

## NC Medicaid Bulletin July 2018

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**Attention: All Providers**

## **NCTracks Provider Training Available in July 2018**

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

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

### **Provider Web Portal Applications (WebEx)**

Monday July 9, 2018, 1 - 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal. This course will also detail what to expect once applications have been submitted.

At the end of this training, the provider will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal and complete the following Provider Enrollment Application processes:
  - Track and submit applications using the Status and Management page
  - Provider enrollment
  - Manage Change Request (MCR)
  - Re-enrollment
  - Re-verification
  - Maintain eligibility

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

Wednesday July 11, 2018, 1 - 2:30 p.m.

This course serves as a refresher for providers to complete the re-verification process through NCTracks. It also covers the steps to enter information 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
- Explain each phase of re-verification
- Complete the re-verification process in NCTracks
- Complete a Manage Change Request (MCR) to update invalid or missing provider data

**Submitting Institutional Prior Approvals (On-Site)**

Friday July 13, 2018, 9:30 a.m. - noon

This course will cover submitting prior approval requests with a focus on nursing facilities to help ensure compliance with Medicaid clinical coverage policy and medical necessity, including inquiring about those requests to determine their status.

After completing this course, authorized users will be able to:

- Submit prior approval requests
- Inquire about the status of prior approval requests

**Submitting Institutional Claims (On-Site)**

Friday July 13, 2018, 1 - 4 p.m.

This course will focus on how to submit an institutional claim with emphasis on long-term care and secondary claims.

At the end of training, providers who are 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

**Provider Web Portal Applications (WebEx)**

Tuesday July 17, 2018, 1 - 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal. This course will also detail what to expect once applications have been submitted.

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 the following Provider Enrollment Application processes:
  - Track and submit applications using the Status and Management page
  - Provider Enrollment
  - Manage Change Request (MCR)
  - Re-enrollment
  - Re-verification
  - Maintain eligibility

**Submitting Professional Claims (On-Site)**

Wednesday July 18, 2018, 1 – 4:30 p.m.

This course will focus on how to submit a Professional Claim. At the end of training, authorized users will be able to:

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

**Submitting A Professional Claim – NEMT Provider (WebEx)**

Monday July 23, 2018, 9 a.m. - noon

This course will review the process of submitting Non-Emergency Medical Transportation (NEMT) claims through NCTracks. At the end of training, users will be able to:

- Understand claims terminology
- Create a professional claim via NCTracks
- Save a draft
- Use Claims Draft Search
- Submit a claim
- View results of a claim submission
- View claim status and make a claim copy
- Resubmit a claim
- Void prior claim or replace prior claims
- Read a remittance advice
- Complete a prior authorization inquiry

**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****NC Medicaid Electronic Health Record (EHR) Incentive Program Announcement**

Centers for Medicare & Medicaid Services (CMS) is streamlining the Electronic Health Record (EHR) Incentive Program. The goal is to move the program beyond requirements for meaningful use (MU) to increase focus on interoperability and improving patient access to health information.

To reflect this change of focus, CMS renamed the Medicaid EHR Incentive Program to “Promoting Interoperability Program” at the federal level, effective **April 24, 2018**.

However, the NC Medicaid EHR Incentive Program’s name will not change. More information about the change can be found on the [CMS Promoting Interoperability Program web page](#).

**North Carolina Medicaid EHR Incentive Payment System (NC-MIPS) is Open for Program Year 2018**

[NC-MIPS](#) is accepting Program Year 2018 Modified Stage 2 and Stage 3 MU attestations.

In Program Year 2018, Eligible Professionals (EPs) may continue using a 90-day EHR (MU objective) reporting period. EPs may attest with a 90-day Clinical Quality Measure (CQM) reporting period if they **only** attested to adopt, implement or upgrade (AIU) thus far **and** will be attesting to MU for the first time in Program Year 2018.

They will see no changes to the attestation process in NC-MIPS.

However, EPs who have met MU in a previous program year will be required to use a full calendar year CQM reporting period in Program Year 2018. Since the CQM reporting period must be a full calendar year for these EPs, they will not be able to submit CQM data in NC-MIPS until Jan. 1, 2019. EPs who would like an early review of requirements, excluding CQMs, will be allowed to submit their attestation in two parts.

Part 1 of the attestation may be submitted between May 1, 2018 and Dec. 31, 2018. It includes demographic, license, patient volume and MU objective data. EPs will **not** be required to sign or email any documentation for Part 1. The signed attestation packet will be emailed only once – after submission of CQMs.

After Part 1 is submitted on NC-MIPS, program staff will conduct validations. The state will notify EPs of any discrepancies, giving EPs ample time to address any issues.

After Part 1 is validated, EPs may return Jan. 1, 2019 through April 30, 2019, to submit their CQM data on NC-MIPS. After submitting that information on NC-MIPS, providers

will email the signed attestation packet and CQM report from the EP's EHR to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) to complete Part 2 of the attestation.

**Note:** This process does not increase or reduce the information being submitted, but allows EPs to complete their attestation in a 12-month window instead of in four months.

Visit the [program website](#) for more information.

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

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## Attention: All Providers

# Submit Fingerprinting Criminal Background Check and Related Information by Deadline to Prevent Termination

**Note:** This article was originally published in the [June 2018 Medicaid Bulletin](#) with a clarification that only high-risk providers must obtain fingerprints.

Fingerprinting is only required for high-risk providers as identified by 42 CFR 424.518(c) and NC General Statute 108C-3g. Refer to the [Provider Permission Matrix](#), on the Provider Enrollment page of NCTracks for more details. High-risk providers will receive a notification through their NCTracks Message Center inbox.

High-risk providers must submit a Fingerprinting Criminal Background Check (FCBC) application **within 30 days of receiving the request notification** to avoid being terminated for cause. After submission of the FCBC application, providers will receive a letter with instructions to complete the fingerprinting process and the Electronic Fingerprint Submission Release of Information (EFSRI) form. If the EFSRI form is not uploaded to the NCTracks provider record **within 30 days**, the provider will be terminated for cause.

More information on the fingerprinting application process, including additional resources, frequently asked questions (FAQs) and locations for fingerprinting services, can be found in the [NCTracks Fingerprinting Application Required Job Aid](#).

**Provider Services, DMA**

**Attention: All Providers****Coverage for CPT Code 95012: Fractional Exhaled Nitric Oxide (FENO) Measurement**

**Effective July 1, 2018**, CPT Code 95012, Fractional Exhaled Nitric Oxide (FENO) measurement, is approved in the assessment of pediatric beneficiaries with suspicion of asthma and for asthma management. Exhaled nitric oxide measurement is considered medically necessary and is covered when used as an adjunct with spirometry.

FENO measurement is considered medical necessary to:

- Monitor anti-inflammatory response,
- Monitor compliance,
- Detect steroid resistance, and,
- Predict exacerbation of disease.

Medicaid beneficiaries between the ages of 5 and 18 and N.C. Health Choice beneficiaries between the age of 6 and 18 are eligible for this service.

North Carolina Medicaid will cover CPT code 95012 five times per 365 days per billing provider.

Prior approval is not required.

**Practitioners, Facilities and Policy Development, DMA**

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**Attention: All Providers****NC Medicaid and N.C. Health Choice Preferred Drug List Changes**

Effective Aug. 1, 2018, North Carolina Medicaid will make a change to the [N.C. Medicaid and N.C. Health Choice Preferred Drug List \(PDL\)](#) in the Antihyperkinesis/Attention Deficit Hyperactivity Disorder (ADHD) class.

Ritalin tablets will be moved to non-preferred status. Generic methylphenidate tablets will remain preferred. Concerta tablets will be moved back to non-preferred status. Concerta was moved to preferred status Jan. 15, 2018, related to shortages in the ADHD class. Aptensio XR will remain preferred.

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

**Attention: All Providers****G**uidance for Submitting Claims for Dually Eligible Beneficiaries

These guidelines assist with claim submissions for dually eligible beneficiaries. This information addresses situations known to affect a significant number of claims. It is not feasible to provide an all-inclusive list due to the variable nature of the programs.

1. Institutional claims submitted by hospital outpatient departments or outpatient clinics should include the National Drug Code (NDC) associated with the HCPCS code.
2. It is not necessary to alter (remove or change) the HCPCS code prior to submission to Medicaid if Medicaid does not require a HCPCS code. For example, revenue codes for emergency room (045X) and clinic (051X) do not require a HCPCS code for Medicaid claims processing. The revenue codes for laboratory services (030X, 031X) and pharmacy (025X, 063X) do require a HCPCS code for Medicaid claims processing. Refer to the appropriate clinical policy for additional program specific guidelines.
3. Modifiers submitted on Medicare Part B claims do not need to be removed before submitting the claim to Medicaid. For example, a Medicare primary claim containing modifier JW, JG, TB, GY or PO (a sample set of modifiers for example purposes only) can be processed in NCTracks without removal of the modifiers required by Medicare. They are identified as “Crossover” modifiers in NCTracks, which means they are accepted for crossover claims but there is no impact on Medicaid claims processing. In addition, modifiers that Medicare does not require should be included on the Medicare claim; Medicare will pass the modifiers to Medicaid for processing, such as with modifier UD (see May 2018 bulletin article).

While the above represents existing submission requirements, guidelines can change. Providers must stay up to date by regularly checking the North Carolina Medicaid and NCTracks websites for updates, reminders and notices.

**Provider Reimbursement, DMA**



## Attention: All Providers

# C Commercial Insurance Disallowance

Medicaid's Third-Party Liability (TPL) contractor, Health Management Systems, Inc. (HMS), will implement a Commercial Insurance (CI) Disallowance project to streamline North Carolina's coordination of benefits and direct billing processes. The expected date for implementation is Oct. 1, 2018. This will result in **higher recoveries** for the state and **higher pay rates** for providers. HMS assists Medicaid providers by identifying and validating other (non-Medicaid) health coverage so that providers can **maximize payment rates** by billing commercial rates rather than Medicaid rates.

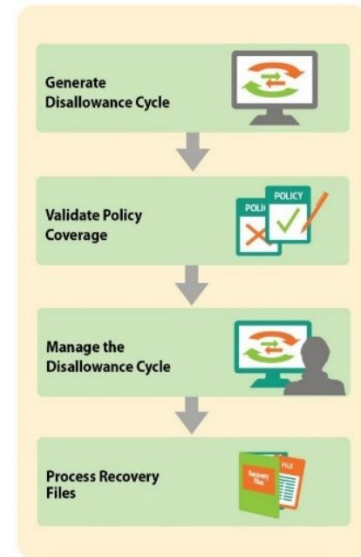
The CI Disallowance process will be like the Medicare Disallowance projects that have been operational in North Carolina for more than 10 years. HMS will validate policy coverage for all claims selected for CI disallowance to mitigate unnecessary work on the part of providers, loads the data into our Provider Portal and then initiate the CI disallowance billing cycle.

To prepare for this change, HMS will be offering webinars to outline the process in detail, as well as provide an opportunity for providers to ask questions. There will be separate webinars for Institutional Providers and Professional Providers. Register by clicking on the titles below:

- [CI Disallowance Overview \(Hospitals\)](#)  
Aug. 7, 2018 – 10 a.m.
- [CI Disallowance Overview \(Physicians\)](#)  
Aug. 9, 2018 – 10 a.m.

Providers with questions should contact HMS North Carolina Provider Relations at 1-877-260-0270.

### Third Party Liability, DMA



**Attention: All Providers****P**rior Approval Reminders

As a reminder, providers are to request and obtain proper PA **before** services are scheduled or rendered. Contractually, CSRA (Medicaid's fiscal vendor) has five business days (excluding holidays and weekends) to process a PA request once **all** required information is obtained. Medical necessity cannot be determined with a partial or incomplete clinical picture.

Failure to obtain PA, rendering services before PA is granted, or the inappropriate use of diagnosis codes or modifiers to bypass the PA requirement will result in claim denials or potential recoupments.

[North Carolina Administrative Code 22J .0106](#) prohibits the billing of Medicaid beneficiaries when a claim is denied due to a provider failing to follow program regulations or if a claim is denied due to lack of medical necessity.

Not all procedures and services require prior approval. Providers will find current PA requirements for each clinical coverage policy on the [Medicaid Clinical Coverage Policy web pages](#).

**Clinical Policy and Programs, DMA**

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**Attention: All Providers****C**linical Coverage Policy 1-H, *Telemedicine and Telepsychiatry*

System changes have been completed to allow non-psychiatric Nurse Practitioners (NPs) and Physician Assistants (PAs) to receive reimbursement for the following CPT codes.

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services

NPs and PAs enrolled in the Medicaid or North Carolina Health Choice (NCHC) programs may bill Medicaid or NCHC for these services.

**Practitioners, Facilities and Policy Development, DMA**

**Attention: All Providers****Coverage for Digital Breast Tomosynthesis Update**

Effective May 1, 2018, North Carolina Medicaid began offering coverage of digital breast tomosynthesis (3D tomosynthesis) for both screening and diagnostic mammography using code G0279 (Diagnostic digital breast tomosynthesis, unilateral or bilateral).

Providers informed Medicaid that the parenthetical information in the *2018 Healthcare Common Procedure Coding System (HCPCS) Manual* for this code was incorrect, stating that G0279 was to be billed with only diagnostic mammography services.

Effective May 1, 2018, in response to feedback received, Medicaid has added coverage for CPT code 77063 (Screening digital breast tomosynthesis, bilateral) to be billed with screening mammograms.

[Clinical coverage policy, 1K-1, Breast Imaging](#), has been updated to reflect the new coverage.

**Clinical Policy and Programs, DMA**

**Attention: All Providers****Adding coverage for CPT code 81528, Cologuard (Multi-target stool DNA-based colorectal screening)**

Effective July 1, 2018, Cologuard (CPT code 81528) has been approved for colorectal cancer screening (CRC). Developed by Exact Sciences, Cologuard is a non-invasive screening that is delivered to the home. The screening can detect colorectal neoplasms associated with DNA markers and the presence of occult blood. Cologuard for CRC is for males or females with average risk of CRC who are between the ages of 50 and 85. It is covered by Medicaid once every three years. Cologuard is not intended to replace diagnostic colonoscopy in high-risk beneficiaries.

Cologuard is not indicated for the following:

1. Beneficiary with a family or personal history of colorectal cancer
2. Previous positive test from another colorectal screening test within the last six months
3. Conditions associated with high risk:
  - a. Inflammatory Bowel Disease
  - b. Crohn's disease
  - c. Chronic Ulcerative Colitis
  - d. History of Polyps
  - e. Neurofibromatosis
  - f. Relevant familial (heredity) cancer syndrome such as Lynch syndrome

**Practitioners, Facilities and Policy Development, DMA**

**Attention: All providers****Laboratory Rate Updates – Effective July 1, 2018**

In accordance with the NC State Plan, Section 4.19-B, Section 3, Page 1, North Carolina Division of Medical Assistance (DMA) will revise rates for the following laboratory procedure codes: 81220, 81221, 81222, 81223, 81228, 81229, 81243, 81244, 81331, and 81507.

The revised rates as shown below will become effective on **July 1, 2018**.

<b>Procedure Code</b>	<b>Facility rate</b>	<b>Non-facility rate</b>
81220	\$ 506.51	\$ 506.51
81221	\$ 88.47	\$ 88.47
81222	\$ 395.91	\$ 395.91
81223	\$ 454.09	\$ 454.09
81228	\$ 819.00	\$ 819.00
81229	\$ 1,055.60	\$ 1,055.60
81243	\$ 51.91	\$ 51.91
81244	\$ 40.85	\$ 40.85
81331	\$ 46.47	\$ 46.47
81507	\$ 723.45	\$ 723.45

These changes will be reflected on the [Laboratory fee schedule](#) and posted on the North Carolina DMA website prior to the effective date of the change:

Providers with questions regarding the revised rates may contact DMA Provider Reimbursement.

**Provider Reimbursement, DMA**

**Attention: All providers****Reprocessing of Medicare Part B Crossover Claims  
Due to System Error**

North Carolina Medicaid will reprocess Medicare Part B Crossover Professional and Outpatient claims submitted to Medicare from Jan. 2, 2017, to Jan. 5, 2017.

Medicare experienced a claims processing issue with claims submitted Jan. 2, 2017 to Jan. 5, 2017, causing incorrect reimbursement. Medicare performed a mass adjustment to correct the reimbursement of the affected claims. However, when the Medicare adjusted claims crossed over to Medicaid, NCTracks denied them in error. The system error that caused the denial of these Medicare adjusted claims has been resolved.

Applicable claims will be voided in the **July 10, 2018, checkwrite**. Providers should submit new day claims within 30 days after the July 10, 2018, checkwrite date (New day claims must include the adjusted claim information received from Medicare).

Voided claims will be displayed in a separate section of the paper Remittance Advice (RA) with the unique Explanation of Benefits (EOB) 10244 -VOID CLAIM TO ALLOW PROVIDER TO RESUBMIT THE CLAIM DUE TO ERRONEOUS DENIAL OF MEDICARE CROSSOVER ADJUSTMENT. The 835 electronic transactions will include the voided claims along with other claims submitted for the checkwrite.

**Note:** There will be no separate 835.

**Provider Reimbursement, DMA**

**Attention: All Providers****Update - NPI Exemption List Extension to Aug. 31, 2018**

**Note:** This article was originally published as a [Special Bulletin in January 2018](#), with updates regarding clinical pharmacist practitioners.

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 through Aug. 31, 2018.**

**Clinical Pharmacist Practitioners (CPPs)**

Effective July 29, 2018, Clinical Pharmacist Practitioner (CPP) taxonomy code 1835P0018X will be added to allow in-state, border and out-of-state individual Medicaid/Health Choice providers to enroll in NCTracks. CPPs will be authorized to act as an ordering, prescribing, referring (OPR) or rendering provider working under the direction or supervision of a licensed physician. For the supervising physician (or the organization employing the supervising physician and the CPP) to bill for the services provided by the CPP, the CPP must complete the full enrollment application to be listed as the rendering provider on a claim. The services provided by the CPP can NOT be billed as incident to the physician. Therefore, CPPs must complete the individual application (full enrollment) instead of the OPR Lite abbreviated application.

Required licensure and certification for the CPP taxonomy are:

- Full and unrestricted license to practice as a pharmacist in North Carolina or the state in which the provider resides, and,
- Full and unrestricted certificate to practice as a CPP in North Carolina.

Out-of-state providers must be certified to practice as a CPP according to the rules of the state in which they practice.

The following enrollment requirements will apply:

- \$100 application fee
- Credentialing and criminal background checks
- Re-credentialing every five years, and,
- Manage Change Request (MCR) submission to update or end date the provider record

**Note: The NPI Exemption List deadline is Aug. 31, 2018. CPPs are encouraged to begin the enrollment process on July 30, 2018.**

[Per 21 N.C.A.C. 46.3101](#), a CPP is approved to provide drug therapy management, including controlled substances, under the direction or supervision of a licensed physician only.

If a claim is submitted with a CPP's NPI and taxonomy as the billing provider, the claim will be denied with Explanation of Benefits (EOB) 01877 - PROVIDER IS NOT AUTHORIZED TO ACT AS A BILLING PROVIDER.

### **Residents and Interns**

Residents and interns licensed through the NC Medical Board and NC Dental Board with a resident in training license (RTL) may enroll as 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 to whom they submitted an order, made a referral or prescribed medications or services. The supervising physician may bill for the services they personally provided during the patient encounter.

### **General Guidelines**

The following enrollment requirements 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
- Revalidation 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**



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

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

If a provider's enrollment application or Manage Change Request (MCR) 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 (NPPES) National Provider Identifier (NPI).
- **Office Administrator (OA)** – Make sure that the OA on record is current. Important notices are sent to the attention of the OA on the provider's record. For more information, see [OA Change Process on NCTracks](#).
- **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 and the practice's owners and agents in accordance with [42 CFR 455.100; 101; 104; 106](#) and [42 CFR 1002.3](#).

If the answer to any of 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, both of which are located in the **Enrollment and Re-Verification** section. These documents contain the list of sanction questions.

- **Managing Entity** - NCTracks is often receiving provider enrollment applications with as many as 25 or more managing entities, which suggests that it may not be clear who should be listed as a managing entity on an application.

The role of Managing Employee is defined in [42 CFR 420.201](#):

“Managing employee means a general manager, business manager, administrator, director or other individual that exercises operational or managerial control over or who directly or indirectly conducts, the day-to-day operation of the institution, organization or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.”

Providers are encouraged to only include those people who match the federal definition as a managing entity on their enrollment application.

Including people who do not match the definition of a Managing Employee on an application is not just inaccurate, but adds unnecessary time and effort to the provider enrollment application process. Remember that every person listed as a managing entity on a provider enrollment application must undergo a background investigation.

Providers can help expedite the review and approval of their enrollment applications by making sure that everyone listed as a managing entity matches the federal definition.

- **Fingerprinting Evidence Release Form Scanning Issue** - When some providers scan and upload the Fingerprinting Evidence Release Form, the embossed seal from the fingerprinting agency often does not scan clearly. Providers are advised to double-check that the seal clearly uploaded.
- **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](mailto:NCTracksProvider@nctracks.com).

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

## Attention: All Providers

### Provider Risk Level Adjustment

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

Federal regulation [42 CFR 455.450](#) requires a state Medicaid agency to screen all initial provider applications based on a categorical risk level of “limited,” “moderate,” or “high.” This includes applications for new practice locations and any applications received in response to a re-enrollment or re-validation of enrollment request.

Providers are categorized by risk level as outlined in [NC General Statute Sec. 108-C3](#).

**Note:** The NCTracks [Provider Permission Matrix](#) provides a full list of provider types and their assigned risk levels for both enrollment and revalidation.

Further, 42 CFR 455.450(e) mandates that state Medicaid agencies adjust the categorical risk level of providers. Per [NC General Statute Sec. 108-C3\(g\)](#) - The N.C. Department of Health and Human Services (the “Department”) must adjust the categorical risk level to “high” for providers who:

- Received a payment suspension based upon a credible allegation of fraud in accordance with [42 CFR 455.23](#) within the previous 12-month period. The Department shall return the provider to its original risk category no later than 12 months after the cessation of the payment suspension.
- Were excluded or whose owners, operators or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General, the Medicare program or another state's Medicaid or Children's Health Insurance Program within the previous 10 years.
- Incurred a Medicaid or Health Choice final overpayment, assessment or fine from the Department of more than 20 percent of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment or fine. [[NC General Statute 108-C3\(g\) \(11\)](#)]
- Were convicted of a disqualifying offense pursuant to G.S. 108C-4, including by owners, operators or managing employees, but were granted an exemption by the Department within the previous 10 years.

In these instances, the provider will be notified by the Department and the new risk level will apply to processing enrollment-related transactions. This may include payment of applicable application fees, submission of fingerprints and onsite visits.

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

### **Provider Services, DMA**

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### **Attention: All Providers**

## **Clinical Coverage Policies**

The following new or amended combined North Carolina and NC Health Choice clinical coverage policies are available on Medicaid's [Clinical Coverage Policy web pages](#).

- 1G-1, *Burn Treatment*, July 1, 2018
- 1K-6, *Radiation Oncology*, July 1, 2018
- 1-O-3, *Keloid Excision and Scar Revision*, July 1, 2018

These policies supersede previously published policies and procedures.

### **Clinical Policy and Programs, DMA**

**Attention: All Providers****Re-credentialing and Ongoing Verification Updates**

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

**List of Providers Due for Re-credentialing**

A list of providers scheduled for re-credentialing in 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 which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this list, 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**

1. Beginning April 29, 2018, the re-credentialing notification and suspension was modified to the following:
  - First notification is now sent 70 days prior to the provider re-credentialing due date.
  - If re-credentialing is not submitted, reminders will be sent at 50 days, 20 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 following 50 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 previous rules to extend the re-credentialing due date if a Manage Change Request (MCR) Application is “In Review” has been removed. Therefore, if a change is required via an MCR, the MCR process must be completed before the re-credentialing due date.
5. The Re-credentialing Application on the NCTracks Provider Portal was 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.

### **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 for updating expiring licenses, certification and accreditations 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 and 14 and the final reminder seven days 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 taxonomy code(s) in which the expired item is required 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](mailto:NCTracksprovider@nctracks.com) (email).

### **Provider Services, DMA**

**Attention: Nurse Practitioners and Physician Assistants****B**illing Code Update for Nurse Practitioners and Physician Assistants

New codes and taxonomies have been added to the procedure code list for nurse practitioners (NPs) and physician assistants (PAs). The codes are:

36011	36011 (B)	51610	51610 (B)
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**\*Codes marked with a (B) were updated for modifier 59.**

The Medicaid website has a complete list of [previously denied billing codes for NPs, 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 North Carolina Medicaid Clinical Policy becomes aware of them.

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



## Attention: Nurse Practitioners, Physician Assistants and Physicians

### **F**ibrinogen Concentrate (Human) Lyophilized Powder for Reconstitution (Fibryga) HCPCS Code J3590: Billing Guidelines

Effective with date of service April 1, 2018, the North Carolina Medicaid and N.C. Health Choice (NCHC) programs cover fibrinogen concentrate (human) lyophilized powder for reconstitution (Fibryga) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 - Unclassified biologics. Fibryga is available as a lyophilized powder in single-use bottles containing approximately 1 g fibrinogen concentrate per bottle.

Fibryga is indicated for the treatment of acute bleeding episodes in adults and adolescents with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. Fibryga is not indicated for dysfibrinogenemia. See full prescribing information for dosing information and further detail.

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

- The ICD-10-CM diagnosis code required for billing is D68.2 - Hereditary deficiency of other clotting factors.
- Providers must bill with HCPCS code J3590 - Unclassified biologics.
- One Medicaid unit of coverage is 1 mg.
- The maximum reimbursement rate per unit is \$1.19.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 68982-0347-01 and 68982-0348-01.
- 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

### **M**ometasone Furoate Sinus Implant (Sinuva) HCPCS Code J3490: Billing Guidelines

Effective with date of service March 8, 2018, the North Carolina Medicaid and N.C. Health Choice (NCHC) programs cover mometasone furoate sinus implant (Sinuva) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. One Sinuva Sinus Implant system contains 1350 mcg of mometasone furoate and a sterile delivery system.

Sinuva is indicated for the treatment of nasal polyps in patients 18 years of age and older who have had ethmoid sinus surgery. One Sinuva Sinus Implant contains 1350 mcg of mometasone furoate, which is loaded into a delivery system and placed in the ethmoid sinus under endoscopic visualization and left in the sinus to gradually release the corticosteroid over 90 days. It may be removed at day 90 or earlier at the physician's discretion. Repeat administration has not been studied.

See full prescribing information for further detail.

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

- The ICD-10-CM diagnosis codes required for billing are J33.0 - Polyp of nasal cavity; J33.1 - Polypoid sinus degeneration; J33.8 - Other polyp of sinus and J33.9 - Nasal polyp, unspecified.
- Providers must bill with HCPCS code J3490 - Unclassified drugs.
- One Medicaid and NCHC unit of coverage is 1 implant.
- The maximum reimbursement rate per unit is \$1,377.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is 10599-0003-01.
- 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

### **N**usinersen injection, for intrathecal use (Spinraza) HCPCS code J2326 - Unclassified Drugs: Billing Guidelines and Change in Coverage

**Effective July 1, 2018**, the North Carolina Medicaid and N.C. Health Choice (NCHC) programs will cover nusinersen injection, for intrathecal use (Spinraza) for use **only** in the Physician's Drug Program (PDP). The HCPCS code is J2326 – Injection, nusinersen.

**Effective June 30, 2018**, Spinraza coverage through outpatient specialty pharmacy and via the prior authorization method will terminate and outpatient pharmacy claims submitted for Spinraza initial treatment or continuation of treatment will be denied. Providers will need to submit claims for Spinraza as per the requirements on Centers for Medicare and Medicaid Services (CMS) 1500/837P form for professional claims.

Spinraza is indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients. It is available as 12 mg/5 mL (2.4 mg/mL) in a single-dose vial for intrathecal administration.

The recommended dosage is 12 mg (5 mL) per administration. Initiate Spinraza treatment with four loading doses; the first three loading doses should be administered at 14-day intervals; the fourth loading dose should be administered 30 days after the third dose; a maintenance dose should be administered once every four months thereafter. See full prescribing information for further detail.

**Note:** All the information mentioned in this article will need to be carefully followed to minimize the possibility of a claim denial. As with all PDP drug products, the cost of drug acquisition is the responsibility of the provider until the claim is processed.

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

- The ICD-10-CM diagnosis code required for billing are G12.0 Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]; G12.1 Other inherited spinal muscular atrophy; G12.8 Other spinal muscular atrophies and related syndromes and G12.9 Spinal muscular atrophy, unspecified.
- Providers must bill with HCPCS code J2326 - Injection, nusinersen.
- One Medicaid unit of coverage is 12 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$135,000.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 64406-0058-01.
- The NDC units should be reported as “UN1.”
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).

- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on the Medicaid 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 340B drugs shall bill the cost that is reflective of their acquisition cost.
- Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on Medicaid’s [PDP web page](#).

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

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Fosnetupitant and palonosetron for injection, for intravenous use (Akynzeo) HCPCS code J3490: Billing Guidelines**

Effective with date of service May 1, 2018, the North Carolina Medicaid and N.C. Health Choice (NCHC) programs covers fosnetupitant and palonosetron for injection, for intravenous use (Akynzeo) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs.

Akynzeo is available as 235 mg fosnetupitant/0.25 mg palonosetron lyophilized powder in a single-dose vial for reconstitution. U.S. Food and Drug Administration (FDA) approved indication(s) include use in combination with dexamethasone in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy.

Akynzeo for injection has not been studied for the prevention of nausea and vomiting associated with anthracycline plus cyclophosphamide chemotherapy.

The recommended dose is one vial of Akynzeo (235 mg fosnetupitant/0.25 mg palonosetron) infused intravenously over 30 minutes starting 30 minutes before chemotherapy. See full prescribing information for further detail.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis codes required for billing are:
  - T45.1X5A - Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter
  - T45.1X5D - Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter
  - T45.1X5S - Adverse effect of antineoplastic and immunosuppressive drugs, sequela
  - Z51.11 - Encounter for antineoplastic chemotherapy required in addition to cancer diagnosis

Accompanied by one or more of the following:

- R11.0 - Nausea; R11.10 - Vomiting, unspecified
- R11.11 - Vomiting without nausea
- R11.12 - Projectile vomiting
- R11.13 - Vomiting of fecal matter
- R11.14 - Bilious vomiting
- R11.2 - Nausea with vomiting, unspecified
- Providers must bill with HCPCS code J3490 - Unclassified drugs.

- One Medicaid unit of coverage is 1 vial. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$550.80.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 69639-0102-01.
- 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 North Carolina 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**

### 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 July 1, 2018, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
1A-5, Child Medical Evaluation and Medical Team Conference for Child Maltreatment (Formerly known as Physician Participation in Case Conference for Sexually Abused Children)	06/21/18	08/05/18
Preferred Drug List (PDL)	06/05/18	07/20/18

### Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
<b>July 2018</b>	06/28/18	07/03/18	07/05/18
	07/05/18	07/10/18	07/11/18
	07/12/18	07/17/18	07/18/18
	07/19/18	07/24/18	07/25/18
	07/26/18	07/31/18	08/01/18
<b>August 2018</b>	08/03/18	08/07/18	08/08/18
	08/10/18	08/14/18	08/15/18
	08/17/18	08/21/18	08/22/18
	08/24/18	08/28/18	08/29/18
	08/31/18	09/05/18	09/06/18

\*Batch cutoff date is previous day



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

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**Paul Guthery**  
**Executive Account Director**  
**CSRA**