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

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Attention: All Providers

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

Effective with a date of service of May 17, 2014, DMA made changes to the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL). These changes include:

- The prior authorization criteria were removed from the second generation anti-convulsant class.

- The use of only Spiriva® in the Chronic Obstructive Pulmonary Disease (COPD) class is required before moving to a non-preferred agent.

- Adderall XR and Adderall generics were removed from the PDL entirely. Prior authorization is required for these generic products.

- New classes were added:
  - CARDIOVASCULAR: Sympatholytics and Combinations
  - ENDOCRINOLOGY: Sodium Glucose Co-Transporter 2 (SGLT2)
  - OPHTHALMIC: Antibiotics-Steroid Combinations
  - OTIC: Anti-Infectives and Anesthetics
  - TOPICALS: Antibiotics-Vaginal
  - MISCELLANEOUS: Estrogen Agent Combinations and Estrogen Agent Oral/Transdermal

In addition to these changes, the preferred brands with non-preferred generic equivalents were updated, as indicated on the following chart:

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accolate</td>
<td>Zafirlukast</td>
</tr>
<tr>
<td>Adderall</td>
<td>Amphetamine Salt Combo</td>
</tr>
<tr>
<td>Adderall XR</td>
<td>Amphetamine Salt Combo ER</td>
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<td>Alphagan P</td>
<td>Brimonidine</td>
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<td>Aricept ODT</td>
<td>Donepezil ODT</td>
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<tr>
<td>Astelin/Astepro</td>
<td>Azelastine Hydrochloride</td>
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<tr>
<td>Benzaclcin</td>
<td>Clindamycin/Benzoyl Peroxide</td>
</tr>
<tr>
<td>Cardizem LA</td>
<td>Diltiazem LA</td>
</tr>
<tr>
<td>Catapress-TTS</td>
<td>Clonidine Patches</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Generic Name</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Derma-Smoothe-FS</td>
<td>Fluocinolone 0.01% Oil</td>
</tr>
<tr>
<td>Differin</td>
<td>Adapalene</td>
</tr>
<tr>
<td>Diovan HCT</td>
<td>Valsartan Hydrochlorothiazide</td>
</tr>
<tr>
<td>Dovonex Cream</td>
<td>Calcipotriene 0.005% Cream</td>
</tr>
<tr>
<td>Diastat / Diastat Accudial</td>
<td>Diazepam Rectal &amp; Rectal Device</td>
</tr>
<tr>
<td>Exelon</td>
<td>Rivastigmine</td>
</tr>
<tr>
<td>Gabitril</td>
<td>Tiagabine</td>
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<tr>
<td>Kadian ER</td>
<td>Morphine Sulfate ER</td>
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<tr>
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<td>Griseofulvin Ultramicrosize</td>
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<td>Enoxaparin</td>
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<td>Marinol</td>
<td>Dronabinol</td>
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<td>Metrogel Vaginal</td>
<td>Metronidazole Gel Vaginal</td>
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<td>Opana ER</td>
<td>Oxymorphone ER</td>
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<tr>
<td>Pulmicort 0.25mg/2ml, 0.5mg/2ml</td>
<td>Budesonide 0.25mg/2ml, 0.5mg/2ml</td>
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<td>Retin-A Micro</td>
<td>Tretinoin Microsphere</td>
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<td>Singulair Granules</td>
<td>Montelukast Granules</td>
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<tr>
<td>Tobradex Suspension</td>
<td>Tobramycin/Dexamethasone Susp</td>
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<td>Toprol XL</td>
<td>Metoprolol Succinate</td>
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<td>Travoprost</td>
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<td>Trilipix</td>
<td>Fenofibric Acid</td>
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<td>Alfuzosin</td>
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<td>Vancocin</td>
<td>Vancomycin</td>
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<tr>
<td>Zovirax Ointment</td>
<td>Acyclovir Ointment</td>
</tr>
</tbody>
</table>

Outpatient Pharmacy Services
919-855-4300
Attention: All Providers

NCTracks Updates

Infant Toddler Program Claims with TPL

When an Infant Toddler Program (ITP) service is denied by a third-party payer as non-covered, providers are encouraged to submit the claim electronically to N.C. Medicaid for processing. The electronic claim should be submitted through the NCTracks Provider Portal with a copy of the Third-Party Explanation of Benefit (EOB) uploaded as an attachment. The Third Party EOB must include an explanation of the claim denial codes. ITP claims previously paid incorrectly would need to be refiled as adjustments.

Electronic adjustments are the preferred method to report overpayments or underpayments to the ITP. There are two separate actions that must be filed:

- Providers must use “void” when they need to cancel or submit refunds for previously paid claims. The entire claim will be recouped under the void process.

- Providers must “replace” a claim if they are updating claim information or changing incorrectly billed information. This term “replacing claims” is interchangeable with “adjusting claims.” The entire claim will be recouped and reprocessed under the replacement process.

Adjustments can be filed on paper, following the instructions outlined in the Claim Submission section on the Provider User Guides and Training page of the NCTracks Provider Portal. However, filing adjustments electronically will facilitate more accurate submissions and expedite their processing.

Check Medicaid Eligibility Later in the Day

Beneficiary eligibility information often isn’t completed until the end of the first day of the month, and sometimes not until the middle of the second day. If eligibility is being renewed or extended at the end of the month, the new eligibility may not yet be in NCTracks.

Many providers check eligibility at the first of the month for the beneficiaries they expect to see that month. The N.C. Division of Health and Human Services (DHHS) recommends checking eligibility on the first couple of days of the month, only for beneficiaries who need services specifically on those days.

For an emergency, contact the Eligibility Information System (EIS) staff at DHHS at 1-919-855-4000.
New User Guide for Claim Adjustments, Time Limit and Medicare Overrides

A new User Guide, titled “How to Submit Claim Adjustments and Time Limit and Medicare Overrides” has been added to the NCTracks Provider Portal. The guide can be found under the heading of “Claim Submission” on the Provider User Guides and Training Web page. Providers are encouraged to consult this guide before submitting claim adjustments, time limit and Medicare overrides to help expedite approval and processing of these requests.

Rate Change for PCS

A rate change for Personal Care Services (PCS) was implemented in NCTracks on May 23, 2014. The updated fees can be found on the N.C. Division of Medical Assistance (DMA) Fee Schedules Web page at www.ncdhhs.gov/dma/fee/.

Two PCS Webinars, which outline the rate change, were conducted by DMA on May 23. A copy of the presentation can be found at www.ncdhhs.gov/dma/pcs/PCS_SPA13009_Provider_Webinar_Presentation.pdf. In addition, Liberty Healthcare – NC is conducting regional seminars for PCS providers. For more information, read the training announcement on the Liberty Healthcare - NC Website at www.nc-pcs.com/training-announcement/.

For additional information about the PCS program, visit DMA’s PCS Web pages at www.ncdhhs.gov/dma/pcs/pas.html.

Claims Pended for Incorrect Location

When a claim is received with an incorrect billing, rendering, or attending provider location, the claim is pended in NCTracks. This occurs when the provider location submitted on the claim does not match the location(s) in the NCTracks provider record.

As of May 24, 2014, when a claim is pended for incorrect location, a secure message will be sent to the provider's NCTracks Message Center Inbox in the provider portal, with a link to a screen that enables them to select the correct location from a drop-down list. The claim is then released to continue processing. This approach allows a provider to correct the claim, rather than having it deny for an incorrect provider location.

There will be one message for every incorrect location (billing, rendering, or attending) on a pended claim. If a single claim has more than one incorrect location, there will be multiple inbox messages.

For more information about claims pended for incorrect location, see the announcement posted on the NCTracks Provider Portal titled “Claims Pended for Incorrect Location.”
Notice of Change in the Orthodontic Prior Approval Process

To correct problems with NCTracks regarding payment of the panoramic films rendered as part of the orthodontic records claim, CSC will grant prior approval (PA) of orthodontic records. PA for the orthodontic records will be granted regardless of the outcome of the review (approval or denial), as long as the recipient has not exceeded the once per lifetime policy limit for orthodontic records.

Effective immediately, orthodontic records rendered on or after May 1, 2014 should be included on the request for orthodontic PA.

Providers should include orthodontic record procedure codes: D0330, D0340, D0470, and D8080.

Providers should not include codes D0150 or D8670.

CSC PA Staff will add Procedure code D8670 for cases that are approved for orthodontic services.

Contact CSC at 1-800-688-6696

Attention: All Providers

NCTracks Tip of the Month: Searching for Answers

Save Time by Taking Advantage of the Search Feature

Both the NCTracks and N.C. Division of Medical Assistance (DMA) Websites have the capability to Search for keywords in announcements, Frequently Asked Questions (FAQs), articles, and Web pages. The Search box is found in the upper right corner of every page on both Websites.

“Searching” is a good place for providers to start if they are unsure if – or where – a topic might be covered on either of the Websites.

The information on the NCTracks Website deals with provider enrollment, claims processing and related activities, while the N.C. DMA Website provides N.C. Medicaid and N.C. Health Choice (NCHC) general policy, clinical policy and program information.

A quick Search can improve the accuracy and processing time of claims and enrollment submissions, and save providers a phone call to the NCTracks Call Center.

Contact CSC at 1-800-688-6696
Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policy is available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/mp/:

- 10A, Outpatient Specialized Therapies (7/1/14)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Nurse Practitioners, Physicians and Physician Assistants

Loxapine powder for inhalation (Adasuve™), HCPCS code C9497: Billing Guidelines

Effective with date of service February 1, 2014, the N.C. Medicaid Program covers loxapine powder for inhalation (Adasuve™) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J3490 (Not otherwise classified, antineoplastic drugs). Adasuve™ is currently commercially available in 1000 mg/40 mL single use vials.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing the loxapine powder for inhalation (Adasuve™) are:
  - 295.00 - 295.95 - Schizophrenic disorders
  - 296.0 - Bipolar I disorder, single manic episode
  - 296.1 - Manic disorder, recurrent episode
  - 296.4 - Bipolar I disorder, most recent episode (or current) manic
  - 296.6 - 296.8 - Bipolar I disorder mixed and unspecified

- Providers must bill the Adasuve™ with HCPCS code J3490 (Loxapine, inhalation powder, 10 mg).

- Providers must indicate the number of HCPCS units.
• One Medicaid unit of coverage for Adasuve™ is 10 mg (one inhaler). The maximum reimbursement per unit is $156.60. One 10 mg dose contains 1 billable unit.

• Adasuve™ must be administered only by a health care provider. There is a safety monitoring program (REMS) associated with the use of this medication.

• Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Adasuve™ 10 mg/dose are 57844-0510-11 and 57844-0510-55.

• The NDC units for loxapine powder for inhalation (Adasuve™) should be reported as “UN1.”

• If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.


• Providers must bill their usual and customary charge.

• The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Attention: Nurse Practitioners, Physicians and Physician Assistants

TBO-filgrastim injection (Granix™), HCPCS code J1446: Billing Guidelines

Effective with date of service February 1, 2014, the N.C. Medicaid Program covers TBO-filgrastim injection (Granix™) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J1446 (Not otherwise classified, antineoplastic drugs). Granix™ is currently commercially available in 300 mcg/0.5 mL and 480 mcg/0.8 mL vials.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing the TBO-filgrastim injection (Granix™) are:
  - 288.0 Neutropenia
  - 288.9 Unspecified disease of white blood cells

- Providers must bill Granix™ with HCPCS code J1446 (TBO-filgrastim, 5 mcg, injection).

- One Medicaid unit of coverage for Granix™ is 5 mcg. The maximum reimbursement rate per unit is $4.31. One 300 mcg/0.5 mL vial contains 60 billable units. One 480 mcg/0.8 mL vial contains 96 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Granix™ 300 mcg/0.5 mL are 63459-0910-11 and 63459-0910-15. The NDCs for Granix™ 480 mcg/0.8 mL are 63459-0912-11 and 63459-0912-15.

- The NDC units for TBO-filgrastim injection (Granix™) should be reported as “UN1.”

- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.


- Providers must bill their usual and customary charge.
• The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Attention: Nurse Practitioners, Physicians and Physician Assistants

**Ferric carboxymaltose injection (Injectafer®), HCPCS code J3490: Billing Guidelines**

Effective with date of service **March 1, 2014**, the N.C. Medicaid Program covers ferric carboxymaltose injection (Injectafer®) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J3490 (Unclassified drugs). Injectafer® is currently commercially available in 750 mg/15 mL single use vials.

**For Medicaid Billing**

- The ICD-9-CM diagnosis codes required for billing the ferric carboxymaltose injection (Injectafer®) are:
  - 280.0 Iron deficiency anemia secondary to blood loss (chronic)
  - 280.1 Iron deficiency anemia secondary to inadequate dietary iron intake
  - 280.8 Other specified iron deficiency anemias
  - 280.9 Unspecified iron deficiency anemia

- Providers must bill Injectafer® with HCPCS code J3490 (Unclassified drugs).

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Injectafer® is 1 mg. The maximum reimbursement rate per unit is $1.16. One 750 mg/15 mL vial contains 750 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Injectafer® 750 mg/15 mL is 00517-0650-01.

- The NDC units for ferric carboxymaltose injection (Injectafer®) should be reported as “UN1.”

- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.


- Providers must bill their usual and customary charge.
The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Attention: Nurse Practitioners, Physicians and Physician Assistants

Posaconazole injection (Noxafil®), HCPCS code J3490: Billing Guidelines

Effective with date of service April 1, 2014, the N.C. Medicaid Program covers posaconazole injection (Noxafil®) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J3490 (unclassified drugs). Noxafil® is currently commercially available in 300 mg per 16.7 mL (18 mg per mL) solution for injection.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing posaconazole (Noxafil®) are:
  - 288.03 Drug induced neutropenia with either:
    - 205 Acute myelogenous leukemia, or,
    - 38.7 Other lymphatic and hematopoietic tissues
  - 279 Disorders involving immune mechanisms

- Providers must bill Noxafil® with HCPCS code J3490 (Unclassified drugs)

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Noxafil® is 1 mg. The maximum reimbursement rate per unit is $1.91. One 18 mg per mL injection contains 300 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Noxafil® 18 mg per mL injection is 00085-4331-01.

- The NDC units for posaconazole (Noxafil®) should be reported as “UN1.”

- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.

• Providers must bill their usual and customary charge.

• The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Attention: Nurse Practitioners, Physicians and Physician Assistants

Coagulation factor XIII a-subunit (recombinant) (Tretten®), HCPCS code J7199: Billing Guidelines

Effective with date of service April 1, 2014, the N.C. Medicaid Program covers coagulation factor XIII a-subunit (recombinant) (Tretten®) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified). Tretten® is currently commercially available in 2,500 IU vials.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing coagulation factor XIII a-subunit (recombinant) (Tretten®) is 286.3 (congenital deficiency of other clotting factors).

- Providers must bill Tretten® with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified).

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Tretten® is 1 IU. The maximum reimbursement rate per unit is $14.36. One 2,500 IU vial contains 2,500 billable units.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Tretten® 2,500 IU vials are 00169-7013-01 and 00169-7113-11.

- The NDC units for coagulation factor XIII a-subunit (recombinant) (Tretten®) should be reported as “UN1.”

- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.

• Providers must bill their usual and customary charge.

• The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Attention: Nurse Practitioners, Physicians and Physician Assistants

Elosulfase alfa injection (Vimizim™), HCPCS code J3590: Billing Guidelines

Effective with date of service March 1, 2014, the N.C. Medicaid Program covers elosulfase alfa injection (Vimizim™) for use in the Physician’s Drug Program (PDP) when billed with HCPCS code J3590 (unclassified biologic drugs). Vimizim™ is currently commercially available in 5 mg/5 mL vials.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing the elosulfase alfa injection (Vimizim™) is 277.5 Mucopolysaccharidosis.

- Providers must bill the Vimizim™ with HCPCS code J3590 (Unclassified biologics).

- Providers must indicate the number of HCPCS units.

- One Medicaid unit of coverage for Vimizim™ is 1 mg. The maximum reimbursement per unit is $230.69. One 1 mg dose contains 1 billable unit.

- Vimizim™ must be administered only by a health care provider. There is a safety monitoring program (REMS) associated with the use of this medication.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Vimizim™ 1 mg/dose is 68135-0100-01.

- The NDC units for elosulfase alfa injection (Vimizim™) should be reported as “UN1.”

- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.

• Providers must bill their usual and customary charge.

• The new fee schedule for the PDP is available on the DMA Website at www.ncdhhs.gov/dma/fee/.

Contact CSC at 1-800-688-6696
Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to:

Richard K. Davis
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2014 Checkwrite Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>Checkwrite Cycle Cutoff Date</th>
<th>Checkwrite Date</th>
<th>EFT Effective Date</th>
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<td>7/09/2014</td>
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<td>8/28/2014</td>
<td>9/03/2014</td>
<td>9/04/2014</td>
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</tbody>
</table>
Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

Sandra Terrell, MS, RN
Acting Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
Computer Sciences Corp. (CSC)