



NC Medicaid Bulletin

September 2018

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Attention: All Providers**D**ivision of Medical Assistance (DMA) is Now the Division of Health Benefits (DHB)

Effective Aug. 1, 2018, the Division of Medical Assistance (DMA) and Division of Health Benefits (DHB) combined into one division called the NCDHHS Division of Health Benefits. Although the division has a new name, the programs—North Carolina Medicaid and NC Health Choice—remain the same, and are collectively referred to as “NC Medicaid” or simply “Medicaid.”

NCTracks and the Medicaid website will be updating content, templates and other information over the next few months. Until then, please use both terms when using the search function in NCTracks or on the Medicaid website.

NC Medicaid Communications, 919-855-4840

Attention: All Providers**C**SR A is Now GDIT

On April 2, 2018, [General Dynamics Information Technology acquired CSRA Inc.](#) CSRA is now “CSRA State and Local Solutions LLC, A General Dynamics Information Technology Company,” or simply “GDIT.”

The role of GDIT as fiscal agent for the NCDHHS and, specifically, the NCTracks claims payment system, remains the same. Changes to website logos and other content are coming soon, but please note that all NCTracks contacts and phone numbers remain the same.

The commitment of GDIT to delivering excellence in every aspect of service remains our top priority.

GDIT Call Center, 1-800-688-6696

Attention: All Providers**Influenza Vaccine and Reimbursement Guidelines for 2018-2019 for Medicaid and NC Health Choice**

Composition of the quadrivalent influenza vaccines for the 2018-2019 influenza season is:

- A/Michigan/45/2015 (H1N1) pdm09-like virus;
- A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus;
- B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage); and
- B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

It is recommended that the influenza B virus component of trivalent vaccines for use in the 2018-2019 northern hemisphere influenza season be a B/Colorado/06/2017-like virus of the B/Victoria/2/87-lineage.

For further details on the 2018-2019 influenza vaccine, visit the [Centers for Disease Control \(CDC\) Flu Season](#).

*FluMist Quadrivalent (LAIV4) may be an option for influenza vaccination of persons for whom it is appropriate for the 2018–2019 season.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

Under North Carolina Immunization Program/Vaccines for Children (NCIP/VFC) guidelines, the NC 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 2018-2019 influenza season, NCIP/VFC influenza vaccine—all quadrivalent—is 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 the [DPH Immunization Branch web page](#).

For providers interested in enrolling in the VFC program, information is on the [CDC information page](#) and the [DPH website](#).

Eligible VFC children include Medicaid beneficiaries and NC Health Choice beneficiaries who are American Indian and Alaska 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 NC Health Choice Identification Cards, or
2. Beneficiaries/parents may self-declare their VFC eligibility status according to NCIP/VFC program policy.

When NC Health Choice beneficiaries self-declare their status as AI/AN, and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with \$0.00 and may bill NC Health Choice 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 NC Health Choice beneficiaries are considered **insured (not VFC eligible)** and must be administered privately purchased vaccines.

For VFC/NCIP vaccines administered to VFC-eligible children, providers must report only the vaccine code(s) with \$0.00. Providers may bill NC Medicaid for the administration fee for Medicaid and eligible AI/AN NC Health Choice 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 must purchase vaccines for children who are **not** VFC-eligible (including all NC Health Choice children who are not AI/AN) and adult patients. For Medicaid-eligible beneficiaries age 19 years and older, purchased vaccine and administration costs may be billed to Medicaid, according to the guidelines stated in Tables 2 and 3 below. To determine who is eligible for NCIP influenza and other vaccines, visit the [DPH Immunization Branch web page](#).

Billing/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 **NC Health Check beneficiaries** can be found in the [Health Check Program 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

Vaccine CPT Code to Report	CPT Code Description
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use

Administrative CPT Codes to Bill

Administration CPT Code(s) to Bill	CPT Code Description
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
+90472EP (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); each additional vaccine (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.
90473EP	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). Do not report 90473 in conjunction with 90471.

*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
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

Administrative CPT Codes to Report

Administrative CPT Code(s) to Report	CPT Code Description
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
+90472EP (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single and combination vaccine/toxoid). (List separately in addition to code for primary procedure.)
90473EP	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). Do not report 90473 in conjunction with 90471.

*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
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

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); one vaccine (single or combination vaccine/toxoid)
+90472 (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); each additional vaccine (single and combination vaccine/toxoid). (List separately in addition to code for primary procedure.)
90473EP	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). Do not report 90473 in conjunction with 90471.

*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/Reporting Influenza Vaccines for NC Health Choice 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 NC Health Choice 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 NC Health Choice Beneficiaries 6 Years through 18 Years of Age Who Receive VFC Vaccine (MIC-A and MIC-S Eligibility Categories or Beneficiaries in Other Categories Who Self-Declare AI/AN Status) or Purchased Vaccine (All Other NC Health Choice Eligibility Categories)

Vaccine CPT Code to Report

Vaccine CPT Code to Report	CPT Code Description
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

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); one vaccine (single or combination vaccine/toxoid)
+90472TJ (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); each additional vaccine (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.
90473TJ	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). Do not report 90473 in conjunction with 90471.

* 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 should **not** be billed on NC Health Choice claims. The TJ modifier should be used.
- There is no copay for office visits and wellness checks.

Immunization Billing for Medicaid and NC Health Choice Beneficiaries from FQHCs and RHCs

For beneficiaries 0 through 20 years of age

- **If vaccines are provided through the NCIP/VFC**, the center/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 shall be reported (with \$0.00 billed) under Physician Services NPI and an administration code shall not be billed.
- **If purchased vaccines (non-VFC eligible)** were administered, the center/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 shall be reported (with \$0.00 billed) under the Physician Services NPI provider number and the administration codes shall not be billed. For detailed billing guidance, refer to the [Health Check Program Guide](#).
- **Note:** When billing for NC Health Choice beneficiaries, refer to the detailed billing guidance above including Table 4 and the Core Visit policy in the [Medicaid 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 shall 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 [Medicaid's Fee Schedule web page](#) and [Physician Services Fee Schedule web page](#).

Immunization Billing for Medicaid Beneficiaries from Immunizing Pharmacies

For beneficiaries 19 years of age and older

- Effective January 1, 2016, NC Medicaid will reimburse pharmacies for covered vaccines, including influenza vaccines, as permitted by G.S. 90-85.15B (see below) when administered to NC Medicaid beneficiaries 19 years of age and older by an immunizing pharmacist.

Table 5

***Billing Codes to be used by Pharmacist for Medicaid Beneficiaries
19 Years of Age or Older***

Vaccine CPT Code to Report	CPT Code Description
90672CG	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90685CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90686CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.25 mL dosage, for intramuscular use
90688CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use
90756CG	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular 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.

***Billing Codes to be used by Pharmacists for NC Medicaid Beneficiaries
19 Years of Age and Older***

CPT Code(s)	CPT Code Description
90471CG	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472CG (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine. (Separately list the add-on code(s) for each additional single vaccine and/or combination vaccine/toxoid administered, in addition to the primary procedure)
90473CG	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). Do not report 90473 in conjunction with 90471.

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.

*Providers *may* bill more than one unit of 90472 as appropriate.

Detailed information about the regulations regarding pharmacist immunization can be found at [Pharmacist Administrated Vaccine and Reimbursement Guidelines](#) published on the October 2016 Medicaid Bulletin.

NDCs Change Each Year for Influenza Vaccines

Providers are required to use appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code. Note that not all products and NDCs under their respective CPT codes will be covered.

Influenza vaccines are licensed each year with new NDCs, so it is important to report the correct code for the products you are using to avoid having claims deny with edit 00996 (Mismatched NDC) which will require the claim to be resubmitted with the correct NDC. Below are the influenza vaccine procedure (CPT) codes and corresponding NDCs that should be used for the 2018-2019 influenza season:

CPT and NDC codes for the 2018-2019 Influenza Vaccine Products

CPT Codes	NDC codes
90672	FluMist Quadrivalent: 66019-0305-01, 66019-0305-10
90685	Fluzone Quadrivalent: 49281-0518-00, 49281-0518-25
90686	Fluarix Quadrivalent: 58160-0898-41, 58160-0898-52 FluLaval Quadrivalent: 19515-0909-41, 19515-0909-52 Fluzone Quadrivalent: 49281-0418-50, 49281-0418-88, 49281-0418-10 49281-0418-58
90687	Fluzone Quadrivalent: 49281-0629-15, 49281-0629-78
90688	Fluzone Quadrivalent: 49281-0629-15, 49281-0629-78
90756	Flucelvax Quadrivalent: 70461-0418-10, 70461-0418-11

GDIT Call Center, 1-800-688-6696

Attention: All Providers
Procedures for Prior Authorization of Synagis® (palivizumab) for Respiratory Syncytial Virus Season 2018/2019

The clinical criteria used by NC Medicaid for the 2018/2019 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the *American Academy of Pediatrics (AAP): 2018 – 2021 Report of the Committee on Infectious Diseases, 31th 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, 2018, through March 31, 2019. Providers are encouraged to review the AAP guidance prior to the start of the RSV season.

Guidelines for Evidenced-based Synagis Prophylaxis

Infants younger than 12 months at start of season with a diagnosis of:

- Prematurity - born before 29 weeks 0 days gestation

Infants in their first year of life with a diagnosis of:

- Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32 weeks 0 days gestation and requiring greater than 21 percent oxygen for at least 28 days after birth),
- Hemodynamically significant acyanotic heart disease, receiving medication to control congestive heart failure, and will require cardiac surgical procedures
- Moderate to severe pulmonary hypertension,

- Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airway because of ineffective cough.

Note: Infants in the first year of life with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.

Infants less than 24 months of age with a diagnosis of:

- 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 the six-month period before start of second RSV season
- Cardiac transplantation during RSV season

Prior Approval Request

During the Synagis coverage period, submit all prior approval (PA) requests electronically to www.documentforsafety.org. 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 CHD, 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 immunocompromise, 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. 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 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 NC Medicaid. 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 must 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. **Use of a point of sale PA override code is not allowed.**

Synagis claims processing will begin on Oct. 29, 2018, to allow sufficient time for pharmacies to provide Synagis by Nov. 1, 2018. Payment of a Synagis claim with a date of service before Oct. 29, 2018, and after March 31, 2019, 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 NC 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 separate individual claims will be subject to recoupment. Physicians and pharmacy providers are subject to audits of beneficiary records by NC Medicaid. Maintain Synagis dose authorizations in accordance with required recordkeeping 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.

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. **Fax the form to 919-715-1255.** The form is available on the [NCTracks Prior Approval web page](#). Information about EPSDT coverage is found on [Medicaid's Health Check and EPSDT web page](#).

Technical Support

Technical support is available Monday to Friday from 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.

NC Medicaid Outpatient Pharmacy Services, 919-855-4306

Attention: All Providers**Balloon Ostial Dilation (BOD) Services Billed with Modifier 50 (Bilateral)**

It has come to NC Medicaid's attention that claims for balloon sinus ostial dilation billed with modifier 50 (bilateral), were resulting in an under payment to providers. The issue has been resolved. Providers with claims for the following procedures billed with modifier 50 on or after July 29, 2018, should resubmit their claims for reprocessing. The procedures are:

- **31295** (nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium),
- **31296** (nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium) and,
- **31297** (nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium).

GDIT Call Center, 1-800-688-6696

Attention: All Providers**Clinical Policy 1E-3, Sterilization Procedures**

Sterilization claims must be submitted with ICD-10-CM diagnosis Z30.2 (encounter for sterilization) as the primary or secondary diagnosis code on the claim.

Effective Oct. 1, 2018, claims submitted without diagnosis Z30.2 as the primary or secondary diagnosis on the claim, will be denied with EOB 01879 (sterilization claims must be submitted with diagnosis Z30.2 (encounter for sterilization) as the primary or secondary diagnosis code. Correct and resubmit claim.).

Providers are encouraged to review Clinical Policy 1E-3 Sterilization Procedures for guidance on billing and completing the sterilization consent form.

GDIT Call Center, 1-800-688-6696

Attention: All Providers**S**terilization Consent Form Status and Denial Reasons
Accessible to Facility Providers

Facility providers can access Sterilization Consent Form status including denial reasons, on the secure NCTracks Provider Portal, if the sterilization consent form has been properly completed.

Once the beneficiary has had the sterilization procedure and before submitting the completed sterilization consent form to the NCDHHS fiscal contractor, the following is required:

- Surgeon's NPI **must be added to the top left** of the consent form.
- Beneficiary's identification number **must be added to the top right** of the Sterilization Consent Form.
- The NPI of the facility in which the sterilization procedure was performed **may be added to the top center** of the consent. The facility NPI field must be populated upon initial submission of the consent form to DHHS fiscal contractor, to ensure that the facility in which the procedure was performed can make inquiries concerning the sterilization consent form status. The service facility NPI cannot be added after the sterilization consent form is in an approved or permanently denied status. The service facility may inquire on the status of the sterilization consent and shall have access to any documents, including the denial letter, associated with the record.

The following providers may receive consent form status from the NCTracks call center: rendering provider, service facility provider, rendering provider's office administrator or service facility's office administrator. **The caller's NPI must match one of the NPI's submitted on the sterilization consent form.**

The NCTracks call center shall provide the following status of the consent form review:

- If the consent has been approved
- If the consent has been denied
- The reason for the denial

Mail completed sterilization consents to:

GDIT
P.O. Box 30968
Raleigh, NC 27622

For more information, providers should refer to the Clinical Coverage Policy 1E-3, *Sterilization Procedures*.

GDIT Call Center, 1-800-688-6696

Attention: All Providers

Clinical Policy 1E-7, Family Planning Services

The following CPT codes should not be billed with a separate office visit. An office visit component is included in reimbursement for these CPT codes.

- 11981 – insertion, non-biodegradable drug delivery implant
- 11982 – removal, non-biodegradable drug delivery implant
- 11983 – removal with reinsertion, non-biodegradable drug delivery implant
- 57170 – diaphragm or cervical cap fitting with instructions
- 58300 – insertion of intrauterine device (IUD)
- 58301 – removal of intrauterine device (IUD)

If during an annual exam, the beneficiary requests an IUD insertion or an IUD removal **or** during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and the IUD insertion or IUD removal. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a **separately identifiable service provided by the same provider on the same day of service**. The providers documentation must support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

If the only reason that the beneficiary is seen in the office is to request an IUD insertion, an IUD removal, insertion of a non-biodegradable drug delivery implant, removal of a non-biodegradable drug delivery implant, removal with reinsertion of a non-biodegradable drug delivery implant, or diaphragm or cervical cap fitting with instructions providers shall not bill a separate office visit. An office visit component is contained in the reimbursement for CPT procedure codes 58300, 58301, 57170, 11981, 11982 and 11983. However, if during the same visit, services are rendered for a **separately identifiable service provided by the same provider on the same day of service**, the provider may bill for the office visit and the IUD insertion or IUD removal. The providers documentation must support that the service rendered was a separately identifiable service.

GDIT Call Center, 1-800-688-6696

Attention: All Providers**Clinical Policy 1E-7, Family Planning Services**

Family Planning Medicaid provides limited coverage to beneficiaries with MAFDN eligibility. MAFDN eligible beneficiaries are only eligible for family planning and family planning-related services. Beneficiaries with MAFDN eligibility are eligible for outpatient services for **sterilization procedures only**.

Outpatient sterilization claims must be submitted with the appropriate family planning modifier (FP). Claims submitted for MAFDN beneficiaries without the appropriate modifier will be denied with the following EOB:

- EOB 01659 (Edit 02608) - CLAIM DENIED. PROCEDURE CODE MUST BILL WITH FP MODIFIER.

Outpatient sterilization claims must be submitted with a family planning procedure code. When billing covered revenue codes for MAFDN beneficiaries, a procedure code will be required on the line item. If no procedure code is found on the line item or the procedure code not covered under the Family Planning Services, the line item will be denied with the following EOB:

- EOB 02609 (Edit 02609) - CLAIM DENIED. FAMILY PLANNING PROCEDURE CODE MUST BE PRESENT ON FAMILY PLANNING CLAIM OR PROCEDURE CODE NOT COVERED BY MAFDN.

Providers can refer to Clinical Policy 1E-7 Family Planning Services for a list of covered procedure codes.

GDIT Call Center, 1-800-688-6696

Attention: All Providers**Coverage for Psychiatric Collaborative Care Management**

In response to provider requests and to allow reimbursement for behavioral health integration in primary care settings, North Carolina Medicaid is adding coverage for the following evaluation and management codes effective October 1, 2018:

- **99492** – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- **99493** – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities

- **99494** – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting. These services are rendered when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning, and provision of brief interventions. These beneficiaries may require assistance engaging in treatment or further assessment prior to being referred to a psychiatric care setting.

Definitions

The American Medical Association (AMA) has defined the following services and providers of psychiatric collaborative care management, summarized below:

Episode of Care: An episode of care begins with the referral from the treating physician or NPP to the behavioral health care manager in their practice and ends with the attainment of treatment goals, failure to attain treatment goals culminating in a referral to a psychiatric care provider, or a lack of continued engagement with no psychiatric collaborative care management services provided over six consecutive months. A new episode may begin after a break in episode of six or more consecutive months.

Health Care Professional: Refers to the treating physician or NPP who manages the beneficiary's care and directs the behavioral health care manager.

Behavioral Health Care Manager: Masters or doctoral-level prepared clinical staff member who provides care management services and assessment of beneficiary needs. The Behavioral Health Care Manager consults with the psychiatric consultant and administers validated rating scales, develops care plans, provides brief interventions, collaborates with other members of the treatment team, and maintains a beneficiary registry. Services are provided face-to-face and non-face-to-face and psychiatric consultation is provided minimally on a weekly basis.

Psychiatric Consultant: Refers to a medical professional who is trained in psychiatry or behavioral health with full prescribing authority. The consultant advises and makes recommendations and referrals as needed for psychiatric and medical care. These recommendations and referrals are communicated to the treating provider through the behavioral health care manager. The psychiatric consultant typically does not see the beneficiary or prescribe medications but must be enrolled in NC Medicaid in order to write prescriptions for Medicaid beneficiaries.

Required Elements for Billing Psychiatric Collaborative Care Management

Psychiatric collaborative care management is billed once monthly and includes the services of the treating physician or NPP, behavioral health care manager, and the psychiatric consultant.

Initial psychiatric collaborative care management (**99492**): First 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or NPP, must contain the following elements:

- Outreach to, and engagement in treatment of a beneficiary directed by a treating physician or NPP;
- Initial assessment of the beneficiary, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering beneficiary in a registry and tracking beneficiary follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

Subsequent psychiatric collaborative care management (**99493**): First 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or NPP, must contain the following elements:

- Tracking beneficiary follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the beneficiary's mental health care with the treating physician or NPP and any other mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of beneficiary outcomes using validated rating scales; **and**

- Relapse prevention planning with beneficiaries as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

Initial or subsequent psychiatric collaborative care management (**99494**): May be billed for each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or NPP. 99494 must be billed with 99492 or 99493.

Additional Billing Guidelines

- Evaluation and management (E/M) and other services may be reported separately by the same physician or NPP during the same calendar month.
- If the treating physician or NPP personally performs behavioral health care manager activities and those activities are not used to meet criteria for a separately reported service, his or her time may be counted toward the required behavioral health care manager time to meet the elements of 99492, 99493, or 99494.
- The behavioral health care manager may report separate services such as therapy, psychiatric evaluation, tobacco cessation, or substance use services during the same calendar month. Activities for separately reported services are not included in the time applied to psychiatric collaborative care management.
- Behavioral health care manager time spent coordinating care with the emergency department may be reported using 99492, 99493, or 99494, but time while the beneficiary is inpatient or admitted to observation status may not be reported using psychiatric collaborative care management codes.
- The psychiatric consultant may provide services such as E/M services and psychiatric evaluations and these services may be separately reported. Activities for services separately reported are not included in the reporting of psychiatric collaborative care management.
- Behavioral health care managers and psychiatric consultants who prescribe medication or make direct referrals for Medicaid beneficiaries must be actively enrolled in NC Medicaid. If they bill for separately reimbursable services, they must be enrolled with a behavioral health Local Management Entity /Managed Care Organization for billing.

Refer to the 2018 Current Procedural Terminology (CPT) manual, published by The American Medical Association (AMA) for more information regarding psychiatric collaborative care management codes and requirements.

GDIT Call Center, 1-800-688-6696

Attention: All Providers**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 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.

TIP: If the provider was paid for Program Year 2017 using a 90-day patient volume reporting period from May 1, 2017 through Dec. 31, 2017, s/he may use the same patient volume reporting period to attest now for Program Year 2018.

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

NC Medicaid EHR Incentive Program, NCMedicaid.HIT@dhhs.nc.gov

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

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

WebEx courses can be attended remotely from any location with a telephone, computer and internet connection. Onsite courses include hands-on training and are limited to 45 participants. They are offered in-person at the GDIT facility at 2610 Wycliff Road in Raleigh.

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

Ortho Helpful Hints (WebEx)

Thursday, Sep. 6, 2018, 1:00–3:00 p.m.

This course discusses some helpful tips to remember when submitting an Orthodontic Prior Approval.

Note: This course will not provide instructions on how to submit an Orthodontic Prior Approval.

The objectives that will be covered are:

- Identify the three (3) methods of Prior Approval submission
- Identify how to upload documents when submitting Prior Approvals via NCTracks or to existing Prior Approvals
- Identify the most common errors when completing the American Dental Association form
- Identify common errors that require requests for Prior Approval additional information
- Requesting payment for orthodontic records
- Submitting Prior Approval for orthodontic treatment requiring orthognathic surgery
- Using the Orthodontic Prior Approval attachment forms

How to Add/Update Your Credentials (WebEx)

Wednesday, Sept. 12, 2018, 1:00–3:00 p.m.

This course will provide instructions for adding and updating licensing or certifications to the provider's record in NCTracks. Some taxonomy codes require the provider to be

licensed, accredited, and/or certified according to the specific laws and regulations that apply to their service type.

Submitting Medical Prior Approvals (Onsite)

Wednesday, Sept. 13, 2018, 9:30 a.m.–Noon

This course shows authorized users how to electronically submit and inquire about prior approvals for different kinds of medical services.

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

- Submit Prior Approvals electronically
- Conduct electronic inquiries about Prior Approvals.

Submitting Professional Claims (Onsite)

Wednesday, Sept. 13, 2018, 1–4:30 p.m.

This course will focus on how an authorized user would submit a Professional Claim.

At the end of training, the user will be able to do the following:

- Enter a Professional claim
- Submit a Professional claim
- Save a Draft
- Use Claims Draft Search
- View results of a claim submission
- Void and Replace paid claims.

AMH Attestation (WebEx)

Friday, Sept. 14, 2018, 9:30–11 a.m.

Friday, Sept. 21, 2018, 9:30–11 a.m.

Friday, Sept. 28, 2018, 9:30–11 a.m.

This course will guide the user through completing the Advanced Medical Home (AMH) Tier Attestation via the secure Provider Portal. For more information on AMH Tier Attestation, refer to the [NC Medicaid webpage](#).

Submitting Institutional Prior Approvals (Onsite)

Wednesday, Sept. 19, 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, inquiring about those requests to determine their status.

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

- Submit Prior Approvals
- Inquire about Prior Approvals.

Submitting Institutional Claims (Onsite)

Wednesday, Sept. 19, 2018, 1–4:30 p.m.

This course will focus on how an authorized user can submit an Institutional claim with emphasis on Long Term Care and Secondary Claims.

At the end of training, you will be able do the following:

- Enter an institutional claim
- Save a draft
- Use the Claims Draft Search tool
- Submit a claim
- View results of a claim submission
- Void and Replace paid claims.

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 subfolders 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.

GDIT Call Center, 1-800-688-6696

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

Medicaid has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

Medicaid has provided instructions to NCTracks on updating the claims processing system. The following procedure code list has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

11755	11755 (B)	20605 (B)	22551 (A)
36478	36478 (B)	37765	37765 (B)
50688	50688 (B)		

* Codes marked with an (A) were updated for modifiers 80 and 82

* Codes marked with a (B) were updated for modifier 59

Note: The following codes were updated:

- 11755, 36478, 37765 and 50688
- 22551 with modifiers 80 and 82
- 11755, 20605, 36478, 37765 and 50688 with modifier 59

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

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

GDIT Call Center, 1-800-688-6696

Attention: Optical Providers

Reminder: Criteria for Polycarbonate Eyeglass Lenses

Providers may request prior approval for polycarbonate lenses without medical justification or additional documentation when eligible beneficiaries meet at least one of the following criteria:

- Age is birth through 6 years old;
- Single vision or bifocal correction with + or – 5.00 diopters or more in one meridian (sphere, cylinder, combination of sphere and cylinder or prism) in one eye;
- Beneficiary is blind or legally blind in one eye, with correction for the sighted eye in accordance with clinical coverage policy 6A, subsection 5.6.1; Note “Blind” or “Legally blind” and best corrected visual acuity in the Note field.

For any condition not listed above, the provider must submit documentation of medical necessity for polycarbonate lenses with the prior approval request. Each prior approval request will be reviewed for medical necessity on an individual basis.

To access the full policy refer to [6A Routine Eye Exams and Visual Services for Beneficiaries Under Age 21](#).

NC Medicaid Clinical Policy and Programs, 919-855-4260

Attention: Physicians

Lutetium Lu 177 Dotatate Injection, for Intravenous Use (Lutathera®), HCPCS Code A9699: Billing Guidelines

Effective with date of service, Aug. 1, 2018, the Medicaid and NC Health Choice programs cover Lutathera for use in the Physician's Drug Program when billed with HCPCS code A9699, Radiopharmaceutical, therapeutic, not otherwise classified.

Lutathera injection containing 370 MBq/mL (10 mCi/ml) of lutetium Lu 177 dotatate is a sterile, preservative-free solution for intravenous use supplied in a colorless Type I glass 30 mL single-dose vial containing 7.4 GBq (200 mCi) \pm 10% of lutetium Lu 177 dotatate at the time of injection. The solution volume in the vial is adjusted from 20.5 mL to 25 mL to provide a total of 7.4 GBq (200 mCi) of radioactivity.

Lutathera is a radiolabeled somatostatin analog indicated for the treatment of adults with somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors.

The recommended dose of Lutathera is 7.4 GBq (200 mCi) every 8 weeks for a total of 4 doses.

See the package insert for important safety information and full prescribing and administration information.

For Medicaid and NC Health Choice Billing

- Providers must bill the product with HCPCS code: A9699 - Radiopharmaceutical, therapeutic, not otherwise classified
- Providers must indicate the number of HCPCS units
- One Medicaid unit of coverage is: 1 vial
- The maximum reimbursement rate per unit is: \$51,300.00 per 1 vial

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 69488-0003-01
- 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-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NC Health Choice beneficiaries by 340B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the Physician's Drug Program is available on Medicaid's [PDP web page](#).

GDIT Call Center, 1-800-688-6696

Attention: Primary Care Providers

Advanced Medical Home Training

The North Carolina Department of Health and Human Services (DHHS) developed the Advanced Medical Home (AMH) program as the primary vehicle for delivering local care management as the state transitions to Medicaid managed care. The AMH program builds on the Carolina ACCESS program primary care standards for clinical service and access to care.

The AMH program creates a new opportunity for primary care practices to provide care management functions if they attest to meeting certain functional and technology requirements. AMHs may provide these care management services “in-house,” they can work with their affiliated health care system, or they arrange with a Clinically Integrated Network, a Care Management vendor, or other population health entity for the provision of the care management functions.

To ensure beneficiaries across the state are receiving high quality care management, DHHS developed standards for AMHs and will be responsible for initially certifying that practices meet AMH criteria.

NC Medicaid has conducted two webinars and will conduct more during the next several months to assist providers through this transition. More information about previous and upcoming webinars will be posted on the AMH training webpage at <https://medicaid.ncdhhs.gov/amh-training>.

Regional Training Forums

NC Medicaid will also offer regional training forums that feature an extended discussion combining elements of AMH 101 and AMH 102 webinars, including a high-level overview of the AMH program and a more detailed look at the transition from Carolina ACCESS to the AMH program. Staff from DHHS will be available on location during these upcoming sessions.

- Sept. 17, 2018 – Greensboro
- Sept. 19, 2018 – Greenville
- Sept. 24, 2018 – Asheville
- Sept. 25, 2018 – Huntersville
- Oct. 4, 2018 – Raleigh

Seating is limited. Please [register](#) in advance if you plan to attend.

AMH Certification (Attestation) Process

NCTracks will host webinars regarding the AMH attestation tool. Dates, times and registration will be posted on the AMH training webpage.

GDIT Call Center, 1-800-688-6696