



NC Medicaid Bulletin

June 2019

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ATTENTION: ALL PROVIDERS**Are you in Compliance with NC Law?****Connecting to NC's Health Information Exchange, NC HealthConnex**

One of the goals of a transformed health care system is for near real-time clinical and demographic data to be made available to all health care providers involved in a patient's care so that they can securely share health information concerning that patient with each other.

North Carolina's state-designated health information exchange, NC HealthConnex, was created in 2015 by the North Carolina General Assembly to help bridge the gap between disparate systems and health care networks to support whole patient care. With six million unique patient records and growing, NC HealthConnex is working to connect the state's health care providers to deliver a holistic view of a patient's record. The North Carolina Health Information Exchange Authority (NC HIEA) is the agency managing the statewide NC HealthConnex.

What's the law?

State law (N.C.G.S. § 90-414.4) requires that all health care providers who receive any state funds for the provision of health care services (e.g. Medicaid, NC Health Choice, State Health Plan, etc.) connect and submit patient demographic and clinical data to NC HealthConnex by certain dates in 2018 and 2019 in order to continue to receive payment for services.

- Hospitals as defined by [G.S. 131E-176\(3\)](#), physicians licensed to practice under [Article 1 of Chapter 90 of the General Statutes](#), physician assistants as defined in [21 NCAC 32S .0201](#) and nurse practitioners as defined in [21 NCAC 36 .0801](#) who provide Medicaid services and who have an electronic health record system shall connect by June 1, 2018.
- All other providers of Medicaid and state-funded services shall connect by June 1, 2019. (*see exceptions below from NCSL 2018-41*)
 - Dentists and ambulatory surgical centers are required to submit clinical and demographic data by June 1, 2021.
 - Pharmacies are required to submit claims data pertaining to State services once per day by June 1, 2021, using pharmacy industry standardized formats.
- LME/MCOs are required to submit claims and encounter data by June 1, 2020.

Note: Recently introduced [legislation](#) (HB70) has a number of provisions that may impact the current state requirements and implementation deadlines. The bill would: delay the June 1, 2019, deadline to June 1, 2020; would exempt certain providers from the requirement to submit data; and would provide a hardship exemption for certain providers based on criteria set by DHHS in consultation with DIT among other

provisions. This is still a bill and has not been signed into law as of April 11, 2019.

How to Connect?

The first step in connection is reviewing and signing the [Participation Agreement](#). The Participation Agreement is the contract that governs the data sharing between your practice and the NC HIEA. For more information, visit the HIEA's [How to Connect Webpage](#).

The second step is to have the technology in place. The NC HIEA Participation Agreement requests EHRs that are minimally capable of sending HL7 messages, version 2 and higher.

Additionally, NC HIEA, in collaboration with the NC Department of Health and Human Services, has established an extension process. Once a health care organization signs the Participation Agreement with the HIEA and begins onboarding, an extension of time is automatically granted to allow time for the provider to become compliant under the HIE Act. Payments will not be withheld from providers who have been granted extensions of time.

The NC HIEA holds monthly "How to Connect" webinars on the last Monday of every month at 12:00 noon. Click here to [register](#).

Providers with questions may contact the NC HIEA at 919-754-6912 or hiea@nc.gov.

ATTENTION: ALL PROVIDERS

Clinical Coverage Policy (CCP) 1A-39 Routine Costs in Clinical Trial Services for Life Threatening Conditions

Clinical Policy, *Routine Costs in Clinical Trial Services for Life Threatening Conditions, 1A-39* has been revised. The revisions, which will become effective July 1, 2019, provide clearer explanations and definitions regarding coverage for routine costs in clinical trial services for life-threatening conditions. Descriptions will be added for the following:

- Clinical trial phases 0-IV
- Investigational Device Exemption (IDE)
- Humanitarian Use Device (HUD)
- Humanitarian Device Exemption (HDE)
- Investigational New Drug (IND)

Definitions will be revised or added for the following:

- Qualifying clinical trial
- Routine costs
- Life-threatening condition
- Informed consent
- ClinicalTrials.gov Identifier (NCT number)

- Institutional Review Boards (IRB)

Prior approval requirements will be clarified for clinical trials in which the underlying service, product or procedure requires prior approval.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS

Diagnosis Code Z71.82 (Exercise Counseling) Added to NCTracks

To align with children’s health quality measure reporting, NC Medicaid has added diagnosis code Z71.82 (Exercise Counseling) to NCTracks as an acceptable secondary diagnosis effective Oct. 1, 2017. Providers may resubmit claims that have previously denied for invalid diagnosis code.

Please note, if a claim is submitted with Z71.82 in the primary position, the claim will deny with the following EOB “PRIMARY OR PRINCIPAL DIAGNOSIS NOT ALLOWED. PLEASE VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUBMIT AS A NEW CLAIM.” If you receive this denial, ensure Z71.82 is not the primary diagnosis on the claim and resubmit.

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ATTENTION: ALL PROVIDERS

Coverage for Central Motor Evoked Potential

In response to provider requests, NC Medicaid has added coverage for central motor evoked potential. The following codes have been added to NCTracks to be billed by physicians only, effective April 1, 2019:

- 95928 – Central motor evoked potential study (transcranial motor stimulation); upper limbs
- 95929 - Central motor evoked potential study (transcranial motor stimulation); lower limbs
- 95939 - Central motor evoked potential study (transcranial motor stimulation); in upper and lower limb

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ATTENTION: ALL PROVIDERS

Clinical Policy Update

The following new or amended clinical coverage policy is available on NC Medicaid’s website at <https://medicaid.ncdhhs.gov/>:

- 10C, Outpatient Specialized Therapies - Local Education Agencies (LEAs) – 05-15-2019

This policy supersedes previously published policies and procedures.

Proposed new or amended Medicaid and NC Health Choice clinical coverage policies are posted for comment throughout the month. Visit [Proposed Medicaid and NC Health Choice Policies](#) for current posted policies and instructions to submit a comment.

NC Medicaid Clinical Policy and Programs, (919) 855-4260 / (888) 245-0179

ATTENTION: ALL PROVIDERS

Updates to NC Medicaid Electronic Health Record (EHR) Incentive Program

NC-MIPS is Open for Program Year 2019

The NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)) is currently accepting Program Year 2019 Stage 3 Meaningful Use (MU) attestations.

All eligible professionals (EPs) attesting in program year 2019 will be required to attest to stage 3 MU and use a 2015 edition of certified EHR technology (CEHRT).

In program year 2019, EPs may continue to use a 90-day MU reporting period. The MU reporting period must be from calendar year 2019 and will be any continuous 90-day period in which an EP successfully demonstrates MU of CEHRT.

EPs who were paid for program year 2018 using a 90-day patient volume reporting period from calendar year 2018 have the option to use the same patient volume reporting period to attest for program year 2019.

CMS has updated its Promoting Interoperability Program website with program year 2019 information and details including the [2019 Medicaid EP specification sheets](#).

Program Year 2019 Webinar Series

The NC Medicaid EHR Incentive Program's webinar series has been updated to reflect the rules and regulations for program year 2019.

The webinars are designed with the busy provider in mind, so most of them are less than five minutes long. Each short webinar explains a different piece of the attestation process such as updating a CEHRT number, updating a username in NC-MIPS, and submitting an attestation.

Other webinar topics include patient volume, auditing, MU and clinical quality measures (CQM) in program year 2019 and more. These webinars can be found on the 'Resources and Webinars' tab of the [program website](#).

The Two-Part Attestation Process

All EPs who have 90 days of MU objective data that meets CMS' requirements may submit their demographic, license, patient volume and MU objective data in NC-MIPS beginning **May 1, 2019**.

In program year 2019, EPs who have successfully attested to MU in a previous program year will be required to use a full calendar year CQM reporting period. Returning meaningful users who would like an early review of requirements, excluding CQMs, may submit their attestation in two parts. Part 1 of the attestation may be submitted **now** through Dec. 31, 2019.

The two-part attestation 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. Submitting in two parts also allows ample time for EPs to address any attestation discrepancies. These EPs will return to NC-MIPS after Jan. 1, 2020 to submit their CQM 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 in Jan. 2020.

EPs who have only attested to adopt, implement, upgrade (AIU), may use a 90-day CQM reporting period and may submit a complete attestation in NC-MIPS beginning May 1, 2019.

EPs who attested in NC-MIPS in a previous year will be automatically directed to the appropriate page in NC-MIPS.

For more information on the two-part attestation process, please email NCMedicaid.HIT@dhhs.nc.gov.

Program Year 2019 CQMs

EPs are required to report on **six** of 50 CQMs. New in program year 2019, CMS is encouraging EPs to report at least one outcome measure and one high priority measure. If any outcome or high priority CQMs are relevant to the EP's scope of practice, those should be reported first. If there are no outcome and/or high priority CQMs that are relevant to the EP's scope of practice, the EP may choose to report on any other six CQMs.

Program year 2019 CQMs are available for review on the [eCQI website](#).

General Reminders

EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting with North Carolina for program year 2019.

For those practices unsure if a new provider may participate in the NC Medicaid EHR Incentive Program in program year 2019, please email the EP's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the provider previously attested with another practice.

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

ATTENTION: ALL PROVIDERS

ICD 10 Codes for Acute Appendicitis

NC Medicaid has received calls concerning the ICD 10 diagnoses codes for acute appendicitis.

NC Medicaid has provided instructions to NCTracks on updating the diagnoses code list for acute appendicitis. The following ICD 10 code list has been updated recently to include the following diagnoses codes:

K35.20 Acute appendicitis with generalized peritonitis, without abscess

K35.21 Acute appendicitis with generalized peritonitis, with abscess

K35.30 Acute appendicitis with localized peritonitis, without perforation or gangrene

K35.31 Acute appendicitis with localized peritonitis and gangrene, without perforation

K35.32 Acute appendicitis with perforation localized peritonitis, without abscess

K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess

(MP 19.156)

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ATTENTION: ALL PROVIDERS

The Office of the State Auditor Single Audit – 2019

In accordance with 2 CFR part 200, subpart F, the North Carolina Office of the State Auditor (OSA) annually selects a sample of NC Medicaid claims to determine the State's accuracy/error rate for claims paid in the prior State fiscal year (July to June). The Office of Compliance & Program Integrity (OCPI) is in the process of sending out record request notifications to providers with a claim(s) in the sample. In order to minimize costs and prevent delays, OCPI may contact you by phone to verify the address where these record requests should be mailed.

The record request contains a listing of the documents that need to be submitted to OCPI for the review of the claim. The requested documents **must** be sent as soon as possible, but no later than 30 calendar days of receipt of the letter. OCPI is requesting that documentation exceeding 25 pages be scanned and submitted via an encrypted CD or flash drive, with the password submitted separately via email to medicaid.sa@dhhs.nc.gov.

During the record request process, OCPI may need to ask for additional documentation to support the claim payment. Failure of the provider to timely respond to a request for documentation may result in the provider being placed on prepayment claims review.

Additionally, NC Medicaid is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR §431.107 to access patient records for purposes directly related to the administration of Medicaid, the Medicaid Waiver, and the NC Health Choice Program. When applying for Medicaid benefits, each recipient signs a release which authorizes access to his/her Medicaid records by NC Medicaid and other appropriate regulatory authorities. Therefore, it is not necessary for you to require a signed consent for the release of records from any affected Medicaid recipient to submit the necessary documentation for this review.

Should you have any questions you may contact us at the following email address:
medicaid.sa@dhhs.nc.gov

NC Medicaid Office of Compliance and Program Integrity, (919) 527-7749

ATTENTION: PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS
Billing Code Update for Physician Assistants and Nurse Practitioners

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

NC 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 updated codes are:

14301 (A)	14302 (A)	25215 (A)	25444 (A)
27487 (A)	27880 (A)	33611 (A)	33612 (A)
33864 (A)	33875 (A)	36832 (A)	44625 (A)
45126 (A)	47562 (A)	49000 (A)	49655 (A)
49656 (A)	60220 (A)	60252 (A)	60521 (A)
63001 (A)	63287 (A)	63710 (A)	64772 (A)

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

The NC 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.

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ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Iobenguane I 131 injection, for intravenous use (Azedra®), HCPCS Code A9699 and A4641: Billing Guidelines

Effective with date of service Oct. 29, 2018, NC Medicaid covers Azedra for use in the Physician’s Administered Drug Program when billed with HCPCS code A9699,

Radiopharmaceutical, therapeutic, not otherwise classified (therapeutic use) or A4641, Radiopharmaceutical, diagnostic, not otherwise classified (dosimetric use).

Azedra injection, containing 555 MBq/mL (15 mCi/mL) of I-131 (as iobenguane I 131) and 0.006 mg/mL of iobenguane, is a sterile, clear, colorless to pale yellow solution for intravenous use supplied in a colorless Type 1 borosilicate glass 30 mL single-dose vial. Azedra is supplied in dosimetric (2 mL) and therapeutic (22.5 mL) presentations:

- Dosimetric: 1,110 MBq (30 mCi) of iobenguane I 131 at calibration time (NDC 71258-0015-02)
- Therapeutic: 12,488 MBq (337.5 mCi) of iobenguane I 131 at calibration time (NDC 71258-0015-22)

Azedra is a radioactive therapeutic agent indicated for the treatment of adult and pediatric patients 12 years and older with iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy.

Administer Azedra intravenously as a dosimetric dose followed by two therapeutic doses administered 90 days apart.

- The recommended dosimetric dose is:
 - Patients greater than 50 kg: 185 to 222 MBq (5 to 6 mCi)
 - Patients 50 kg or less: 3.7 MBq/kg (0.1 mCi/kg)
- The recommended therapeutic dose for each of the 2 doses is:
 - Patients greater than 62.5 kg: 18,500 MBq (500 mCi)
 - Patients 62.5 kg or less: 296 MBq/kg (8 mCi/kg)
- Adjust AZEDRA therapeutic doses based on radiation dose estimates results from dosimetry, if needed.

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

For North Carolina Medicaid and NC Health Choice Billing

- Providers must bill the product with HCPCS code: A9699 - Radiopharmaceutical, therapeutic, not otherwise classified (therapeutic use) or A4641, Radiopharmaceutical, diagnostic, not otherwise classified (dosimetric use).
- Providers must indicate the number of HCPCS units.
- One Medicaid and NC Health Choice unit of coverage is: 1 mL
- The maximum reimbursement rate per unit is: \$4,892.40 per 1 mL
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 71258-0015-02 (dosimetric vial) and 71258-0015-22 (therapeutic vial)
- 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 PADP, refer to [the PADP Clinical Coverage Policy 1B](#).

- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 Administered Drug Program is available on DHB's [PADP web page](#).

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ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Gemcitabine in sodium chloride injection, for intravenous use (Infugem™) HCPCS code J9999: Billing Guidelines

Effective with date of service March 12, 2019, the North Carolina Medicaid and NC Health Choice programs cover gemcitabine in sodium chloride injection, for intravenous use (Infugem) for use in the Physician Administered Drug Program when billed with HCPCS code J9999 - not otherwise classified, antineoplastic drugs.

Strength/Package Size(s): Injection: single-dose premixed infusion bags containing 10 mg/mL of gemcitabine in 0.9% sodium chloride: 1200 mg in 120 mL, 1300 mg in 130 mL, 1400 mg in 140 mL, 1500 mg in 150 mL, 1600 mg in 160 mL, 1700 mg in 170 mL, 1800 mg in 180 mL, 1900 mg in 190 mL, 2000 mg in 200 mL, 2200 mg in 220 mL

Indicated:

- In combination with carboplatin, for the treatment of advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy.
- In combination with paclitaxel, for first-line treatment of metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless anthracyclines were clinically contraindicated.
- In combination with cisplatin for the treatment of non-small cell lung cancer.
- As a single agent for the treatment of pancreatic cancer.

Recommended Dose: Intravenous infusion only.

- Ovarian Cancer: 1000 mg/m² over 30 minutes on Days 1 and 8 of each 21-day cycle.
- Breast Cancer: 1250 mg/m² over 30 minutes on Days 1 and 8 of each 21-day cycle.
- Non-Small Cell Lung Cancer: 1000 mg/m² over 30 minutes on Days 1, 8, and 15 of each 28-day cycle or 1250 mg/m² over 30 minutes on Days 1 and 8 of each 21-day cycle.

- Pancreatic Cancer: 1000 mg/m² over 30 minutes once weekly for the first 7 weeks, then one week rest, then once weekly for 3 weeks of each 28-day cycle.
- Refer to package insert for dose reduction information AND see full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

The ICD-10-CM diagnosis code(s) required for billing are:

Pancreatic Cancer:

C25.0 - Malignant neoplasm of head of pancreas; C25.1 - Malignant neoplasm of body of pancreas; C25.2 - Malignant neoplasm of tail of pancreas; C25.3 - Malignant neoplasm of pancreatic duct; C25.4 - Malignant neoplasm of endocrine pancreas; C25.7 - Malignant neoplasm of other parts of pancreas; C25.8 - Malignant neoplasm of overlapping sites of pancreas; C25.9 - Malignant neoplasm of pancreas, unspecified

NSCLC:

C33 - Malignant neoplasm of trachea; C34.00 - Malignant neoplasm of unspecified main bronchus; C34.01 - Malignant neoplasm of right main bronchus; C34.02 - Malignant neoplasm of left main bronchus; C34.10 - Malignant neoplasm of upper lobe, unspecified bronchus or lung; C34.11 - Malignant neoplasm of upper lobe, right bronchus or lung; C34.12 - Malignant neoplasm of upper lobe, left bronchus or lung; C34.2 - Malignant neoplasm of middle lobe, bronchus or lung; C34.30 - Malignant neoplasm of lower lobe, unspecified bronchus or lung; C34.31 - Malignant neoplasm of lower lobe, right bronchus or lung; C34.32 - Malignant neoplasm of lower lobe, left bronchus or lung; C34.80 - Malignant neoplasm of overlapping sites of unspecified bronchus and lung; C34.81 - Malignant neoplasm of overlapping sites of right bronchus and lung; C34.82 - Malignant neoplasm of overlapping sites of left bronchus and lung; C34.90 - Malignant neoplasm of unspecified part of unspecified bronchus or lung; C34.91 - Malignant neoplasm of unspecified part of right bronchus or lung; C34.92 - Malignant neoplasm of unspecified part of left bronchus or lung

Ovarian Cancer:

C48.0 - Malignant neoplasm of retroperitoneum; C48.1 - Malignant neoplasm of specified parts of peritoneum; C48.2 - Malignant neoplasm of peritoneum, unspecified; C48.8 - Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum; C56.1 - Malignant neoplasm of right ovary; C56.2 - Malignant neoplasm of left ovary; C56.9 - Malignant neoplasm of unspecified ovary; C57.00 - Malignant neoplasm of unspecified fallopian tube; C57.01 - Malignant neoplasm of right fallopian tube; C57.02 - Malignant neoplasm of left fallopian tube

Breast Cancer:

C50.011 - Malignant neoplasm of nipple and areola, right female breast; C50.012 - Malignant neoplasm of nipple and areola, left female breast; C50.019 - Malignant neoplasm of nipple and areola, unspecified female breast; C50.021 -

Malignant neoplasm of nipple and areola, right male breast; C50.022 - Malignant neoplasm of nipple and areola, left male breast; C50.029 - Malignant neoplasm of nipple and areola, unspecified male breast; C50.111 - Malignant neoplasm of central portion of right female breast; C50.112 - Malignant neoplasm of central portion of left female breast; C50.119 - Malignant neoplasm of central portion of unspecified female breast; C50.121 - Malignant neoplasm of central portion of right male breast; C50.122 - Malignant neoplasm of central portion of left male breast; C50.129 - Malignant neoplasm of central portion of unspecified male breast; C50.211 - Malignant neoplasm of upper-inner quadrant of right female breast; C50.212 - Malignant neoplasm of upper-inner quadrant of left female breast; C50.219 - Malignant neoplasm of upper-inner quadrant of unspecified female breast; C50.221 - Malignant neoplasm of upper-inner quadrant of right male breast; C50.222 - Malignant neoplasm of upper-inner quadrant of left male breast; C50.229 - Malignant neoplasm of upper-inner quadrant of unspecified male breast; C50.311 - Malignant neoplasm of lower-inner quadrant of right female breast; C50.312 - Malignant neoplasm of lower-inner quadrant of left female breast; C50.319 - Malignant neoplasm of lower-inner quadrant of unspecified female breast; C50.321 - Malignant neoplasm of lower-inner quadrant of right male breast; C50.322 - Malignant neoplasm of lower-inner quadrant of left male breast; C50.329 - Malignant neoplasm of lower-inner quadrant of unspecified male breast; C50.411 - Malignant neoplasm of upper-outer quadrant of right female breast; C50.412 - Malignant neoplasm of upper-outer quadrant of left female breast; C50.419 - Malignant neoplasm of upper-outer quadrant of unspecified female breast; C50.421 - Malignant neoplasm of upper-outer quadrant of right male breast; C50.422 - Malignant neoplasm of upper-outer quadrant of left male breast; C50.429 - Malignant neoplasm of upper-outer quadrant of unspecified male breast; C50.511 - Malignant neoplasm of lower-outer quadrant of right female breast; C50.512 - Malignant neoplasm of lower-outer quadrant of left female breast; C50.519 - Malignant neoplasm of lower-outer quadrant of unspecified female breast; C50.521 - Malignant neoplasm of lower-outer quadrant of right male breast; C50.522 - Malignant neoplasm of lower-outer quadrant of left male breast; C50.529 - Malignant neoplasm of lower-outer quadrant of unspecified male breast; C50.611 - Malignant neoplasm of axillary tail of right female breast; C50.612 - Malignant neoplasm of axillary tail of left female breast; C50.619 - Malignant neoplasm of axillary tail of unspecified female breast; C50.621 - Malignant neoplasm of axillary tail of right male breast; C50.622 - Malignant neoplasm of axillary tail of left male breast; C50.629 - Malignant neoplasm of axillary tail of unspecified male breast; C50.811 - Malignant neoplasm of overlapping sites of right female breast; C50.812 - Malignant neoplasm of overlapping sites of left female breast; C50.819 - Malignant neoplasm of overlapping sites of unspecified female breast; C50.821 - Malignant neoplasm of overlapping sites of right male breast; C50.822 - Malignant neoplasm of overlapping sites of left male breast; C50.829 - Malignant neoplasm of overlapping sites of unspecified male breast; C50.911 - Malignant neoplasm of unspecified site of right female breast; C50.912 - Malignant neoplasm of

unspecified site of left female breast; C50.919 - Malignant neoplasm of unspecified site of unspecified female breast; C50.921 - Malignant neoplasm of unspecified site of right male breast; C50.922 - Malignant neoplasm of unspecified site of left male breast; C50.929 - Malignant neoplasm of unspecified site of unspecified male breast

- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
- One Medicaid and NC Health Choice unit of coverage is: 10 mg
- The maximum reimbursement rate per unit is: \$4.10
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 62756-0073-60, 62756-0008-60, 62756-0102-60, 62756-0219-60, 62756-0321-60, 62756-0438-60, 62756-0533-60, 62756-0614-60, 62756-0746-60, 62756-0974-60
- 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 PADP, refer to the [PADP Clinical Coverage Policy 1B](#), Attachment A, H.7 on DHB's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 Administered Drug Program is available on DHB's [PADP web page](#).

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ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Tagraxofusp-erzs injection, for intravenous use (Elzonris™) HCPCS code J9999: Billing Guidelines

Effective with date of service March 7, 2019, the North Carolina Medicaid and NC Health Choice programs cover tagraxofusp-erzs injection, for intravenous use (Elzonris) for use in the Physician Administered Drug Program when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs.

Elzonris is available as a 1,000 mcg in 1 mL in a single-dose vial for injection. It is indicated for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

Recommended Dose: 12 mcg/kg intravenously over 15 minutes once daily on days 1 to 5 of a 21-day cycle.

See package insert for recommended dose modifications and for CLS management guidelines AND see full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

- The ICD-10-CM diagnosis code required for billing is: C86.4 - Blastic NK-cell lymphoma
- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
- One Medicaid and NC Health Choice unit of coverage is: 1 mcg
- The maximum reimbursement rate per unit is: \$26.38
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 72187-0401-01
- 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 PADP, refer to the [PADP Clinical Coverage Policy 1B](#), Attachment A, H.7 on DHB's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 Administered Drug Program is available on DHB's [PADP web page](#).

GDIT, (800) 688-6696

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Esketamine nasal spray (Spravato™) HCPCS code J3490: Billing Guidelines

Effective with date of service 3/8/2019, the North Carolina Medicaid and NC Health Choice programs cover esketamine nasal spray (Spravato™) for use in the Physician Administered Drug Program when billed with HCPCS code J3490 - Unclassified drugs.

Spravato is available as a nasal spray: 28 mg of esketamine per device. Each nasal spray device delivers two sprays containing a total of 28 mg of esketamine. Spravato is indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults.

Recommended Dose:

Induction Phase (Weeks 1 to 4): Administer twice weekly. Day 1: 56 mg, subsequent doses: 56 mg or 84 mg.

Maintenance Phase (Weeks 5 to 8): Administer 56 mg or 84 mg once weekly.

Maintenance Phase (Week 9 and after): Administer 56 mg or 84 mg once weekly or every 2 weeks.

See full prescribing information for further detail.

For Medicaid and NC Health Choice Billing

- The ICD-10-CM diagnosis code(s) required for billing is/are: F32.1 - Major depressive disorder, single episode, moderate; F32.2 - Major depressive disorder, single episode, severe without psychotic features; F32.4 - Major depressive disorder, single episode, in partial remission; F33.1 - Major depressive disorder, recurrent, moderate; F33.2 - Major depressive disorder, recurrent severe without psychotic features; F33.41 - Major depressive disorder, recurrent, in partial remission;
- Providers must bill with HCPCS code: J3490 - Unclassified drugs
- One Medicaid and NC Health Choice unit of coverage is: 1 device (28 mg)
- The maximum reimbursement rate per unit is: \$318.60
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 50458-0028-00, 50458-0028-02, 50458-0028-03
- 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 PADP, refer to the [PADP](#), Attachment A, H.7 on DHB's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PADP 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 Administered Drug Program is available on DHB's [PADP web page](#).

GDIT, (800) 688-6696

ATTENTION: BEHAVIORAL HEALTH PROVIDERS

Rutherford County Transition Effective July 2019

The Secretary of the N.C. Department of Health and Human Services (DHHS) has approved the disengagement of Rutherford County from the VAYA Health Local Management Entity-Managed Care Organization (LME-MCO) and their alignment with Partners Behavioral Health Management LME-MCO.

Effective July 1, 2019, Partners will be the LME-MCO responsible for enrollees whose Medicaid county of eligibility is Rutherford County. Any provider delivering Medicaid behavioral health services to a Rutherford County enrollee after June 30, 2019, must be contracted with Partners. This only applies to mental health, substance use disorder and intellectual/developmental disability services for Medicaid beneficiaries three years of age and older.

NC Medicaid Behavioral Health Unit, (919) 527-7630

ATTENTION: LOCAL EDUCATION AGENCIES (LEAs)

Updates to Clinical Coverage Policy 10C: Outpatient Specialized Therapies, Local Education Agencies (LEAs)

On May 15, 2019, an amended version of Clinical Coverage Policy 10C, *Outpatient Specialized Therapies, Local Education Agencies (LEAs)*, was posted to the North Carolina Medicaid website. The following updates were made in accordance with State Plan Amendment (SPA) NC 18-0005.

The following SPA-related updates became effective **October 1, 2018**:

In Subsection **1.0 Description of the Procedure, Product, or Service**, the following two bullets were updated to read:

- The service(s) are documented on the beneficiary's Individualized Education Program (IEP), Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP) or 504 Plan according to 34 C.F.R. 104.36; and
- Provided by school staff or contracted personnel.

In Subsection **2.1.2 Eligibility Requirements, Specific, Medicaid**, criterion d. was deleted, and criterion c. was updated to read:

c. the beneficiary receives the service(s) in the public school setting or a setting identified in an IEP, or IFSP, IHP, BIP or 504 Plan, and is receiving services as part of an IEP, IFSP, IHP, BIP or 504 Plan.

In Subsection **3.2.2 Medicaid Additional Criteria Covered** was updated to read:

Medicaid shall cover audiology, counseling, nursing, occupational therapy, physical therapy, and speech/language therapy services that are medically

necessary and documented on any one of the following: IEP; IFSP; IHP; BIP; or 504 Plan.

In Subsection **3.8 Psychological and Counseling Services**, the list of areas of functioning was updated to read:

- a. Cognitive
- b. Emotional and personality;
- c. Adaptive behavior;
- d. Behavior; and/or
- e. Perceptual or visual motor

In Subsection **3.9 Evaluation Services**, the following covered services were added:

3.9.1 Vision Screening Services

Vision Screening Services must be administered by licensed registered nurses (RNs) or licensed practical nurses (LPNs) prior to providing a billable psychological evaluation, occupational therapy evaluation, physical therapy evaluation or speech/language evaluation service.

3.9.2 Hearing Screening Services

Hearing Screening Services must be administered by licensed RNs, Audiologists or Speech/Language Pathologists prior to providing a billable psychological evaluation, occupational therapy evaluation, physical therapy evaluation or speech/language evaluation service.

In Subsection **3.11 Treatment Services**, criterion b.6 was updated to read:

For a Local Education Agency (LEA), the prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with and obtaining a dated physician order with signature. The IEP, IFSP, IHP, BIP or 504 Plan requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the IEP, IFSP, IHP, BIP or 504 Plan goals by the end of the school year;

Subsection **5.1, Prior Approval** was updated to read:

The prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes.

In Subsection **5.2, Limitations or Requirements**, paragraph four, sentences one and two were updated to read:

All treatment services shall be provided as outlined in an IEP, IFSP, IHP, BIP or 504 Plan. Occupational therapy and physical therapy services can be provided in a group setting with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) of three children per group.

Subsection **5.3, Location of Service** was updated to read:

The service must be performed at the location identified on the IEP, IFSP, IHP, BIP or 504 Plan.

In Subsection **7.2 Documenting Services**, criteria c. and j. and paragraph two were updated to also include the IFSP, IHP, BIP or 504 Plan.

In **Attachment A, Section C, Code(s)**, added V5008 (hearing screen) to Audiology, SLP and Nursing code lists; 99173 (vision screen) to Nursing code list; and 97150 (group therapy) to OT and PT lists.

Attachment A, Section C, Third Party Liability, was updated to also include the IFSP, IHP, BIP or 504 Plan.

In **Attachment A, Section E, Treatment Services**, the last sentence of paragraph one was **deleted**:

All treatment services must be provided on an individualized basis except for speech-language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group.

Attachment A, Section F, Place of Service, was updated to also include the IFSP, IHP, BIP or 504 Plan.

These additional updates, unrelated to the SPA, became effective **January 1, 2019**:

In **Attachment A, Section C, Code(s)**, the following updates were made:

End-dated psychological and counseling evaluation CPT code 96101 was deleted and replaced with 96130, 96131, 96136 & 96137.

End-dated psychological and counseling evaluation CPT code 96111 was deleted and replaced with 96112 & 96113.

End-dated psychological and counseling evaluation CPT code 96118 was deleted and replaced with 96132 & 96133.

Added 96121 which is new code paired with newly divided code 96116.

In Subsection **5.2, Limitations or Requirements**, to the first sentence of paragraph three, the following language was **added**:

Except where permitted by covered Psychological and Counseling Services Assessment procedure codes.

These additional updates, unrelated to the SPA, became effective **May 15, 2019**:

- In Subsection **2.1, Provisions**, criterion b., the reference to NC Health Choice was deleted.
- Subsection **3.2.2, NC Health Choice Additional Criteria Covered** was renumbered as **Subsection 3.2.3**.
- In Subsection **3.10, Treatment Plan (Plan of Care)**, added criterion i. treatment plan date, beneficiary's name and date of birth or Medicaid identification number.

- In Subsection **6.1, Provider Qualifications and Occupational Licensing Entity Regulations**, updated references to Federal Register qualifications for OT, PT, SLP and audiology.

Additional Resources

The full text of Clinical Coverage Policy 10C is available at North Carolina Medicaid's [Outpatient Specialized Therapy Services](#) web page. Additional information can also be found at the [ChoicePA](#) website.

ATTENTION: OPTICAL PROVIDERS

Co-payments for Adult Optical Services

The following co-payments are applicable for adult Medicaid beneficiaries (21 years of age and older):

- \$3.00 - Routine eye exam (S0620 and S0621)
- \$3.00 - Refraction only (92015)
- \$2.00 - All visual aids (eyeglasses and medically necessary contact lenses)

In accordance with NCAC 22J. 0106, a provider may **not** withhold services from a beneficiary who is unable to pay a co-payment at the time the service is rendered. If a beneficiary is unable to pay, the provider may bill the beneficiary after the service is rendered for the unpaid co-payment.

For more information, please refer to Clinical Coverage Policies 6A: Routine Eye Examination and Visual Aids for Beneficiaries Under 21 Years of Age and 6B: Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older. Policies can be found at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

GDIT, (800) 688-6696 or NCTracksprovider@nctracks.com

ATTENTION: OPTICAL PROVIDERS

Provision of Services for Routine Eye Exams and Visual Aids

Subsection 7.2, Provision of Service, in Clinical Coverage Policies 6A: Routine Eye Examination and Visual Aids for Beneficiaries Under 21 Years of Age and 6B: Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older, the following requirement is stated:

Optical providers shall extend the services of routine eye exams and visual aid fitting and dispensing for a North Carolina Medicaid and NC Health Choice beneficiary if these same services are extended to a private patient in the same practice or business.

- a. If both routine eye exams and visual aids are not available in the provider's office for all patients, the provider shall inform the beneficiary prior to services being offered or scheduled. The beneficiary shall be given the option to select a provider who will provide both services.

- b. If the beneficiary elects to have the exam, a written prescription for the lenses must be given or offered to the beneficiary at the time of the exam. The prescribing provider shall not withhold the prescription pending payment for the routine eye exam or previously unpaid Medicaid or private bills.

In summary, providers must provide routine eye exams and visual aids (eyeglasses and contact lenses) for Medicaid and NC Health Choice beneficiaries if both services are provided for non-Medicaid and non-NC Health Choice patients in the same practice or business location. If a provider does not provide visual aids for any patient, the provider must inform Medicaid and NC Health Choice beneficiaries that visual aids are not available before a routine eye exam is scheduled. Once the routine eye exam is completed, providers must release the written prescription, prior to receiving payment from NC Medicaid.

For more information, please refer to Clinical Coverage Policies 6A: Routine Eye Examination and Visual Aids for Beneficiaries Under 21 Years of Age and 6B: Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older. Policies can be found at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

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