



# North Carolina Medicaid Bulletin October 2016

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

**All Providers**

NCTracks Provider Training Available in October 2016.....2  
 N.C. Medicaid Electronic Health Record (EHR) Incentive Program Announcements.....5  
 Clinical Coverage Policies.....6  
 Affiliation Claim Edit.....7  
 Claim Edit for Rendering Provider Service Location.....9  
 Diagnosis-Related Group (DRG) Grouper 34 and Associated Rates for Inpatient  
 Institutional Claims.....11  
 ICD-10 Update for 2017.....11  
 Re-credentialing Due Dates for Calendar Year 2016.....12  
 Influenza Vaccine and Reimbursement Guidelines for 2016-2017 .....14  
 Procedures for Prior Authorization of Synagis for Respiratory Syncytial Virus (RSV)  
 Season 2016/2017.....22

**Dialysis Facilities and Professionals Billing For End Stage Renal Disease**

Diagnosis Code for End Stage Renal Disease.....29

**Durable Medical Equipment**

Reprocessing of Claims Due to SMAC Rate Change.....30  
 Durable Medical Equipment Update – Modification to Clinical Coverage Policy 5A.....31

**Hospice Providers**

CBSA Codes and Hospice Payment Reform.....33

**Nurse Practitioners, Physicians, Physicians Assistants**

Reslizumab injection, for intravenous use (Cinqair®) HCPCS code J3590:  
 Billing Guidelines.....34

**Pharmacist Providers**

Pharmacist Administrated Vaccine and Reimbursement Guidelines for 2016-2017  
 for N.C. Medicaid.....25

*Providers are responsible for informing their billing agency of information in this bulletin.  
 CPT codes, descriptors and other data only are copyright 2016 American Medical  
 Association.  
 All rights reserved. Applicable FARS/DFARS apply.*

**Attention: All Providers****NCTracks Provider Training Available in October 2016**

Registration is open for several provider training courses, which will be held in October. The courses are instructor-led and duration varies depending on the course.

**Note:** All courses and the day/time offered are subject to change.

Below are details on the courses, dates and times and instructions for how to enroll.

**Provider Web Portal Applications (WebEx)**

- Wednesday, Oct. 5 - 1 p.m. to 4 p.m.

This course guides providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal. At the end of this training, providers will be able to:

- Understand the provider enrollment application processes
- Navigate to the NCTracks Provider Portal and complete provider enrollment, Manage Change Request (MCR), re-enrollment, and reverification and maintain eligibility requests
- Track and submit applications using the Status and Management page

This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

**ES User Role, Abbreviated Managed Change Requests and Upload Documents (WebEx)**

- Monday, Oct. 10 - 10 a.m. to 1 p.m.

This course guides providers through new enhancements on the provider enrollment application processes. At the end of training, providers will be able to:

- Explain the enrollment specialist user role
- Identify the abbreviated MCR applications
- Upload supporting documents

This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **How to Submit a Medical Prior Approval (On-Site Training)**

- Friday, Oct. 14 – 9:30 a.m. to noon

This course trains authorized users how to electronically submit and inquire about prior approvals (PA) for various medical services. After completing this course, authorized users will be able to submit prior approvals and managed care referrals electronically and conduct electronic inquiries about PAs.

The course is being offered **in-person** at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

### **How to Submit a Professional Claim (On-Site Training)**

- Friday, Oct. 14 - 1 p.m. to 3 p.m.

This course focuses on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to:

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

The course is being offered **in-person** at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

### **Create and Submit a Prior Approval for Home Health Supplies and DME using Electronic Signature (WebEx)**

- Monday, Oct. 17 – 1 p.m. to 3 p.m.

This course guides users through the process that allows the requesting provider to enter a PA on the provider portal and route it through NCTracks to the prescribing provider for review and approval using an electronic signature (PIN). At the end of training, providers will be able to:

- Assign a user role to a provider
- Assign a Durable Medicaid Equipment (DME) PA request to the prescribing provider
- Assign a Home Health Supply PA request to the prescribing provider
- Access the notification of the PA request within the NCTracks provider Portal message center
- Accept a PA request and confirm with an electronic signature
- Reject a PA request and send back to the requesting provider
- Revise a PA request and re-assign to the prescribing provider

This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **Provider Re-Credentialing/Reverification Refresher (WebEx)**

- Thursday, Oct. 20 – 1:00 p.m. to 2:30 p.m.

This course provides instructions on how to complete the reverification process through NCTracks and how to submit a Manage Change Request (MCR) in the event the user is prompted to complete an MCR during reverification/re-credentialing. At the end of training, providers will know how to:

- Understand and explain each phase of reverification
- Complete the reverification process in NCTracks
- Complete and MCR for invalid or missing provider data

This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

### **Training Enrollment Instructions**

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Log on 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 web page](#) of the public provider portal for specific instructions on how to use SkillPort. The Provider Training web page also includes a quick reference regarding Java, which is required for the use of SkillPort.

**CSRA, 1-800-688-6696**

## Attention: All Providers

# N.C. Medicaid Electronic Health Record (EHR) Incentive Program Announcements

### Program Year 2016 is the last year to begin participating

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program is reminding the provider community that **Program Year 2016 is the last year a provider can begin participating and receive the first year payment of \$21,250.**

The N.C. Medicaid EHR Incentive Program has paid over \$285 million in incentives to N.C. providers. It encourages eligible providers to take advantage of this opportunity to attest. The N.C. Medicaid Incentive Payment System ([NC-MIPS](#)) is now accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and Meaningful Use (MU) attestations, so providers can get started today.

In addition to receiving \$63,750 over six years of successful participation, the use of certified EHR technology can help a practice achieve measurable improvements in patient health care.

Providers are eligible for the incentive if they:

1. Have a [CMS-certified EHR](#),
2. Are Medicaid physicians, nurse practitioners, certified nurse midwives or dentists (some physician assistants also qualify) and,
3. At least 30 percent of their patients are Medicaid-enrolled.

Assistance is available through step-by-step attestation guides, an extensive library of answers to Frequently Asked Questions (FAQs), webinars and a dedicated [help desk](#). Providers can receive free onsite support for meeting MU criteria, and guidance in registering and attesting, from technical assistance partners at regional [N.C. AHECs](#). [Email](#) the N.C. Medicaid EHR Incentive Program help desk to get connected to the best resources to meet your needs.

For more information on how to start participating, visit the [N.C. Medicaid EHR Incentive Program web page](#), or send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

### 'Quick Tip' Webinar Series

Those who want to learn more about the program but are short on time can review the "Quick Tip" webinar series. These webinars were designed with the busy practice in mind and feature basic webinars between two and five minutes long. Topics include enrolling in the Centers for Medicare and Medicaid Services (CMS) Registration and

Attestation System, and what MU looks like in Program Year 2016. These webinars can be found on the [N.C. Medicaid EHR Incentive Program web page](#) under the “Resources and Webinars” tab.

**N.C. Medicaid EHR Incentive Program**  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) (email preferred)

---

## **Attention: All Providers**

### **Clinical Coverage Policies**

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the Division of Medical Assistance (DMA) website at <https://dma.ncdhhs.gov/providers/clinical-coverage-policies>:

- 1A-7, *Neonatal and Pediatric Critical and Intensive Care Services* (10/5/15)
- 8A, *Enhanced Mental Health and Substance Abuse Services* (10/1/16)

These policies supersede previously published policies and procedures.

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

**Attention: All Providers****A**ffiliation Claim Edit

**Note:** This is an update of an article from the [June 2016 Medicaid Bulletin](#), **including a revised implementation date.**

One of the requirements associated with NCTracks is that attending/rendering providers must be affiliated with the billing providers who are submitting claims on their behalf. Currently, the disposition of Edit 07025 has been set to “pay and report.” The “pay and report” disposition means that claims where the attending/rendering provider is **not** affiliated with the billing provider will **not** deny, but Edit 07025 and EOB 07025 will post on the provider's Remittance Advice (RA).

EOB 07025 reads:

THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED.

The intent was to alert providers to situations in which the affiliation relationship does not exist. This allows the attending/rendering provider to initiate a Manage Change Request (MCR) to add the affiliation to the provider record.

**This is the revised implementation date: Effective Feb. 6, 2017, the claim edit disposition will change from “pay and report” to “pend” and will no longer give the informational message. Once the disposition is changed, a claim failing the edit will suspend for 60 days. Providers will continue to receive EOB 07025:**

THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED.

**If the affiliation relationship is not established within 60 days, the claim will be denied.** Providers must correct any affiliation issues immediately.

**Note:** The MCR to establish or change a provider affiliation must be initiated by the OA of the individual attending/rendering provider. A group or hospital that acts as a billing provider cannot alter affiliations in NCTracks.

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

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



**Attention: All Providers****C**laim Edit for Rendering Provider Service Location

**Note:** This is a reposting of an article from the [June 2016 Medicaid Bulletin](#) with a revised implementation date.

**On March 2, 2015**, NCTracks claims processing began searching for any active location on the provider record for which the rendering taxonomy code on the claim is valid. The claim is then processed using that location.

An Informational (pay and report) Edit 04528 RENDERING PROVIDER LOCATION CODE SET BASED ON TAXONOMY has been posted with Explanation of Benefits (EOB) 04528 on the Remittance Advice (RA). This edit alerts providers to take action to update the rendering provider location on the provider record.

EOB 04528 states:

“UNABLE TO DETERMINE RENDERING PROVIDER LOCATION CODE BASED ON THE SUBMITTED ADDRESS. LOCATION CODE HAS BEEN SET BASED ON THE RENDERING PROVIDER TAXONOMY ONLY. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING THE SERVICE FACILITY ON THIS CLAIM AS AN ACTIVE SERVICE LOCATION.”

This was intended to be a temporary change to allow providers time to update their provider records with the correct rendering provider location information. The User Guide, *How to Change the Primary Physical Address in NCTracks*, which explains how to update provider location information, can be found under the heading “Provider Record Maintenance” on the [Provider User Guides and Training page](#) of the NCTracks Provider Portal.

**This is the revised implementation date: Effective Nov. 1, 2016**, the claim edit disposition for invalid rendering provider location will change from “pay and report” to “pend.” Rendering providers must have the addresses of all facilities where they perform services listed as provider service locations under their National Provider Identifiers (NPIs) in NCTracks. The system uses a combination of NPI, taxonomy code, and service location in processing claims. If the address where the service was rendered is not listed in the provider record as a service location for the rendering provider's NPI, the claim will suspend with Edit 04526 and EOB 04526 – RENDERING LOCATOR CODE CANNOT BE DERIVED. This will delay the completion of claim adjudication and payment.

For more information regarding how to correct these pended claims, see the [May 27, 2014 announcement](#) on the NCTracks Provider Portal.

**Note:** Claims with invalid billing or attending provider locations also will continue to pend.

Rendering providers can add service locations to their provider record by having their Office Administrator (OA) complete a Manage Change Request (MCR) in the *Enrollment Status and Management* section of the secure NCTracks provider portal.

**Note:** When adding a new service location, the application also will require that taxonomies and applicable accreditations be added to the new service location. The pending claims are recycled periodically and will recognize changes in the provider record that alleviate Edit 04526. The provider does not need to resubmit the claim.

When updating a provider record in NCTracks, the MCR will assign a default effective date of the current date to most changes. **This is important because the system will edit subsequent transactions against the effective dates in the provider record.** For example, claims are edited against the effective date of the taxonomy codes on the provider record. **The claim will deny if a provider bills for a service rendered prior to the effective date of the relevant taxonomy code on the provider record.**

**Some effective dates can be changed from the default date.** When providers add or reinstate a health plan, service location, or taxonomy code, the effective dates can be changed from the default date. However, the effective date must be changed **before** the MCR is submitted. (The effective date also cannot precede the enrollment date or the date associated with the relevant credential or license and cannot be older than 365 days.)

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

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

**Attention: All Providers****D** **Diagnosis-Related Group (DRG) Grouper 34 and Associated Rates for Inpatient Institutional Claims**

On Oct. 1, 2016, NCTracks will implement the Diagnosis-Related Group (DRG) Grouper 34, along with the associated rates for inpatient institutional claims with dates of discharge between Oct. 1, 2016, and Sept. 30, 2017.

The weights for newborn deliveries have increased to encourage the use of long-acting reversible contraceptives (LARC) procedures in the inpatient setting.

A copy of the DRG Grouper Version 34 weights and thresholds in Excel format are posted to the N.C. Division of Medical Assistance (DMA) [Hospital Fee Schedule web page](#) which includes the Grouper 34 DRG Weight Table.

Provider with question can contact Bill Connelly in Provider Reimbursement at 919-814-0049.

**Provider Reimbursement**  
**DMA, 919-814-0049**

---

**Attention: All Providers****I** **CD-10 Update for 2017**

The 2017 ICD-10 update will be in place effective Oct. 1, 2016 through Sept. 30, 2017 for provider use. Providers can access the list of ICD-10 codes at <https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMS.html>.

**Practitioners and Facilities**  
**DMA, 919-855-4320**

## Attention: All Providers

# Re-credentialing Due Dates for Calendar Year 2016

**Note:** This article was *originally* published as a [February 2016 Special Medicaid Bulletin](#).

### List of Providers due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2016 is available on the [provider enrollment page](#) of the DMA 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 NPI numbers and provider names, to compare with their provider list.

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

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

- 1) In Review,
- 2) Returned,
- 3) Approved or
- 4) Payment Pending.

Providers are required to complete the re-credentialing application after the full MCR is completed. If the provider does not complete the process **within the allotted 45 days, payment will be suspended.** Once payment is suspended, the provider must submit a re-credentialing application or the full MCR before payment suspension will be lifted. When the provider does **not** submit a reverification application by the reverification due date **and** the provider has an MCR application in which the status is In Review, Returned, Approved or Payment Pending, the provider’s due date will be reset to the current date plus 45 calendar days.

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

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

Providers with questions about the re-credentialing process can contact the CSRA Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com) (email).

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

**Attention: All Providers (except pharmacists\*)****Influenza Vaccine and Reimbursement Guidelines for 2016-2017**

(\* Pharmacy providers: see [page 25](#) in this October bulletin)

Composition of the trivalent influenza vaccines for the 2016-2017 influenza season is:

- A/California/7/2009 (H1N1)pdm09-like virus,
- A/Hong Kong/4801/2014 (H3N2)-like virus,
- B/Brisbane/60/2008-like (Victoria lineage) virus.

Quadrivalent influenza vaccines will contain these vaccine viruses and a B/Phuket/3073/2013-like (Yamagata lineage) virus.

[CDC's Advisory Committee on Immunization Practices \(ACIP\)](#) determined that live attenuated influenza vaccine (LAIV), also known as the “nasal spray” flu vaccine, should **not** be used during the 2016-2017 flu season. As a result, this vaccine will **not be reimbursed nor will the administration fee be covered** if administered for any N.C. Medicaid or N.C. Health Choice (NCHC) beneficiary.

For further details on the 2016-2017 influenza vaccine, visit the [Centers for Disease Control \(CDC\) Flu Season web page](#).

N.C. Division of Medical Assistance (DMA) does not expect that providers will be vaccinating beneficiaries with the 2016-2017 influenza season's vaccine after date of service June 30, 2017.

**N.C. Immunization Program/Vaccines for Children (NCIP/VFC)**

Under N.C. Immunization Program/Vaccines for Children (NCIP/VFC) guidelines, the N.C. Division of Public Health (DPH) Immunization Branch distributes all required childhood vaccines to local health departments, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), hospitals and private providers.

For the 2016-2017 influenza season, NCIP/VFC influenza vaccines – all quadrivalent – are available at no charge to providers for children 6 months through 18 years of age who are eligible for the VFC program, according to the NCIP coverage criteria. The current NCIP coverage criteria and definitions of VFC categories can be found on [DPH's Immunization Branch web page](#).

For providers interested in enrolling in the VFC program, information can be found on the [CDC information page](#).

All Medicaid beneficiaries aged 6 months to 18 years are eligible for the VFC vaccines. NCHC beneficiaries are not eligible unless they are American Indian or Alaskan Native (AI/AN). These beneficiaries can be identified as AI/AN in one of two ways.

1. They are either identified as MIC-A and MIC-S on their NCHC Identification Cards or,
2. Beneficiaries or their parents may self-declare their VFC eligibility status according to NCIP/VFC program policy.

When NCHC beneficiaries self-declare their status as AI/AN, and the provider administers the state-supplied vaccine, the provider shall report the CPT vaccine code with \$0.00 and may bill NCHC for the administration costs only. For further details, refer to the June 2012 Medicaid Bulletin article [Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients](#).

All other NCHC beneficiaries are **not VFC eligible**. Providers should use **privately purchased vaccines**. **DMA will reimburse the cost of the vaccine and the administration fee.**

**For VFC/NCIP vaccines administered to VFC-eligible children, providers shall report only the vaccine code(s) with \$0.00. Providers may bill DMA for the administration fee for VFC eligible Medicaid and AI/AN NCHC beneficiaries.**

**Providers who administer privately purchased vaccines to VFC eligible beneficiaries will not be reimbursed for the vaccine and cannot bill the beneficiary for that cost. Only the administration fee(s) will be reimbursed.**

Providers shall purchase vaccines for those children who are **not** VFC-eligible (including all NCHC children who are not AI/AN) and adult patients. For Medicaid-eligible beneficiaries age 19 and older, purchased vaccine and administration costs may be billed to N.C. Medicaid, according to the guidelines stated in Tables 2 and 3 below. To determine who is eligible for NCIP influenza and other vaccines, visit [DPH's Immunization Branch web page](#).

### **Billing and Reporting Influenza Vaccines for Medicaid Beneficiaries**

The following tables indicate the vaccine codes that may be either reported (with \$0.00 billed) or billed (with the usual and customary charge) for influenza vaccine, depending on the age of the beneficiaries and the formulation of the vaccine. The tables also indicate the administration codes that may be billed, depending on the age of the beneficiaries and the vaccine(s) administered to them.

**Note:** The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for **Health Check beneficiaries** can be found in the [Health Check Billing Guide](#).

**Table 1**  
***Influenza Billing Codes for Medicaid Beneficiaries Less Than 19 Years of Age Who Receive VFC Influenza Vaccine. These codes are reported with \$0.00.***

Vaccine CPT Codes to Report

<b>Vaccine CPT Code to Report</b>	<b>CPT Code Description</b>
90674**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, when administered to individuals 4 years and older, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals age 3 years and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to children 6 through 35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years and older, for intramuscular use

\*\* The vaccine will be available after Oct. 15, 2016.

Administrative CPT Codes to Bill

<b>Administration CPT Code(s) to Bill</b>	<b>CPT Code Description</b>
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)
+90472EP (add-on code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); <b>each additional vaccine</b> (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).
90460EP	Immunization administration through 18 years via any route of administration, with counseling by physician or other qualified health care professional.

\*\* 90472 will only be used if another vaccine is given in addition to the flu vaccine. Providers *may* bill more than one unit of 90472 as appropriate.



**Table 2**  
**Influenza Billing Codes for Medicaid Beneficiaries 19 and 20 Years of Age**

Use the following codes to bill Medicaid for an influenza vaccine **purchased** and administered to beneficiaries aged **19-20 years**.

**Note:** The VFC/NCIP provides influenza products for recipients aged 6 months through 18 years **only**. The VFC/NCIP will **NOT** provide influenza vaccine for recipients 19 years and older.

Vaccine CPT Codes to Report

Vaccine CPT Code to Report	CPT Code Description
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals 18 through 64 years, for intradermal use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 4 years and older, for intramuscular use
90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 4 years and older, for intramuscular use
90674**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, when administered to individuals 4 years and older, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals age 3 years and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years and older, for intramuscular use

\*\* The vaccine will be available after Oct. 15, 2016.

Administrative CPT Codes to Report

Administrative CPT Code(s) to Report	CPT Code Description
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)
+90472EP (add-on code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>each additional vaccine</b> (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).

\*\* 90472 will only be used if another vaccine is given in addition to the flu vaccine. Providers *may* bill more than one unit of 90472 as appropriate.

**Table 3**  
***Influenza Billing Codes for Medicaid Beneficiaries 21 Years of Age and Older***

Use the following codes to **bill** Medicaid for an *injectable* influenza vaccine **purchased** and administered to beneficiaries **21 years of age and older**.

**Note:** The VFC/NCIP provided influenza products for VFC-age (6 months through 18 years of age) beneficiaries **only**. The VFC/NCIP will **not** provide influenza vaccine for beneficiaries 19 years and older.

Vaccine CPT Code to Report

Vaccine CPT Code to Report	CPT Code Description
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals 18 through 64 years, for intradermal use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 4 years and older, for intramuscular use
90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 4 years and older, for intramuscular use
90674**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, when administered to individuals 4 years and older, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals age 3 years and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years and older, for intramuscular use

\*\* The vaccine will be available after Oct. 15, 2016.

Administrative CPT Code(s) to Bill

Administrative CPT Code(s) to Bill	CPT Code Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)
+90472 (add-on code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>each additional vaccine</b> (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure)

\*\* 90472 will only be used if another vaccine is given in addition to the flu vaccine. Providers *may* bill more than one unit of 90472 as appropriate.

For beneficiaries 21 years or older receiving an influenza vaccine, an evaluation and management (E/M) code cannot be reimbursed to any provider on the same day that injection administration fee codes (e.g., 90471 or 90471 and +90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

### **Billing and Reporting Influenza Vaccines for NCHC Beneficiaries**

The following table indicates the vaccine codes that may be either reported (with \$0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on an NCHC beneficiary's VFC eligibility (that is, if the beneficiary is AI/AN) and the formulation of the vaccine. The table also indicates the administration codes that may be billed.

**Table 4**  
***Influenza Billing Codes for NCHC Beneficiaries***

Vaccine CPT Code to Report

Vaccine CPT Code to Report	CPT Code Description
90630	Influenza virus vaccine, quadrivalent (IIV4-ID), split virus, preservative free, when administered to individuals 18 through 64 years, for intradermal use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 4 years and older, for intramuscular use
90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 4 years and older, for intramuscular use
90674**	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, when administered to individuals 4 years and older, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals age 3 years and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years and older, for intramuscular use

\*\* The vaccine will be available after Oct. 15, 2016.

Administrative CPT Code(s) to Bill

Administrative CPT Code(s) to Bill	CPT Code Description
90471TJ	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)
+90472TJ (add-on code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); <b>each additional vaccine</b> (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).
90460TJ	Immunization administration through 18 years via any route of administration, with counseling by physician or other qualified health care professional.

\*\* 90472 will only be used if another vaccine is given in addition to the flu vaccine. Providers *may* bill more than one unit of 90472 as appropriate

**Notes**

- The EP modifier must **not** be billed on NCHC claims. The TJ modifier must be used.
- There is no co-pay for office visits and wellness checks.

**Immunization Billing for Medicaid and NCHC Beneficiaries from FQHCs and RHCs**

- *For beneficiaries 0 through 20 years of age*

If **vaccines are provided through the NCIP/VFC**, the center or clinic shall report the CPT vaccine codes (with \$0.00 billed) under Physician Services NPI and may bill for the administration codes (CPT procedure codes 90471EP through 90472EP OR 90460EP). This billing is appropriate when only vaccines are provided at the visit, or if vaccines were provided in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes must be reported (with \$0.00 billed) under Physician Services NPI and an administration code must not be billed.

If **purchased vaccines (non-VFC eligible)** were administered, the center or clinic may bill the CPT vaccine codes (with their usual and customary charge) under the Physician Services NPI for the vaccines administered and may bill for the administration codes (with the usual and customary charge). This billing is appropriate if only vaccines were given at the visit or if vaccines were given in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes must be reported (with \$0.00 billed) under the Physician Services NPI provider number and the administration codes must not be billed. For detailed billing guidance, refer to the [Health Check Billing Guide](#).

**Note:** When billing for NCHC beneficiaries, refer to the detailed billing guidance above including Table 4 and the Core Visit policy in [DMA's Provider Library web page](#).

- *For beneficiaries 21 years of age and older*

When purchased vaccines are administered, CPT vaccine codes may be billed (with the usual and customary charge) and administration codes may be billed (with the usual and customary charge) under the Physician Services NPI. This is applicable when vaccine administration was the only service provided that visit. When a core visit is billed, the CPT vaccine code must be reported (with \$0.00 billed) under the Physician Services NPI and an immunization administration code may not be billed.

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

**CSRA, 1-800-688-6696**

**Attention: All Providers****Procedures for Prior Authorization of Synagis for Respiratory Syncytial Virus (RSV) Season 2016/2017**

**Note:** This article was previously published in Sept. 2016

The clinical criteria used by N.C. Medicaid for the 2016/2017 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the American Academy of Pediatrics (AAP): *2015 Report of the Committee on Infectious Diseases, 30<sup>th</sup> Edition*. This guidance for Synagis use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription.

**The coverage season is Nov. 1, 2016 through March 31, 2017.** Providers are encouraged to review the AAP guidance prior to the start of the RSV season. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are evaluated for Synagis requests.

**Guidelines for Evidenced Based Synagis Prophylaxis**

- Infants younger than 12 months at start of season with diagnosis:
  - Prematurity – born before 29 weeks 0 days gestation
  - Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32 weeks 0 days gestation and required greater than 21 percent oxygen for at least 28 days after birth)
  - Hemodynamically significant acyanotic heart disease and receiving medication to control congestive heart failure, will require cardiac surgical procedures and moderate to severe pulmonary hypertension
  - Infants with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.
- Infants during first year of life with diagnosis:
  - Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways
- Infants less than 24 months of age with diagnosis:
  - Profound immunocompromise during RSV season

- CLD of prematurity (see above definition) and continue to require medical support (supplemental oxygen, chronic corticosteroid or diuretic therapy) during 6 month period before start of second RSV season
- Cardiac transplantation during RSV season

### **Prior Approval Request**

Submit all Prior Approval (PA) requests for coverage of Synagis during the coverage season electronically at [www.documentforsafety.org/](http://www.documentforsafety.org/). (Those using Internet Explorer might get a pop-up menu and have to click “Continue to this Website.”) The web-based program will process PA information in accordance with the guidelines for use. A PA request can be automatically approved based on the information submitted. The program allows a provider to self-monitor the status of a request. Up to five doses can be approved for coverage. Coverage of Synagis for neuromuscular disease or congenital anomaly that impairs ability to clear respiratory secretions from the upper airway will terminate when the beneficiary exceeds 12 months of age. Coverage of Synagis for CLD, profound immunocompromised or cardiac transplantation, will terminate when the beneficiary exceeds 24 months of age.

### **Dose Authorization**

Each Synagis dose will be individually authorized to promote efficient product distribution. Providers must submit a “**next dose request**” to obtain an authorization for each dose. Providers should ensure the previously obtained supply of Synagis is administered before submitting a next dose request. Providers will fax each single dose authorization to the pharmacy distributor of choice.

If an infant received one or more Synagis doses prior to hospital discharge, the provider should indicate as part of the request the most recent date a dose was administered and the number of doses administered by the provider should be adjusted accordingly. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough laboratory confirmed RSV hospitalization, coverage of Synagis will be discontinued.

### **Pharmacy Distributor Information**

Single dose vial specific authorizations, not to exceed the maximum number of doses approved for the beneficiary, will be issued by the Division of Medical Assistance (DMA). It is important for the Synagis distributor to have the appropriate single dose authorization on hand and a paid point of sale (POS) claim prior to shipping Synagis. An individual dose authorization is required for each paid Synagis claim. The drug quantity submitted on the claim should not exceed the quantity indicated on the authorization. Payment for a Synagis claim will be denied if a dose request was not done by the provider.

Synagis claims processing will begin on Oct. 26, 2016, to allow sufficient time for pharmacies to provide Synagis by Nov. 1, 2016. Payment of Synagis claims with date of service before Oct. 26, 2016, and after March 31, 2017 is not allowed. POS claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound-drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment.

Physicians and pharmacy providers are subject to audits of beneficiary records by DMA. Maintain Synagis dose authorizations in accordance with required record keeping time frames.

### **Provider Information**

Providers without internet access should contact the Medicaid Outpatient Pharmacy Program at 919-855-4300 to facilitate submission of a PA request for Synagis. More information about the Synagis program is available at [www.documentforsafety.org/](http://www.documentforsafety.org/). (Those using Internet Explorer might get a pop-up menu and have to click "Continue to this Website.")

### **Submitting a Request to Exceed Policy**

The provider should use the **Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age** to request Synagis doses exceeding policy or for coverage outside the defined coverage period. The form, and more information about EPSDT coverage, is available on [DMA's EPSDT web page](#).

### **Technical Support**

Technical support is available Monday through Friday, 8 a.m. to 5 p.m. by calling 1-855-272-6576 (local: 919-926-3986). Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions.

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



## Attention: Pharmacist Providers

### **P**harmacist Administrated Vaccine and Reimbursement Guidelines for 2016-2017 for N.C. Medicaid

Information about rules and regulations regarding pharmacist-administrated vaccinations can be found on the [N.C. Board of Pharmacy web page](#). The specific text of the statute can be found on [House Bill 832](#).

Effective Jan. 1, 2016, N.C. Medicaid is reimbursing pharmacies for covered vaccines as permitted by G.S. 90-85.15B when administered to NC Medicaid beneficiaries 19 years of age and older by an immunizing pharmacist. These vaccines are:

- Herpes zoster vaccine
- Hepatitis B vaccine
- Influenza vaccine
- Meningococcal polysaccharide or meningococcal conjugate vaccines
- Pneumococcal polysaccharide or pneumococcal conjugate vaccines
- Tetanus toxoid vaccine/tetanus-diphtheria/tetanus-diphtheria-pertussis/tetanus-diphtheria-acellular pertussis vaccines

N.C. Division of Public Health (DPH) has determined that pharmacies are ineligible to enroll in the Vaccines for Children (VFC) program (a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay). Pharmacies who administer privately purchased vaccines to VFC eligible N.C. Medicaid beneficiaries will **NOT** be reimbursed for the vaccine and **CANNOT** bill the beneficiary for that cost. Only the administration fee(s) will be reimbursed.

**For this reason, immunizing pharmacists should only administer vaccinations to N.C. Medicaid beneficiaries 19 years of age and older, as these beneficiaries are not eligible for the VFC program.**

Professional claims for covered vaccinations administered to N.C. Medicaid beneficiaries 19 years of age and older should be billed by pharmacies according to the guidelines stated in Tables 1 and 2 below and submitted electronically through the NCTracks website using the professional claim format ([CMS 1500 form](#)) or an [837P electronic batch transaction](#). NCTracks has instructor-led and computer-based training on “How to File a Professional Claim” that can be found in the secure NCTracks Provider Portal. NDC’s **should not** be listed on the claim for vaccine reimbursements; only vaccine and administration CPT codes are required. **Any claim submitted for vaccine reimbursement with a NDC listed will be denied.**

All N.C. Medicaid covered vaccines are reimbursed according to the [Physicians Drug Program \(PDP\) vaccine fee schedule](#) and administration rates as per the [Physician’s](#)

[Services Fee Schedule](#). Medicaid will reimburse immunizing pharmacists (vaccine rate and administration fee) the same as all other providers.

According to N.C. Board of Pharmacy rules, within 72 hours of administering any vaccine, the immunizing pharmacist must notify the patient’s identified primary care provider and the N.C. Immunization Registry. The N.C. Association of Pharmacists has an [Immunization Registry Pharmacy User Webinar](#) that contains useful information.

**Table 1**  
**Billing Codes for Medicaid Beneficiaries 19 Years of Age or Older**

<b>CPT Code</b>	<b>Vaccine</b>
90746CG*	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
90630CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90656CG	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, for intramuscular use
90658CG	Influenza virus vaccine, trivalent (IIV3), split virus, for intramuscular use
90674CG**	Influenza virus vaccine, quadrivalent (IIV4), split vaccine, for intramuscular use
90686CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intramuscular use
90688CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, for intramuscular use
90620CG	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use
90621CG	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use
90733CG	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use
90734CG	Meningococcal conjugate vaccine, serogroups A, C, Y, W-135, quadrivalent (MenACWY) for intramuscular use
90670CG	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90732CG	Pneumococcal Polysaccharide Vaccine, 23-valent, for subcutaneous or intramuscular use
90714CG	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
90715CG	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90736CG	Zoster (shingles) vaccine (HZV), live, for subcutaneous use

\*The CG modifier must be appended to every vaccine and vaccine administration CPT code used to bill vaccines by pharmacists. The CG modifier identifies a Pharmacy Provider in NCTracks for vaccine claims billing purposes. Additionally, NDCs should not be included in the claim as they will deny in NCTracks. Vaccines do not have a rebate nor fall under 340B rules and, therefore, must not contain NDCs.

\*\*Available only after Oct. 15, 2016.

[CDC’s Advisory Committee on Immunization Practices \(ACIP\)](#) voted that live attenuated influenza vaccine (LAIV), also known as the “nasal spray” flu vaccine, should **not** be used during the 2016-2017 flu season. **As a result, the nasal flu vaccine will not be reimbursed nor will the administration cost be covered for any N.C. Medicaid beneficiary.**

N.C. Division of Medical Assistance (DMA) does not expect that providers will be vaccinating beneficiaries with the 2016-2017 influenza season’s vaccine after date of service June 30, 2017.

**Table 2**  
**Billing Codes for N.C. Medicaid Beneficiaries 19 Years of Age and Older**

CPT Code(s)	CPT Code Description
90471CG*	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>one vaccine</b> (single or combination vaccine/toxoid)
90472CG (add-on code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); <b>each additional vaccine.</b> (Separately list the add-on code(s) for each additional single vaccine and/or combination vaccine/toxoid administered, in addition to the primary procedure)

\*The CG modifier must be appended to every vaccine and vaccine administration CPT code used to bill vaccines by pharmacists. The CG modifier identifies a Pharmacy Provider in NCTracks for vaccine claims billing purposes. Additionally, NDCs should not be included in the claim as they will deny in NCTracks. Vaccines do not have a rebate nor fall under 340B rules and, therefore, must not contain NDCs.

\*\*Providers *may* bill more than one unit of 90472 as appropriate (see examples below).

**Example of billing a single vaccine for an adult:**

Vaccines Provided	Administration Codes	CPT Vaccine Codes
Influenza, quadrivalent, split virus	90471CG	90686CG

Coding required on the claim for proper reimbursement:

90471CG	1 unit	There would be a billed amount.
90686CG	1 unit	There would be a billed amount.

**Example of billing multiple vaccines for an adult:**

Vaccines Provided	Administration Codes	CPT Vaccine Codes
Zoster	90471CG	90736CG
PCV13	90472CG	90670CG
Influenza, quadrivalent, split virus	90472CG	90686CG

Coding required on the claim for proper reimbursement:

90471CG	1 unit	There would be a billed amount.
90472CG	2 units	There would be a billed amount.
90736CG	1 unit	There would be a billed amount.
90670CG	1 unit	There would be a billed amount.

Pharmacists can verify beneficiary eligibility in NCTracks using the [provider portal](#), the [Automated Voice Response System \(AVRS\)](#), or a [270/271 X12](#) transaction. Verification of eligibility does not ensure payment since some Medicaid programs do not provide full Medicaid coverage and therefore, would not provide coverage for vaccinations [e.g. MAF-D (Family Planning), MQB (Medicare Dual Eligible); and if the 4<sup>th</sup> character of the recipient’s program classification code is F, H, O or R]. Medicaid for Pregnant Women (MPW) only provides limited coverage for conditions that affect the pregnancy; related vaccinations are covered prior to delivery.

Beneficiaries shall not be charged a copay associated with pharmacist administered vaccines. Pharmacies may submit claims to NCTracks as per their preferred frequency (daily, weekly, etc.) and call the CSRA pharmacy call center (1-800-246-8505) for any claims related issues or questions. Reimbursement should be expected as per the established weekly electronic cutoff and checkwrite schedules.

**CSRA, 1-800-688-6696**

**Attention: Dialysis Facilities and Professionals Billing For End Stage Renal Disease Services****D** **Diagnosis Code for End State Renal Disease**

Effective with claims processed on or after Nov. 6, 2016, all claims billed by Dialysis Facilities, taxonomy 261QE0700X, for End Stage Renal Disease (ESRD) patients, must have the ESRD diagnosis code 585.6 or N186 as the principal diagnosis on the claim.

In addition, physicians rendering end stage renal disease services, must have the ESRD diagnosis in pointer position 1 on their professional claim. If the ESRD diagnosis code is not on the above mentioned claims or not in the proper position, the claim will be denied.

**Practitioners and Facilities****DMA, 919-855-4320**

## Attention: Durable Medical Equipment and Pharmacy Providers

### Reprocessing of Claims Due to SMAC Rate Change

The State Maximum Allowable Cost (SMAC) rates for five National Drug Codes (NDCs) were changed in NCTracks on July 6, 2016. **Effective July 1, 2014**, the rate changes affect NDCs:

- 50924045001
- 50924098850
- 65702028810
- 65702046810
- 65702048810

Durable Medical Equipment (DME) and pharmacy claims for the affected NDCs that were originally processed and paid in NCTracks between July 1, 2014, and July 6, 2016, are being reprocessed to apply the rate changes.

The claims will be reprocessed and will appear in the Oct. 18, 2016, checkwrite. The reprocessed claims will be displayed in a separate section of the paper Remittance Advice (RA) with a unique Explanation of Benefits (EOB) code: EOB 10200 - CLAIMS REPROCESSING DUE TO RATE CORRECTION. The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

**Note:** Reprocessing does not guarantee payment for the claim. While some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to reprocessed claims. Therefore, the reprocessed claims could deny for other reasons.

The claim reprocessing may result in a recoupment. If there are insufficient funds in the current checkwrite to fully satisfy the recoupment, an Accounts Receivable (AR) will be created. Affected providers will receive a **First Demand Letter** when the AR is created. Recoupment of the AR will begin with the subsequent NCTracks checkwrite. If funds are insufficient to completely collect the amount due from the NPI for which the AR was generated, NCTracks will automatically seek to recoup the AR from other NPIs with the same Internal Revenue Service (IRS) Taxpayer Identification Number (TIN). For more information about the AR process, see the [February 29, 2016, announcement](#) in NCTracks.

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

## Attention: Durable Medical Equipment Providers

### **D**urable Medical Equipment Update – Modification to Clinical Coverage Policy 5A

#### **5.3.3 Pressure-Reducing Support Surfaces – Group 2**

Effective **Oct. 1, 2016**, Durable Medical Equipment (DME) providers requesting prior authorization for **Group 2 Pressure-reducing Support Surfaces** as described in section **5.3.3** of **Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies***, shall note the following change to the initial prior authorization period:

Group 2 Pressure-Reducing Support Surfaces, including a powered air flotation bed, powered pressure-reducing air mattress or pressure reducing overlay, are covered when they are medically necessary for the beneficiary:

Prior approval is required for all Group 2 support surfaces. Initial approval is given for a maximum of **six** months.

All other criteria for medical necessity and prior approval remain unchanged.

#### **5.3.5 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable, and Related Supplies**

Effective **Oct. 1, 2016**, DME providers requesting prior authorization for **Negative Pressure Wound Therapy Pump (NPWT) and wound care set** as described in section **5.3.5** of **Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies***, shall note the following change to the initial prior authorization period:

NPWT is the use of an electrical pump to convey sub-atmospheric pressure to a specialized wound dressing and thereby promote wound healing.

The NPWT pump and wound care set are covered when they are medically necessary for the beneficiary. These items require prior approval. Initial authorization is given for a maximum of **six** months.

All other criteria for medical necessity and prior approval remain unchanged.

#### **5.6.1 Delivery Directly to the Beneficiary**

Effective **Oct. 1, 2016**, DME providers delivering DME and supplies as described in section **5.6.1 Delivery Directly to the Beneficiary** of **Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies***, shall note the following added requirement for beneficiary education:

When an item is delivered directly to a beneficiary, the delivery slip must be signed by the beneficiary or a designee. The provider shall assemble the equipment and provide teaching and training on the safe use of the equipment. The provider shall ensure the equipment or supply is appropriate for the beneficiary's needs in the home, **and the beneficiary will be educated on the lifetime expectancy and the warranty of the item.**

All other criteria for medical necessity and prior approval remain unchanged.

### **Time limits for retro-active Medicaid DME prior authorization requests**

Effective **Oct. 1, 2016**, DME providers will have up to three months after a beneficiary becomes retro-actively eligible for Medicaid to submit prior authorization requests. The three month limit will be measured from the date the retro-active Medicaid eligibility was entered into NCTracks ("Last Date Updated").

**Example:** Recipient is approved for Medicaid on Oct. 15, 2016; eligibility is retro-active back to Sept. 1, 2016; eligibility was entered into NCTracks on Oct. 22, 2016. In this scenario, DME provider must submit PA requests by Jan. 22, 2017.

### **Additional Resources**

For more information, consult [Clinical Coverage Policy 5A](#), *Durable Medical Equipment and Supplies*:

- Section 5.3.3 Pressure-Reducing Support Surfaces – Group 2
- Section 5.3.5 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable, and Related Supplies
- Section 5.6.1 Delivery Directly to the Beneficiary

**DME Section, Clinical Policy and Programs**  
**DMA, 919-855-4310**



**Attention: Hospice Providers**

**CBSA Codes and Hospice Payment Reform**

**CBSA Codes**

Effective Oct. 1, 2016, the Core Based Statistical Area (CBSA) delineations will be revised as indicated in the table below.

<b>FY 2016 October CBSA Code</b>	<b>CBSA Name</b>	<b>FY 2017 October CBSA Code</b>
50103	Rural North Carolina	99934
50104	Rural North Carolina	99934
50105	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	34820
50106	Charlotte-Concord-Gastonia, NC-SC	16740
50107	Virginia Beach-Norfolk, Newport News, VA-NC	47260
50108	Winston-Salem, NC	49180
50109	Winston-Salem, NC	49180
50110	Virginia Beach-Norfolk, Newport News, VA-NC	47260
50111	Rural North Carolina	99934
50112	Charlotte-Concord-Gastonia, NC-SC	16740

These changes will be reflected on the Hospice fee schedule and posted on the N.C. Division of Medical Assistance (DMA) website prior to the effective date of the change.

**Hospice Payment Reform**

As previously communicated in a [January 2016 Medicaid Special Bulletin](#), *CBSA Codes and Hospice Payment Reform*, the Centers for Medicare and Medicaid Services (CMS) issued guidance on Hospice Payment Reform ([42 CFR 418](#)). CSRA is in the process of implementing NCTracks system changes to be in compliance with these federal requirements, with an anticipated completion of Spring 2017.

A systematic reprocessing of claims with dates of service Jan. 1, 2016, forward will occur following the implementation date in NCTracks. Additional information will be communicated in the Medicaid Bulletin when it becomes available. Those with questions can contact Michelle Counts in Provider Reimbursement at 919-814-0059.

**Provider Reimbursement  
919-814-0060**

## Attention: Nurse Practitioners, Physician Assistants and Physicians

### **R**eslizumab injection, for intravenous use (Cinqair®) HCPCS code J3590: Billing Guidelines

Effective with date of service April 25, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover reslizumab (Cinqair®), for beneficiaries 18 years of age or older, for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified biologics. Cinqair is currently commercially available as a 100 mg/10 mL (10 mg/mL) solution in single-use vials for injection.

Cinqair is indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype. Cinqair is **not** indicated for treatment of other eosinophilic conditions or relief of acute bronchospasm or status asthmaticus.

Cinqair is for intravenous infusion only. Do not administer as an intravenous push or bolus. The recommended dosage regimen is 3 mg/kg once every four weeks administered by intravenous infusion over 20-50 minutes. Discontinue the infusion immediately if the patient experiences a severe systemic reaction, including anaphylaxis.

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

- The ICD-10-CM diagnosis code required for billing Cinqair is: J82 - Pulmonary eosinophilia, not elsewhere classified.
- Providers must bill Cinqair with HCPCS code J3590 - Unclassified biologics.
- One Medicaid unit of coverage for Cinqair is one mL. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is \$90.18.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Cinqair is 59310-0610-31.
- The NDC units for Cinqair 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 DMA'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 DMA’s [PDP web page](#).

**CSRA 1-800-688-6696**

## Proposed Clinical Coverage Policies

According to NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the 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 as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

### Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
<b>October 2016</b>	10/06/16	10/12/16	10/13/16
	10/13/16	10/18/16	10/19/16
	10/20/16	10/25/16	10/26/16
	10/27/16	11/01/16	11/02/16
<b>November 2016</b>	11/03/16	11/08/16	11/09/16
	11/10/16	11/15/16	11/16/16
	11/17/16	11/22/16	11/23/16
	11/24/16	11/29/16	11/30/16

---

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

---

**Paul Guthery**  
 Executive Account Director  
 CSRA