.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is D66 - Hereditary factor VIII deficiency.
- Providers must bill with HCPCS code J3590 - Unclassified biologics.
- One Medicaid unit of coverage is 1 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$107.14.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 50242-0920-01, 50242-0921-01, 50242-0922-01 and 50242-0923-01.
- 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 Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Billing Guidelines: Treprostinil injection, for subcutaneous or intravenous use (Remodulin) HCPCS code J3285 - Injection, treprostinil, 1 mg**

Effective with date of Service Jan. 1, 2018, the North Carolina Medicaid and NC Health Choice (NCHC) programs cover treprostinil injection (Remodulin), for subcutaneous infusion or intravenous infusion in the Physician's Drug Program (PDP) when billed with HCPCS code J3285 - Injection, treprostinil, 1 mg. Treprostinil is available as 20 mL vials containing 20, 50, 100 or 200 mg of treprostinil (1, 2.5, 5 or 10 mg/mL).

Treprostinil is indicated for treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) to diminish symptoms associated with exercise and to diminish the rate of clinical deterioration in patients requiring transition from Flolan. For PAH in patients with New York Heart Association (NYHA) Class II-IV symptoms the initial dose for patients new to prostacyclin infusion therapy is 1.25 ng/kg/min; increases are based on clinical response in increments of 1.25 ng/kg/min per week for the first four weeks of treatment, later 2.5 ng/kg/min per week. For patients transitioning from Flolan, the recommendation is to increase dose gradually as the Flolan dose is decreased, based on constant observation of response.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing are:
 - I27.0 - Primary pulmonary hypertension
 - I27.20 - Pulmonary hypertension, unspecified
 - I27.21 - Secondary pulmonary arterial hypertension
 - I27.22 - Pulmonary hypertension due to left heart disease
 - I27.23 - Pulmonary hypertension due to lung diseases and hypoxia
 - I27.24 - Chronic thromboembolic pulmonary hypertension
 - I27.29 - Other secondary pulmonary hypertension
- Providers must bill with HCPCS code J3285 - Injection, treprostinil, 1 mg.
- One Medicaid unit of coverage is 1 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$61.24.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 66302-0101-01, 66302-0102-01, 66302-0105-01 and 66302-0110-01.
- 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 Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Billing Guidelines: Fluciclovine F 18 injection, for intravenous use (Axumin), HCPCS Code A4641**

Effective with date of service, June 1, 2016, the North Carolina Medicaid program covers Axumin for use in the Physician's Drug Program (PDP) when billed with HCPCS code A4641, radiopharmaceutical, diagnostic, not otherwise classified. Axumin is available in a 30 mL multiple-dose glass vial containing clear, colorless solution of 335-8200 MBq/mL (9-221mCi/mL) fluciclovine F 18 at calibration time and date.

Axumin is a radioactive diagnostic agent indicated for positron emission tomography (PET) imaging in men with suspected prostate cancer recurrence based on elevated blood prostate specific antigen (PSA) levels following prior treatment. Axumin is administered with a recommended dose of 370 MBq (10 mCi) as a bolus intravenous injection.

See the package insert for full prescribing information and for detailed instructions on how to prepare fluciclovine F 18 injection.

For Medicaid Billing

- Providers must bill Axumin with HCPCS code A4641- radiopharmaceutical, diagnostic, not otherwise classified.
- Providers must indicate the number of HCPCS units (assumption: 1 unit = 1 study dose of 370 MBq [10 mCi]).
- One Medicaid unit of coverage for Axumin is 1 study dose = 370 MBq (10mCi).
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Axumin is 69932-0001-01.
- 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 Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Billing Guidelines: Aprepitant injectable emulsion, for intravenous use (Cinvanti) HCPCS code J3490**

Effective Jan. 4, 2018, the North Carolina Medicaid and NC Health Choice (NCHC) programs will cover aprepitant injectable emulsion (Cinvanti), for intravenous use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs.

Cinvanti is available as 130 mg in a single-dose vial. It is approved by the Food and Drug Administration (FDA) for adults, in combination with other antiemetic agents, for the prevention of:

- Acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin
- Nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC)

Cinvanti has not been studied for treatment of established nausea and vomiting.

The recommended dose of Cinvanti is:

- HEC (Single Dose Regimen): 130 mg on Day 1 as an intravenous infusion over 30 minutes approximately 30 minutes prior to chemotherapy.
- MEC (3-Day Regimen): 100 mg administered on Day 1 as an intravenous infusion over 30 minutes approximately 30 minutes prior to chemotherapy. Aprepitant capsules (80 mg) are given orally on Days 2 and 3.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is Z51.11 - Encounter for antineoplastic chemotherapy.
- Providers must bill with HCPCS code J3490 - Unclassified drugs
- One Medicaid unit of coverage is 1 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$2.45.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 47426-0201-01.
- 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 Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians**Billing Guidelines: Buprenorphine extended-release injection, for subcutaneous use (Sublocade) HCPCS code J3490: Billing Guidelines**

Effective with date of service March 1, 2018, North Carolina Medicaid and NC Health Choice (NCHC) programs cover buprenorphine extended-release injection (Sublocade), for subcutaneous use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs.

Sublocade will be available as an injection of 100 mg/0.5 mL and 300 mg/1.5 mL provided in a prefilled syringe. It is indicated for the treatment of moderate to severe opioid-use disorder in adult patients who have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of seven days.

The recommended dose for Sublocade is two once monthly initial doses of 300 mg followed by 100 mg once monthly maintenance doses. Increasing the maintenance dose to 300 mg once monthly may be considered for patients in which the benefits outweigh the risks. See full prescribing information for further detail.

Under the Drug Addiction Treatment Act (DATA), use of Sublocade in the treatment of opioid dependence is limited to healthcare providers who meet Drug Enforcement Administration (DEA) waiver requirements and who have notified the Secretary of Health and Human Services of their intent to prescribe this product for the treatment of opioid dependence.

To mitigate the risk of serious harm or death that could result from intravenous self-administration of Sublocade, healthcare facilities are required to register for the FDA approved [Sublocade Risk Evaluation and Mitigation Strategy \(REMS\) program](#). In addition, waived providers who choose to utilize Sublocade must meet [NC controlled substances regulations and C-3 handling and storage requirements](#).

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing are:
 - F11.10 - Opioid abuse, uncomplicated;
 - F11.11 - Opioid abuse, in remission;
 - F11.120 - Opioid abuse with intoxication, uncomplicated;
 - F11.121 - Opioid abuse with intoxication delirium;
 - F11.122 - Opioid abuse with intoxication with perceptual disturbance;
 - F11.129 - Opioid abuse with intoxication, unspecified;
 - F11.14 - Opioid abuse with opioid-induced mood disorder;
 - F11.150 - Opioid abuse with opioid-induced psychotic disorder with delusions;
 - F11.151 - Opioid abuse with opioid-induced psychotic disorder with hallucinations;
 - F11.159 - Opioid abuse with opioid-induced psychotic disorder, unspecified;
 - F11.181 - Opioid abuse with opioid-induced sexual dysfunction;
 - F11.182 - Opioid abuse with opioid-induced sleep disorder;
 - F11.188 - Opioid abuse with other opioid-induced disorder;
 - F11.19 - Opioid abuse with unspecified opioid-induced disorder;
 - F11.20 - Opioid dependence, uncomplicated;

- F11.21 - Opioid dependence, in remission;
 - F11.220 - Opioid dependence with intoxication, uncomplicated;
 - F11.221 - Opioid dependence with intoxication delirium;
 - F11.222 - Opioid dependence with intoxication with perceptual disturbance;
 - F11.229 - Opioid dependence with intoxication, unspecified;
 - F11.23 - Opioid dependence with withdrawal;
 - F11.24 - Opioid dependence with opioid-induced mood disorder;
 - F11.250 - Opioid dependence with opioid-induced psychotic disorder with delusions;
 - F11.251 - Opioid dependence with opioid-induced psychotic disorder with hallucinations;
 - F11.259 - Opioid dependence with opioid-induced psychotic disorder, unspecified;
 - F11.281 - Opioid dependence with opioid-induced sexual dysfunction;
 - F11.282 - Opioid dependence with opioid-induced sleep disorder;
 - F11.288 - Opioid dependence with other opioid-induced disorder;
 - F11.29 - Opioid dependence with unspecified opioid-induced disorder;
 - F11.90 - Opioid use, unspecified, uncomplicated;
 - F11.920 - Opioid use, unspecified with intoxication, uncomplicated;
 - F11.921 - Opioid use, unspecified with intoxication delirium;
 - F11.922 - Opioid use, unspecified with intoxication with perceptual disturbance;
 - F11.929 - Opioid use, unspecified with intoxication, unspecified;
 - F11.93 - Opioid use, unspecified with withdrawal;
 - F11.94 - Opioid use, unspecified with opioid-induced mood disorder;
 - F11.950 - Opioid use, unspecified with opioid-induced psychotic disorder with delusions;
 - F11.951 - Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations;
 - F11.959 - Opioid use, unspecified with opioid-induced psychotic disorder, unspecified;
 - F11.981 - Opioid use, unspecified with opioid-induced sexual dysfunction;
 - F11.982 - Opioid use, unspecified with opioid-induced sleep disorder;
 - F11.988 - Opioid use, unspecified with other opioid-induced disorder;
 - F11.99 - Opioid use, unspecified with unspecified opioid-induced disorder
-
- Providers must bill with HCPCS code J3490 - Unclassified drugs.
 - One Medicaid unit of coverage is one syringe. NCHC bills according to Medicaid units.
 - The maximum reimbursement rate per unit is \$1706.40.
 - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 12496-0100-01 and 12496-0300-01.
 - 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 Medicaid’s website.
 - Providers shall bill their usual and customary charge for non-340-B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians and Physicians Assistants**Billing Guidelines: Letermovir injection, for intravenous use (Prevymis) HCPCS code J3490**

Effective with date of service Dec. 11, 2107, the North Carolina Medicaid and NC Health Choice (NCHC) programs cover letermovir injection (Prevymis) for intravenous use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs.

Prevymis is available as 240 mg/12 mL (20 mg/mL) or 480 mg/24 mL (20 mg/mL) in a single-dose vial. Prevymis is indicated for prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT).

The recommended dose of Prevymis is 480 mg administered intravenously once daily through 100 days post-transplant. If Prevymis is co-administered with cyclosporine, the dosage of Prevymis should be decreased to 240 mg once daily. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is Z41.8 - Encounter for other procedures for purposes other than remedying health state.
- Providers must bill with HCPCS code J3490 - Unclassified drugs.
- One Medicaid unit of coverage is 1 vial.
- The maximum reimbursement rate per unit is \$291.60.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 00006-5003-01 and 00006-5004-01.
- 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 Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall 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 Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Personal Care Service Providers**R**egional Provider Trainings

Personal Care Services (PCS) regional training sessions will be held April 30 – May 16, 2018. Registration begins at 8 a.m. and training will be held from 9 a.m. to 1 p.m. Training sessions are free, but registration is required. Providers can register through the [Liberty Healthcare Corp. of North Carolina's Medicaid PCS Website](#). Prior to training, training topics and materials will be available to registered participants on Liberty's website.

Providers with additional questions may contact Liberty Healthcare Corp. of NC at 1-855-740-1400 or North Carolina Medicaid at 919-855-4360.

Event Dates and Locations

- **Monday, April 30, 2018 – Asheville**
Doubletree by Hilton-Biltmore, 115 Hendersonville Road
Burghley Room
- **Tuesday, May 1, 2018 – Charlotte**
Great Wolf Lodge Convention Center, 10175 Weddington Road
White Pine Room
- **Wednesday, May 2, 2018 – Greensboro/Winston Salem**
Greensboro-High Point Marriott Airport, One Marriott Drive
Grand Ballroom
- **Monday, May 14, 2018 - Raleigh**
Jane S. McKimmon Conference and Training Center-NCSU, 1101 Gorman St.
Room will be posted at Information Desk
- **Tuesday, May 15, 2018 - Fayetteville**
Holiday Inn Fayetteville I95 South, 1944 Cedar Creek Road
Grande Ballroom
- **Wednesday, May 16, 2018 – Greenville**
Holiday Inn-Greenville, 203 SW Greenville Blvd.
Ballroom

Long-Term Services and Supports**DMA, 919-855-4340**

Attention: Personal Care Service Providers**Non-Compliance with PCS Service Plan Requirements**

Effective March 2018, DMA will begin a quarterly review of providers identified as non-compliant with the timely completion of the online Personal Care Services (PCS) service plan as required by Clinical Coverage Policy 3L, *State Plan Personal Care Services*.

DMA Clinical Policy has partnered with the Office of Compliance and Program Integrity (OCPI) to explore educational options and opportunities to best equip providers with the necessary knowledge to meet policy requirements. In addition, Medicaid Clinical Policy in conjunction with its IT Vendor and Independent Assessment Entity is working to identify providers that are continually non-compliant.

Currently, there are 566 outstanding online PCS service plans that are more than 7 days outstanding and out of compliance with Section 6.1.4 (i) of Clinical Coverage Policy 3L. In addition, there are 426 outstanding on-line PCS service plans that are 14 or more days outstanding and are out of compliance with Section 6.1.4 (j) of Clinical Coverage Policy 3L.

Providers identified as non-compliant will receive a notification which will state Clinical Coverage Policy 3L requirements and indicate that the online PCS service plan must be completed within seven business days of the date on the letter. Failure to comply with Clinical Coverage Policy 3L within the designated seven-day period may result in referral to the OCPI, require face-to-face meetings with representatives of the NC Division of Medical Assistance (DMA), and if non-compliance continues, providers will be subject to the voiding of service authorizations.

Clinical Coverage Policy 3L, *State Plan Personal Care Services*, Section 6.1.4 (i), requires providers to develop an online Personal Care Services (PCS) service plan through the Provider Interface. The PCS service plan must be developed and validated within seven business days of the provider accepting the Independent Assessment Entity referral.

In addition, Clinical Coverage Policy 3L Section 6.1.4 (j) states that the provider organization shall obtain written consent in the form of signature of the beneficiary or their legally responsible person within 14 business days of the validated service plan. This written consent of the service plan must be printed out and uploaded into the Provider Interface.

The PCS online service plan must be completed any time a provider accepts a beneficiary's referral and any time there is a change in hours. A change in hours may occur due to:

- Annual assessments
- Medical and non-medical change of status requests
- Mediations
- Court settlements, and
- Appeals when Maintenance of Service hours have been granted.

Per policy, prior approval for PCS hours or units is **not** granted until the online PCS service plan is entered and validated by the Provider Interface.

DMA has provided trainings on the completion of the online PCS service plan since implementation in June 2015. These trainings can be found on the [Liberty Healthcare Corp. of NC website](#). In addition to this training, an extensive list of Frequently Asked Questions directly related to the completion of the online PCS service plan can be found on the Provider Portal (providers must be registered with QiRePort.net to access these questions and answers).

It should be noted that the PCS service plan is not a plan of care as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance to licensure requirements as specified in 10A NCAC 13F, 13G, 13J and 27G.

Providers with questions regarding the Service Plan Requirement or the PCS Clinical Coverage Policy may contact PCS_Program_Questions@dhhs.nc.gov.

Long-Term Services and Supports
DMA, 919-855-4360

Attention: Pharmacists**Upcoming Changes to the Roche Rebate Program for Preferred Roche Diabetic Supplies**

Beginning **April 1, 2018**, diabetic testing supplies will be transitioned to the [North Carolina Medicaid and NC Health Choice Preferred Drug List \(PDL\)](#) and Roche diabetic testing supplies will remain preferred. Pharmacy point-of-sale providers will no longer receive two separate payments for claims for Roche diabetic testing supplies. Instead, providers will receive one payment based on a State Maximum Allowable Cost (SMAC).

The following chart outlines the Roche diabetic testing supplies with their corresponding NDC number that will be preferred and their specific reimbursement amount and point-of-sale quantity limit:

Product	NDC Number	NC Medicaid SMAC Rate	Point of Sale Limit
ACCU-CHEK AVIVA PLUS 50 ct Test Strips	65702-0407-10	\$79.63/50 strips	200/month
ACCU-CHEK SMARTVIEW 50 ct Test Strips	65702-0492-10	\$79.63/50 strips	200/month
ACCU-CHEK COMPACT 51 ct Test Strips	50924-0988-50	\$81.67/51 strips	204/month
ACCU-CHEK GUIDE 50 ct Test Strips	65702-0711-10	\$21.56/50 strips	200/month
ACCU-CHEK SOFTCLIX Lancing Device Kit (Black)	65702-0400-10	\$22.63/each	2/year
ACCU-CHEK FASTCLIX Lancing Device Kit	65702-0481-10	\$17.55/each	2/year
ACCU-CHEK MULTICLIX 102 ct Lancets	50924-0450-01	\$15.68/102 lancets	204/month
ACCU-CHEK SOFTCLIX 100 ct Lancets	50924-0971-10	\$13.93/100 lancets	200/month
ACCU-CHEK FASTCLIX 102 ct Lancets	65702-0288-10	\$13.68/102 lancets	204/month
ACCU-CHEK AVIVA Glucose Control Solution (2 levels)	65702-0107-10	\$11.13/bottle	4/year
ACCU-CHEK COMPACT PLUS CLEAR Glucose Control Solution (2 levels)	65702-0468-10	\$11.13/bottle	4/year
ACCU-CHEK GUIDE Glucose Control Solution (2 levels)	65702-0713-10	\$11.13/bottle	4/year
ACCU-CHEK SMARTVIEW Glucose Control Solution (2 levels)	65702-0488-10	\$11.13/bottle	4/year

CSRA 1-800-688-6696

Proposed Clinical Coverage Policies

Per NCGS Section 108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the NC 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 NC 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 March 1, 2018, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
PA Criteria Antinarcotepoly/Antihyperkinesis Agents	02/09/18	03/25/18
Preferred Drug List (PDL) Sublocade	02/07/18	03/23/18
Preferred Drug List (PDL) Respiratory Anticholinergics	02/07/18	03/23/18
Preferred Drug List (PDL) PAH	02/07/18	03/23/18
Preferred Drug List (PDL) ARBs	02/07/18	03/23/18
PA criteria Nucala	02/07/18	03/23/18
PA Criteria Monoclonal Antibody	02/07/18	03/23/18
PA Criteria Lupus Medications	02/07/18	03/23/18
PA Criteria Systemic Immunomodulators (Reflexis) (Taltz)	02/07/18	03/23/18
PA Criteria Emflaza	02/07/18	03/23/18
PA Criteria Neuromuscular Blocking Agents	02/02/18	03/19/18
Preferred Drug List (PDL) Biguanides and Combinations	02/02/18	03/19/18

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
March 2018	03/02/18	03/06/18	03/07/18
	03/09/18	03/13/18	03/14/18
	03/16/18	03/20/18	03/21/18
	03/23/18	03/27/18	03/28/18
April 2018	03/30/18	04/03/18	04/04/18
	04/06/18	04/10/18	04/11/18
	04/13/18	04/17/18	04/18/18
	04/20/18	04/24/18	04/25/18

* 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