



N.C. Medicaid Bulletin November 2017

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*Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**M**edicaid Secondary Claims Where Cost Share Does Not Apply, and Contractual Obligations Reporting on Medicaid Secondary Claims

On Oct. 29, 2017, the N.C. Department of Health and Human Services (DHHS) will implement new business rules in NCTracks for processing Medicaid secondary claims and claim adjustments where a third-party payer made a payment on the claim and cost share (patient responsibility) was not applicable.

For claims meeting this condition, the “lesser of logic” pricing method is **not** appropriate and will **not** be performed. Additional changes will include the creation of an “other payer adjustment” segment for 835 reporting of all Medicaid secondary claims where a prior payment exists. Medicare claims are not affected by these changes.

As is standard practice for Coordination of Benefits (COB) segments, when entering Third Party prior payer information, the provider must select the appropriate “payer filing indicator.” It is recommended the provider attach the Remittance Advice/Explanation of Benefit (EOB) of the prior payer with the Medicaid claim to confirm that cost share is not applicable when they have selected one of these filing indicators. The following specific COB payer filing indicators will identify third party claims that will price without cost share:

- AM – Automobile Medical
- LM – Liability Medical
- WC – Workers’ Compensation Health Claim
- TV – Title V (All other policies that do not have Cost Share information)

The paid amount associated with these payer filing indicators will be used only as a reduction to any Medicaid payment amount.

This new method will apply to all X12 837 Institutional, Professional, and Dental claim transaction types (837I/P/D) as well as claims keyed into the secure provider portal. Pharmacy claims are excluded. Paper claims are also excluded as the claim filing indicator cannot be submitted. The new method will be applicable for any claim that meets the criteria adjudicated after Oct. 29, regardless of the date of service.

Note: If a provider submits a claim with a payer filing indicator of AM, LM, WC or TV, and a cost share amount greater than \$0, the claim will be denied due to billing error with EOB code 02470:

**COST SHARE IS NOT APPLICABLE FOR THE CLAIM FILING INDICATOR SELECTED.
PLEASE SUBMIT A CLAIM FILING INDICATOR APPLICABLE TO INSURANCE POLICIES
WITH COST SHARE INFORMATION OR REMOVE THE INVALID COST SHARE AMOUNTS.**

If the claim also contains claim indicators other than AM, LM, WC or TV, and/or Medicare, the claim will perform the “lesser of logic” pricing method. The “lesser of logic” pricing method refers to payment for services at the lesser of the cost share (patient responsibility) or the difference (if any) between the amount paid by the Third Party/Medicare and the Medicaid state plan rate.

The “other payer adjustment” is to be calculated and reported on the 835 prior to determining and reporting the contractual obligation. The other payer adjustment will be calculated as the difference between all prior patient responsibility amounts and the billed charge amount. Any remaining difference (if any) between the submitted billed charge amount and the Medicaid allowable amount (after the other payer adjustment has been determined) will be reported as contractual obligation.

CSRA, 1-800-688-6696

Attention: All Providers

New Features for Voided Prior Approval Requests

A Prior Approval (PA) request may be voided in NCTracks for several reasons, including incorrect PA type, exact duplicate of an existing PA, and recipient not being eligible for the requested service dates. Beginning Oct. 29, 2017, the reason a PA request was voided will be available on the secure NCTracks provider portal.

The void description will be in the details of a PA inquiry performed through the provider portal. The void description will help providers understand why the PA request was voided, so they can determine how to proceed. In some cases, the reason for the void may be correctable through submission of a new PA request. For guidance on performing PA inquiry on the NCTracks provider portal, refer to “How to Determine the Status of Pharmacy PAs” under Prior Approval on the [Provider User Guides and Training page](#) of the NCTracks provider portal. (The instructions apply to all types of PA submitted to NCTracks.)

In addition, per N.C. Medicaid policy, PA is not required when the recipient has Medicare as the primary insurance. Historically, PA requests submitted for Medicare primary recipients have been denied. Beginning Oct. 29, these requests will be voided. A new letter will be generated to inform the provider that the request was voided because the recipient has Medicare as the primary insurance. The letter will also list the options for the provider/recipient to receive approval for the service. The letter will be posted on the Message Center Inbox of the secure NCTracks provider portal.

CSRA, 1-800-688-6696

Attention: All Providers**V**alidation of Prior Approval Requests Submitted via NCTracks Portal

Effective Oct. 29, 2017, the N.C. Department of Health and Human Services (DHHS) added four new data validations during the entry of prior approval (PA) requests through the NCTracks secure provider portal.

Specifically:

- The requesting provider must be an in-state/border provider.
- All providers on the PA record must have an active status in NCTracks by the requested PA begin date on each detail line.
- All providers on the PA record must be actively enrolled in the health plan selected for the PA as of the requested PA begin date on each detail line.
- The recipient must be actively enrolled in the health plan selected for the PA by the requested PA begin date on each detail line.

Currently, these data validations are performed after the PA is submitted in NCTracks, which results in the denial or void of a PA record. As of Oct. 29, if a validation fails during PA entry, the user will not be able to submit the record until the data are corrected. Adding the validations to PA entry will inform the provider of the issue immediately, and prevent submission of a PA record that would not be approved.

Exceptions to the new validations include Orthodontic and Dental PA requests. The in-state/border provider requirement does not apply to Pharmacy, Durable Medical Equipment, out-of-state ambulance or auditory implant PA requests.

For more information on the submission of PA requests, refer to the [Prior Approval page](#) of the and the [Provider User Guides and Training page](#) on the general NCTracks provider portal, and the Provider Training catalog in SkillPort on the NCTracks secure provider portal.

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

Attention: All Providers**Hospice Payment Reform**

Effective Oct. 29, 2017, the N.C. Department of Health and Human Services (DHHS) will implement hospice payment reform in NCTracks based on guidance from the Centers for Medicare & Medicaid Services (CMS). The reform consists of Service Intensity Add-on (SIA) payments for hospice social worker and registered nurse visits provided during the last seven days of life, when provided during routine home care.

Payment reform also includes the implementation of two routine home care rates. Based on paid claim history, a higher rate will be paid in the first 60 days of a hospice election and a lower rate for days 61 and later. This two-tiered rate calculation is effective for dates of service on and after Jan. 1, 2016. This was first announced in the [January 2016 Medicaid Special Bulletin](#), titled *CBSA Codes and Hospice Payment Reform*.

- A. Specific payment rules apply for patients discharged from hospice within the first 60 days and later readmitted.

Note: The two-tier pricing and discharge rules are recipient specific. Change in hospice provider does not impact pricing.

- B. Claims that are billed out of sequence and are determined to have overpaid based on subsequent claim receipts for prior dates of service may be voided. Providers will be responsible for resubmission.

- C. Among the changes associated with hospice payment reform, and directly related to the SIA payment, is the discontinuation of bill status code 20 to denote the death of a hospice patient. Per Medicare guidelines, hospice claims must bill using a hospice-specific patient status code when the patient has died. Effective Oct. 29, 2017, valid discharge codes denoting death of the patient for hospice claims are:

- 40 - Expired at home
- 41 - Expired at medical facility
- 42 - Expired place unknown

Important: The seven-day service intensity add-on must be billed on the same claim that is denoting the patient expiration status code.

These changes are specific to Medicaid primary claims. For additional information, including links to the hospice fee schedule and clinical coverage policy, refer to the [hospice services page](#) on the N.C. Division of Medical Assistance website. There will also be a new Hospice Job Aid in SkillPort on the secure NCTracks provider portal. An announcement will be posted on the [Provider Training page](#) of the NCTracks provider portal when the Job Aid is available.

Hospice claims paid with a date of service on or after Jan. 1, 2016, and processed before Oct. 29, 2017, will be reprocessed later. An additional provider communication will be published in the Medicaid Bulletin and as an NCTracks Announcement when the hospice claims affected by this update are scheduled to be reprocessed.

CSRA, 1-800-688-6696

Attention: All Providers**NCTracks Provider Training Available in November 2017**

Registration is open for several instructor-led training courses for providers that will be held in Nov. 2017. The duration varies depending on the course. **WebEx** courses are limited to 115 participants. They can be attended remotely from any location with a telephone, computer and internet connection. **On-site** courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. Following are details on the courses, including dates, times and how to enroll.

Out of State (OOS) Provider Enrollment (WebEx)

- Thursday, Nov. 2 – 10 a.m. to 11:30 a.m.

This course will guide the user through the process of submitting an Out of State (OOS) full and lite provider enrollment application. Upon completion of this course the user will be able to:

- Understand the differences between OOS full and OOS lite provider enrollment
- Submit an OOS lite enrollment application
- Convert from an OOS lite provider to an OOS full provider with a Manage Change Request (MCR).

Ordering, Prescribing and Referring (OPR) Provider Enrollment (Webex)

- Thursday, Nov. 2 - 1 p.m. to 2:30 p.m.

This course will guide the user through the process of submitting an Ordering, Prescribing and Referring (OPR) provider full and lite enrollment applications. At the end of the course the user will be able to:

- Understand the differences between a full provider enrollment and an OPR lite provider enrollment.
- Submit an OPR Lite Application
- Upgrade from an OPR lite provider to a fully enrolled provider via Manage Change Request (MCR).

Prior Approval - Medical (Professional) (On-site)

- Wednesday, Nov. 15 - 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA request.

Submitting a Professional Claim (On-Site)

- Wednesday, Nov. 15 – 1 p.m. to 4 p.m.

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

- Enter a professional claim
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim, and,
- View the results of a claim submission.

Create and Submit a PA for Durable Medicaid Equipment and Home Health Supplies Using Electronic Signature (WebEx)

- Tuesday, Nov. 14 – 10 a.m. to noon

The e-signature process allows requesting providers to answer all questions related to the recipient's medical status when they enter PA requests on the Provider Portal. The PA requests will then be sent to the prescribing providers for review, and the providing providers will sign an attestation statement saying they agree with the information entered by the requesting providers.

At the end of training, the participant will be able to:

- Assign a user role to a provider
- Assign a Durable Medical Equipment (DME) PA request to the prescribing provider
- Assign a home health supply PA request to the prescribing provider
- Access the notification of the PA request within NCTracks Provider Portal Message Center
- Accept a PA request and confirm with an electronic signature
- Reject a PA request and send back to the requesting provider
- Revise a PA request and re-assign to the prescribing provider

Submitting Pharmacy Prior Approvals (WebEx)

- Tuesday, Nov. 14 - 1 p.m. to 2:30 p.m.
- Tuesday, Nov. 28 - 1 p.m. to 3 p.m.

This course will show participants how to submit and inquire about pharmacy PA requests on the NCTracks Provider Portal. It will also cover PA inquiry to check on the status of the pharmacy PA request.

Submitting Institutional Prior Approvals (On-site)

- Thursday, November 16 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) Requests with a focus on nursing facilities, to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It will also cover PA inquiry to check on the status of a PA Request.

Submitting Institutional Claims (On-site)

- Thursday, Nov. 16 – 1 p.m. to 4 p.m.

This course will focus on how to submit an institutional claim via the NCTracks Provider Portal with emphasis on long term care and secondary claims. At the end of training, providers will be able to:

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

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

Refer to the [Provider Training page](#) of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

CSRA, 1-800-688-6696

Attention: All Providers**Hysterectomy Claim Submission**

Since July 1, 2013, some hysterectomy claims billed without a diagnosis that supports medical necessity have processed in error. The claims have not processed through hysterectomy edits, as they did prior to July 1, 2013. Providers are encouraged to review Clinical Policy 1E-1, *Hysterectomy*, for specific diagnosis that validate medical necessity for a hysterectomy procedure.

All provider types submitting claims for reimbursement, including any associated services following a hysterectomy procedure, **will be denied or recouped** if a diagnosis that supports medical necessity is not submitted on the hysterectomy claim.

A provider notification will be posted when claim reprocessing is required.

For more information, providers should refer to the Clinical Coverage Policy 1E-1, *Hysterectomy*, on [DMA's Obstetrics and Gynecology Clinical Coverage Policy web page](#).

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or

NCTracksprovider@nctracks.com.

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**Clinical Coverage Policies**

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the Division of Medical Assistance [Clinical Coverage Policies web pages](#).

- 1A-13, Ocular Photodynamic Therapy – Nov. 7, 2017
- 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) – Nov. 1, 2107
- 1B-3, Intravenous Iron Therapy – Nov. 1, 2017
- 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring – Nov. 1, 2017
- 1T-2, Special Ophthalmological Services – Nov. 1, 2107
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – Nov. 1, 2017
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – Nov. 1, 2017

These policies supersede previously published policies and procedures.

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**N.C. Medicaid Electronic Health Record (EHR) Incentive Program
Announcement****Program Reminders**

There are only six months left to submit an attestation for Program Year 2017.

Providers will have until April 30, 2018, to submit a complete and accurate attestation for Program Year 2017. **After that no changes can be made.** Providers are encouraged to attest as soon as possible to give time to address any problems and discrepancies.

Providers need six years of successful participation to earn the full incentive payment of \$63,750. This means providers who started participating in the N.C. Medicaid EHR Incentive Program in Program Year 2016 must successfully attest each remaining year of the program, through Program Year 2021, to receive the full incentive payment.

As a reminder, if providers were paid for Program Year 2016 using a patient volume reporting period from calendar year 2016, they may use the same patient volume reporting period when attesting in Program Year 2017.

In Program Year 2017, providers have the option to attest to Modified Stage 2 Meaningful Use (MU) or Stage 3 MU. For objective and measure requirements, providers should refer to the CMS Specification Sheets below.

- [Click here](#) for CMS' Modified Stage 2 MU Specification Sheets.
- [Click here](#) for CMS' Stage 3 MU Specification Sheets.

The attestation guides are updated each year, so providers must use the updated attestation guide every year they attest. The attestation guides may be found on the right-hand side of the N.C. Medicaid EHR Incentive Payment System ([NC-MIPS](#)). To see the current Modified Stage 2 MU Attestation Guide, [click here](#). To see the current Stage 3 MU Attestation Guide, [click here](#).

NOTE: Clinical Quality Measures (CQM) have been updated in Program Year 2017. Providers will now select six CQMs from a list of 53. To see the Program Year 2017 CQMs, visit the [Electronic Clinical Quality Improvement Resource Center \(eCQI\) website](#).

For more information, visit the [N.C. Medicaid EHR Incentive Program web page](#).

Updates for Program Year 2018

On Aug. 14, 2017, the Centers for Medicare and Medicaid Services (CMS) issued the [Inpatient Prospective Payment System \(IPPS\) Final Rule](#). The release of this final rule has made the following impacts to the N.C. Medicaid EHR Incentive Program for program year 2018:

- Stage 3 Meaningful Use (MU) is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU
- Providers may choose to use a 2014 Edition Certified EHR Technology (CEHRT), 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT;
- Providers will now be selecting six CQMs from a list of 53 (applicable in Program Year 2017); and,
- Providers will be able to continue using a 90-day MU reporting period.

Visit the [N.C. Medicaid EHR Incentive Program website](#) for additional updates as they become available.

N.C. Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers**P**rogram Integrity Prepayment Claims Review

The Office of Compliance and Program Integrity (OCPI) is charged with compliance, efficiency, and accountability within the N.C. Medicaid program. OCPI performs detection and prevention activities to mitigate fraud, waste and program abuse, and ensure Medicaid dollars are paid appropriately. It accomplishes this by identifying avenues for cost avoidance, educating providers, identifying underpayments and overpayments, and pursuing recoupments.

In accordance with [N.C.G.S § 108C-7](#), [10A NCAC 22F.0104\(c\)](#) and Title 42 of the Code of Federal Regulations Parts [455](#), [456](#) and [457](#), N.C. Division of Medical Assistance (DMA) is authorized to conduct prepayment review of claims. Pursuant to § 108C-7(b) and federal regulation, providers are **not** entitled to payment prior to claims review by the N.C. Department of Health and Human Services (DHHS). A provider may be required to undergo prepayment claims review by the DHHS to ensure that claims presented by a provider meet the requirements of federal and state rules and regulations, and include medical necessity criteria.

In accordance with § 108C-7(f) a provider may not appeal or otherwise contest a decision of the DHHS to place or maintain a provider on prepayment review. The Carolinas Center for Medical Excellence (CCME), is a vendor authorized by the DMA Program Integrity Unit to conduct Prepayment Claims Review.

A provider may be placed on prepayment claims review where there is:

- Credible allegations of fraud
- Identification of aberrant billing practices found through investigation or data analysis
- Failure of the provider to make a timely response to a request for documentation made by DHHS or one of its authorized representatives
- Other grounds as defined by DHHS in rule.

All claims which are subject to prepayment claims review will remain subject to the prepayment claims review process until the provider achieves and maintains a claims submission accuracy rate of 70 percent for three consecutive calendar months. This is the case only if the number of claims submitted per month is no less than fifty percent of the provider's average monthly submission of claims for the three-month period before being placed on prepayment claims review.

DMA Program Integrity will calculate a provider's pre-audit monthly average claim detail line items for the claim types that are subject to prepayment claims review. The monthly average claim detail is based on the billing threshold as established by the provider's prior claims submission. Providers shall not withhold claims to avoid the prepayment claims review process. If a provider does not meet this standard within six months of being placed on prepayment claims review, DMA may implement sanctions, including removal of the provider from the N.C. Medicaid program.

CCME, on behalf of DMA Program Integrity, will notify the provider in writing of placement on prepayment claims review. Upon receipt of written notification, DMA Program Integrity recommends the provider

immediately contact CCME to review the audit requirements. Contact information will be provided on the notification letter.

CCME will work closely with the provider, DMA, and DMA's fiscal agent throughout the claims submission and review process. CCME will advise the provider where and how to submit its claims for review, and will address provider questions regarding the prepayment claims review process.

Claims are reviewed by CCME to determine if they meet federal and state rules and regulations, DHHS documentation requirements, and applicable criteria set forth in the following:

- Clinical Coverage Policy
- Medicaid Bulletins, and,
- Implementation updates as required by the provider's Medicaid Provider Participation Agreement.

CCME uses audit tools developed by DMA.

Note: CCME review and approval of dates of service on a provider's claims does not guarantee payment by the fiscal agent. There may be other reasons a claim is denied by the fiscal agent. The providers' Remittance Advice (RA) provides information regarding both approvals and denials of claims.

**Office of Compliance and Program Integrity
DMA, 919-814-8000**

Attention: All Providers**Abbreviated Application for Ordering, Prescribing and Referring Practitioners
-Update**

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished **with updates** to address the enrollment of residents and interns.

Effective Oct. 29, 2017, an abbreviated enrollment application will be available for **ordering, prescribing and referring (OPR)** practitioners. As required by [42 CFR 455.410](#), physician and non-physician practitioners who solely order, refer, or prescribe items for N.C. Medicaid or N.C. Health Choice (NCHC) beneficiaries **must** enroll in the Medicaid program.

Physician and non-physician practitioners may elect to enroll as OPR-only providers (OPR lite). Billing providers will use the National Provider Identifier (NPI) of the OPR lite provider on their claims when OPR providers order or refer items or services. NCTracks will **not** reimburse OPR lite providers when their NPI is used as “rendering” or “attending” on a claim.

Starting Nov. 1, 2017, residents and interns licensed through the N.C. Medical Board with a resident in training license (RTL) will also be able to enroll as OPR lite providers via the abbreviated application. These practitioners will use the taxonomy 390200000X, Student Health Care, when enrolling as an OPR lite provider.

The services of residents or interns are **not** billable to Medicaid in the teaching setting. Therefore, residents and interns who order services, prescribe medications or services, or make referrals **must** provide their NPI (if appropriate) or their supervising physician’s NPI to the provider submitting claims for service reimbursement. The supervising physician may bill for the services they personally provided during the patient encounter.

Note: On Jan. 31, 2018, the use of the NPI exemption list for residents and interns will cease. The exemption from the provider enrollment requirement **does not** include an exemption from the U.S. Drug Enforcement Administration (DEA) registration required for controlled substances.

The following enrollment requirements will apply to OPR lite providers:

- \$100 application fee
- Credentialing and Background Checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- Revalidate every five years
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they are to be reimbursed for claims.

Training on the new abbreviated application enrollment process will be conducted during the months of October and November.

Note: OPR lite providers may request a retroactive effective date up to 365 days preceding the date of application.

Provider Services
DMA, 919-855-4050

Attention: All Providers**C**laims Pended for Incorrect Billing Location – Update Change in Edit Disposition

Note: This article was previously published in the [September 2017 Medicaid Bulletin](#). It is being republished with updates.

Effective Oct. 29, 2017, the N.C. Department of Health and Human Services (DHHS) will validate through NCTracks that the billing provider's address submitted on the claim corresponds to the location listed on the provider record for the dates of service submitted. The billing provider address, city, state, and zip code (first 5 digits) on all N.C. Medicaid and N.C. Health Choice claims must match exactly with the corresponding information on the provider record. (The match is not case sensitive.)

Note: It was previously announced the claim would pend for 60 days. The edit will be implemented with a "pay and report" status. Providers will receive an informational Explanation of Benefits (EOB) 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE.

NCTracks will use the address submitted on the claim (Loop 2010AA / block 33) to match to a service location address on the provider's record. If NCTracks cannot match the billing provider's address to an active service location in the NCTracks provider's file, the provider will receive on the paper Remittance Advice (RA) the informational EOB code 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE. This EOB indicates that the provider should add or correct the billing provider address on the provider's record in NCTracks or correct the address submitted on the claim.

The edit disposition of pay and report is temporary. Announcement to providers will be made when the edit disposition will change to pend. Claims pended with EOB 04529 will automatically recycle daily, so if the provider adds the correct address to the provider record, the claim will resume processing. If the provider does not add the correct address to the provider record within 60 days, the claim will be denied.

Provider records can be updated with a new billing provider address by submitting a Manage Change Request (MCR) in the secure NCTracks provider portal. Alternatively, providers can correct the billing provider's address on the claim so it matches a service location on the billing provider's record.

Note: MCRs may be subject to credentialing and verification. For guidance on submitting an MCR, refer to the User Guide, *How to Change the Physical Address in NCTracks*, in SkillPort.

Claims with dates of service prior to Oct. 29, 2017, will not be subjected to the edit. Pharmacy and crossover claims also will be excluded from the edit. Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers**Fingerprinting Process for Providers**

Note: This article was originally published in the [October 2017 Medicaid Bulletin](#).

‘High risk’ individual providers and provider organizations, as outlined in [NC General Statute 108C-3g](#), and individual owners with 5 percent or more direct or indirect ownership interest in a “high risk” organization are required to submit fingerprints to the N.C. Medicaid program.

The provider’s Office Administrator (OA) will receive two notifications through the NCTracks provider portal, Provider Message Center Inbox, for each person required to submit fingerprints. One notification will be a letter with instructions and the other will be a Fingerprint Submission Release of Information Form. The OA also will receive an email for each party required to submit fingerprints. The email will have the Fingerprint Submission Release of Information Form attached.

The Fingerprint Submission Release of Information form should be printed and completed by the provider prior to taking it to any one of the [LiveScan locations](#). There is also a section on this form that **must be signed by the Official taking the fingerprints**.

Once the provider is fingerprinted and the Fingerprint Submission Release of Information form is signed at the LiveScan location, the OA will electronically upload the form to the provider’s record in NCTracks by using the following steps:

1. From the Submitted Applications section of the Status and Management page, the OA will see that any NPI that has a status of “In Review” will also have a hyperlink to Upload Documents.
2. Select the Upload Documents link. Once the link is selected, the OA will be able to browse for and attach the form.
3. Select the Upload Documents link found under the Fingerprint Evidence Documents section.

At this point the process is complete, and the provider will be able to go to the Status and Management page for an updated application status.

Note: Individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken. It is recommended that you contact the agency to confirm the fee prior to going.

If the applicant opts to do a Fingerprinting card, rather than a live scan, they must mail the fingerprint card to the SBI for processing at NCSBI/Applicant Unit 3320 Garner Road Raleigh, NC 27626. The Electronic Submission Release of information form is still required to be uploaded to NCTracks.

Note: The Fingerprinting card should not be mailed to the address on the form. Mailing these documents will delay the application processing and could result in a for cause denial or termination.

More information on the Fingerprinting Application Process can be found in the [NCTracks Fingerprinting Application Required Job Aid](#). This link also provides additional resources and information including answers to Frequently Asked Questions (FAQs) and locations for fingerprinting services. Providers can also refer to the Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks article in the [August 2017 Medicaid Bulletin](#).

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

Provider Services
DMA, 919-855-4050

Attention: All Providers**M**edicaid Required Enrollment Fees

Note: This article was originally published in the [September 2017 Medicaid Bulletin](#). It is being republished with **updates** until November 2017.

The N.C. Medicaid and N.C. Health Choice (NCHC) application fee is \$100, which covers costs associated with processing enrollment applications. The \$100 application fee is required for both in-state and border-area (within 40 miles) providers during initial enrollment and when providers complete the five-year re-verification process.

If an out of state provider chooses to enroll using the full-enrollment application, the \$100 fee will apply. Out of state providers using the lite-enrollment application have the option to change from lite to full enrollment by submitting a Manage Change Request (MCR). In that case, they also will also be required to pay the \$100 application fee.

If the application is abandoned, withdrawn, or denied, the provider will be required to pay the application fee a second time upon re-submission of the application.

In addition, some providers are required to pay the Affordable Care Act (ACA) application fee. These providers are defined in federal regulation at [42 CFR 455.460](#), and in [N.C. General Statute 108C-3 \(e\) and \(g\)](#) as moderate- or high-risk. The ACA application fee is \$560 for calendar year 2017, and may be adjusted by the Centers for Medicare and Medicaid Services (CMS) annually. This fee covers the costs associated with provider screening during the enrollment process. The application fee will be collected during initial enrollment, adding a new site location, re-enrollment, and five-year re-verification.

Currently the fee collection is a manual process for NCTracks internally. On Jan. 28, 2018, system modifications in NCTracks will be made to automate the fee collection for a more efficient processing time for enrollment, re-enrollment, MCR and re-verification applications. Because of the changes, all enrollment, re-enrollment, MCR and re-verification applications currently in “saved draft” status will be deleted on Jan. 28, 2018. To prevent these applications from being deleted, the draft must be completed. Applications created on or after Jan. 29th can once again be saved to draft.

Providers are encouraged to review the Status and Management page on the secure NCTracks Provider Portal for applications that have been initiated by the Enrollment Specialist (ES) or Office Administrator (OA), but not completed. When there is a saved draft application provider’s will see “N/A” under the “Select” column of the Records Results. For more information on enrollment fees, refer to in the [September 2017 Medicaid Bulletin](#) article, “*Medicaid Required Enrollment Fees.*”

Provider Services
DMA, 919-855-4050

Attention: All Providers**Maintain Eligibility Process**

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished until November 2017.

Effective Oct. 29, 2017, NCTracks will implement a quarterly Maintain Eligibility Process which identifies providers with no claim activity within the past 12 months. NCTracks will notify the provider via the secure provider portal mailbox. The provider must attest electronically to remain active.

When a provider is identified with having no claims activity in 12 months, a Maintain Eligibility Due Date will be set. Providers will be notified 30 days before the due date that they must submit a Maintain Eligibility Application. Upon submission of the Maintain Eligibility Application, the provider's enrollment record will be updated with the current date.

If the provider does not submit the application by the due date, the provider's participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs **will be end dated**. This will prevent fraud, waste and abuse in the N.C. Medicaid and NCHC programs.

Provider Services
DMA, 919-855-4050

Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2017**

Note: This article is being republished monthly. It was originally published in the [December 2016 Medicaid Bulletin](#).

List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2017 is available on the [provider enrollment page](#) of the N.C. Medicaid website under the “Re-credentialing” header. Providers can use this resource to determine their re-credentialing/re-validation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

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

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

- In Review
- Returned
- Approved
- Payment Pending

Providers are required to complete the re-credentialing application after the full MCR is completed. Payment will be suspended if the provider does not complete the process by the due date. To lift payment suspension, the provider must submit a re-credentialing application or the full MCR (if required).

When the provider does not submit a reverification application by the reverification due date and the provider has an MCR application in which the status is “In Review, Returned, Approved or Payment Pending,” the provider’s due date resets to the current date plus 45 calendar days.

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

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

Providers with questions about the re-credentialing process can contact the NCTracks Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Out of State Provider Enrollment

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished until November 2017.

Effective Oct. 29, 2017, Out of State (OOS) providers who are seeking to enroll with N.C. Medicaid or the Children's Health Insurance Program (CHIP) – also known as N.C. Health Choice (NCHC) – will have the option to enroll using a full-enrollment application or a lite-enrollment application.

If an out of state provider chooses to enroll using the lite-enrollment application the following will apply:

- The provider will complete an abbreviated application
- Enrollment is limited to one year
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- There is no application fee for lite-enrollment

If an out of state provider chooses to enroll using the full-enrollment application the following will apply:

- The provider will complete a full-enrollment application
- The provider is required to complete re-verification every five years
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- The provider will be required to pay the \$100 N.C. application fee during enrollment and re-verification

Note: A provider has the option to change from lite enrollment to full enrollment by submitting a Manage Change Request (MCR). The provider will be required to pay the \$100 N.C. application fee.

Provider Services
DMA, 919-855-4050

Attention: All Providers**NC HealthConnex Connection Required for Medicaid Hospitals, Physicians and Mid-Level Practitioners by June 1, 2018**

Per [Session Law \(S.L.\) 2015-241](#), as amended by [S.L. 2017-57](#), North Carolina providers who are reimbursed by the state for providing health care services under Medicaid and N.C. Health Choice programs must join NC HealthConnex, the state-designated Health Information Exchange.

As of June 1, 2018, hospitals, mid-level physicians and nurse practitioners who currently have an electronic health record system are to be connected to NC HealthConnex to continue to receive payments for Medicaid and N.C. Health Choice (NCHC) services. **By June 1, 2019**, all other Medicaid and state funded providers must be connected (e.g., state health Plan, Program for All Inclusive Care of the Elderly (PACE), and state grants).

The NC Health Information Exchange Authority (HIEA), the N.C. Department of Information Technology agency that manages NC HealthConnex, will be hosting “How to Connect” webinars on the last Monday of each month at noon to educate providers affected by this law, describe the technical and onboarding requirements and answer questions about the legal [Participation Agreement](#) which governs the data connection. In the meantime, providers can learn more at nchealthconnex.gov/how-connect.

To register for the next webinar at noon on Monday, Nov. 26, 2017, and to learn more about **NC HealthConnex**, visit nchealthconnex.gov.

NC HealthConnex links disparate systems and existing North Carolina HIE networks together to deliver a holistic view of a patient’s record. It currently houses 3.9 million unique patient records, allowing providers to access their patients’ comprehensive records across multiple providers, and review consolidated lists of items including labs, diagnoses, allergies and medications.

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

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

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

Effective **Nov. 1, 2017**, the N.C. Division of Medical Assistance (DMA) will implement approved changes to the [N.C. Medicaid and N.C. Health Choice Preferred Drug List \(PDL\)](#).

Below are a few highlights of the changes:

Opioid Analgesics

- This class name was updated from “Narcotic Analgesics” to “Opioid Analgesics”
- Opana ER will be removed from the PDL as it has been discontinued from the market

Anti-Infective-Systemic (Antibiotics - Inhaled)

- A new PDL drug class has been added. It is “Anti-Infective-Systemic (Antibiotics- Inhaled).” This class requires a trial and failure of only one preferred drug

Antiviral (Hepatitis C Agents)

- Mayvret (for 8 weeks of therapy) will be preferred for all genotypes without cirrhosis
- Mayvret (for 12 weeks of therapy) will be preferred for all genotypes with compensated cirrhosis (Child Pugh A)
- Epclusa Tablet (in combination with ribavirin) will be preferred for all genotypes with decompensated cirrhosis (Child Pugh B and C)
- Vosevi will be preferred for all genotypes previously treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor
- Harvoni Tablet will remain preferred until April 30, 2018, only for beneficiaries who start Harvoni therapy prior to Nov. 1, 2017, to allow for completion of the therapy

Behavioral Health (Antihyperkinesia/ADHD)

- Metadate CD capsules have been removed from the PDL as they are discontinued
- Clonidine ER tablet (generic for Kapvay), Desoxyn Tablet (methamphetamine HCl), dextroamphetamine ER capsule (generic for Dexedrine Spansules), all methylphenidate ER tablets, Ritalin LA Capsule (methylphenidate 20 mg, 30 mg, 40 mg, 60 mg) will move from preferred to non-preferred
- Quillichew ER Oral (methylphenidate), Vyvanse Chewable Tablets and Aptenzio XR will move from non-preferred to preferred

Cardiovascular (ACE Inhibitors)

- Qbrelis Solution (Lisinopril) will be non-preferred, with an age exemption allowed for children less than 12 years of age

Endocrinology (Growth Hormone)

- Nutropin AQ Pen / Nuspin (somatropin) will move from preferred to non-preferred status
- Genotropin Cartridge / Miniquick (somatropin) will move from non-preferred to preferred status

Endocrinology (Hypoglycemics – Injectable)

- Humalog Kwikpen will move from preferred to non-preferred status (Rapid Acting Insulin)
- Humulin R-U500 Kwikpen will be added as a new non-preferred drug (Short Acting Insulin)
- Humulin N Pen will move from preferred to non-preferred status (Intermediate Acting Insulin)
- Basaglar Kwikpen (insulin glargine) will be added as a new non-preferred drug (Long Acting Insulin)
- Humulin 70/30 Pen will move from preferred to non-preferred status (Combination Insulin)

Endocrinology (Hypoglycemics – Oral- Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor and Combinations)

- Farxiga Tablet (dapagliflozin) and Jardiance Tablet (empagliflozin) will move from non-preferred to preferred status.
- Invokana and Invokamet will move from preferred to non-preferred status
- Added Synjardy XR and Invokamet XR tablet as a new non-preferred product

Respiratory (COPD Agents)

- Combivent Respimat Inhalation Spray will move from preferred to non-preferred status.
- Stiolto Respimat Inhalation Spray will move from non-preferred to preferred status

Topicals (Immunomodulators- Atopic Dermatitis)

- Eucrisa 2% Ointment will move from non-preferred to preferred status. Clinical criteria continues to apply.

Topicals (Steroids, Low Potency)

- Desonide cream/ointment (generic for DesOwen) will move from preferred to non-preferred status with an age exemption allowed for children less than 12 years of age.

These changes could affect pharmacy stocking needs, generic substitution, product substitution, and Point of Sale (POS) overrides. If a brand is Preferred with a Non-Preferred generic equivalent, “brand medically necessary” is NOT needed on the face of the prescription. Below is a chart of preferred brands with non-preferred generics.

As a reminder, a 72-hour emergency supply may be provided if a prescription is awaiting prior authorization. A “3” in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill.

**2017-2018 NC Medicaid and Health Choice Preferred Drug List
Preferred Brands with Non-Preferred Generic Alternatives
Effective 11-1-2017 (*bold items are newly preferred*)**

| Preferred Brand | Non-Preferred Generic |
|------------------------------|------------------------------|
| Abilify Discmelt | aripiprazole ODT |
| Actiq Lozenge | fentanyl citrate lozenge |
| Adderall XR | amphetamine Salt Combo ER |
| Aggrenox | aspirin-dipyridamole ER |
| Alphagan P | brimonidine P |
| Androgel | testosterone |
| Avelox | moxifloxacin |
| Bactroban Cream | mupirocin Cream |
| Benzaclin | clindamycin/benzoyl Peroxide |
| Butrans | buprenorphine |
| Catapres-TTS | clonidine patches |
| Cipro Suspension | ciprofloxacin suspension |
| Derma-Smoothe FS | fluocinolone 0.01% oil |
| Differin | adapalene |
| Diovan | valsartan |
| Diastat Accudial/Pedi System | diazepam rectal/system |
| Emend | aprepitant |
| Evista | raloxifene |
| Exelon Patch | rivastigmine patch |
| Exforge | amlodipine / valsartan |
| Exforge-HCT | amlodipine / valsartan / HCT |
| Focalin / Focalin XR | dexmethylphenidate |
| Gabitril | tiagabine |
| Glyset | migliitol |
| Hepsera 10 mg | adefovir |
| Invega ER | paliperidone ER |
| Kapvay | clonidine ER |
| Lovenox | enoxaparin |
| MetroCream | metronidazole cream |
| MetroLotion | metronidazole lotion |
| Metrogel Topical | metronidazole gel topical |
| Methylin Solution | methylphenidate solution |
| Namenda Solution | memantine solution |
| Natroba | spinosad |
| Nexium RX | esomeprazole |
| Nuvigil | armodafinil |
| Orapred ODT | prednisolone ODT |

| Preferred Brand | Non-Preferred Generic |
|------------------------|----------------------------------|
| Oxycontin | oxycodone ER |
| Patanase | olopatadine |
| Provigil | modafinil |
| Pulmicort respules | budesonide respules |
| Renvela powder pkt | sevelamer powder pkt |
| Retin-A Cream/Gel | tretinoin cream/gel |
| Rythmol SR | propafenone SR |
| Seroquel XR | quetiapine |
| Strattera | atomoxetine |
| Suprax Susp | cefixime Susp |
| Symbyax | olanzepine / fluoxetine |
| Tamiflu | oseltamivir |
| Tegretol Tab/ Susp /XR | carbamazepine Tab/ Susp / XR |
| TobraDex Drops | tobramycin / dexamethasone drops |
| Vigamox | moxifloxacin |
| Vivelle-Dot Patch | estradiol patch |
| Voltaren Gel | diclofenac gel |
| Zetia | ezetimibe |

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

The N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

DMA 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:

| | | | |
|-----------|-----------|-----------|-----------|
| 33025 (A) | 33475 (A) | 33697 (A) | 69200 (B) |
|-----------|-----------|-----------|-----------|

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

***Codes marked with a (B) were updated for 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 DMA Clinical Policy becomes aware of them.

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician's Assistants and Physicians**Inotuzumab Ozogamicin Injection, For Intravenous Use (Besponsa) HCPCS Code J9999: Billing Guidelines**

Effective with date of service Aug. 30, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover inotuzumab ozogamicin injection, for intravenous use (Besponsa) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs. Besponsa is available as a single-dose vial containing 0.9 mg lyophilized powder for reconstitution and further dilution.

Besponsa is indicated for the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

Recommended Dose

Dosing Regimen For Cycle 1 (Cycle Length = 21 Days):

- All patients: Dose: 0.8 mg/m² on day 1; 0.5 mg/m² on day 8; 0.5 mg/m² on day 15
- For patients who achieve a Complete Remission (CR) or Complete Remission with Incomplete Marrow Recovery (CRi), and/or to allow for recovery from toxicity, the cycle length may be extended up to 28 days (i.e., 7-day treatment-free interval starting on Day 21)

Dosing Regimen For Subsequent Cycles Depending on Response to Treatment:

- Patients who have achieved a CR or CRi (cycle length = 28 days):
 - Dose = 0.5 mg/m² on day 1; 0.5 mg/m² on day 8; 0.5 mg/m² on day 15
- Patients who have not achieved a CR or CRi (cycle length = 28 days):
 - Dose = 0.8 mg/m² on day 1; 0.5 mg/m² on day 8; 0.5 mg/m² on day 15

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing are:
 - C91.00 - Acute lymphoblastic leukemia not having achieved remission
 - C91.01 - Acute lymphoblastic leukemia, in remission
 - C91.02 - Acute lymphoblastic leukemia, in relapse
- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs.
- One Medicaid unit of coverage is: 1 vial. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is: \$20,196.00 per vial.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is: 00008-0100-01.
- 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 DMA's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC 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 PDP is available on DMA's [PDP web page](#).

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**E**daravone Injection, For Intravenous Use (Radicava) HCPCS Code J3490 -
Unclassified Drugs: Billing Guidelines

Effective with date of service Aug. 15, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover edaravone injection, for intravenous use (Radicava) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. Radicava is available as a single-dose polypropylene bag containing 30 mg edaravone per 100 mL.

It is indicated for the treatment of amyotrophic lateral sclerosis.

Recommended Dose

60 mg administered as an intravenous infusion over 60 minutes as follows:

- Initial treatment cycle: daily dosing for 14 days followed by a 14-day drug-free period
- Subsequent treatment cycles: daily dosing for 10 days out of 14-day periods, followed by 14-day drug-free periods.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is G12.21 Amyotrophic lateral sclerosis.
- Providers must bill with HCPCS code: J3490 - Unclassified drugs.
- One Medicaid unit of coverage is: 1 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is: \$19.55 per 1 mg.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 70510-2171-01, 70510-2171-02.
- 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 DMA's website.
- Providers shall bill their usual and customary charge for non-340B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC 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 PDP is available on DMA's [PDP web page](#).

CSRA, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**D** **Daunorubicin And Cytarabine Liposome Injection, For Intravenous Use (Vyxeos) HCPCS Code J9999 - Not Otherwise Classified, Antineoplastic Drugs: Billing Guidelines**

Effective with date of service Aug. 11, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover daunorubicin and cytarabine liposome injection, for intravenous use (Vyxeos) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 - Not otherwise classified, antineoplastic drugs. It is available as a lyophilized cake supplied in single-dose vials for reconstitution containing 44 mg daunorubicin and 100 mg cytarabine encapsulated in liposomes.

Vyxeos is indicated for the treatment of adults with newly-diagnosed therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC).

Recommended Dose:

- Induction: Vyxeos (daunorubicin 44 mg/m² and cytarabine 100 mg/m²) liposome via intravenous infusion over 90 minutes on days 1, 3 and 5 and on days 1 and 3 for subsequent cycles of induction, if needed.
- Consolidation: Vyxeos (daunorubicin 29 mg/m² and cytarabine 65 mg/m²) liposome via intravenous infusion over 90 minutes on days 1 and 3.

See full prescribing information for detailed induction and consolidation schedule information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing are:
 - C92.00 - Acute myeloblastic leukemia, not having achieved remission
 - C92.01 - Acute myeloblastic leukemia, in remission
 - C92.02 - Acute myeloblastic leukemia, in relapse
 - C92.40 - Acute promyelocytic leukemia, not having achieved remission
 - C92.41 - Acute promyelocytic leukemia, in remission
 - C92.42 - Acute promyelocytic leukemia, in relapse
 - C92.50 – Acute myelomonocytic leukemia, not having achieved remission
 - C92.51 – Acute myelomonocytic leukemia, in remission
 - C92.52 – Acute myelomonocytic leukemia, in relapse
 - C92.60 - Acute myeloid leukemia with 11q23-abnormality not having achieved remission
 - C92.61 – Acute myeloid leukemia with 11q23-abnormality in remission
 - C92.62 - Acute myeloid leukemia with 11q23-abnormality in relapse
 - C92.A0 - Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
 - C92.A1 - Acute myeloid leukemia with multilineage dysplasia, in remission
 - C92.A2 - Acute myeloid leukemia with multilineage dysplasia, in relapse

- C93.00 - Acute monoblastic/monocytic leukemia, not having achieved remission
 - C93.01 – Acute monoblastic/monocytic leukemia, in remission
 - C93.02 - Acute monoblastic/monocytic leukemia, in relapse
 - C94.00 - Acute erythroid leukemia, not having achieved remission
 - C94.01 – Acute erythroid leukemia, in remission
 - C94.02 - Acute erythroid leukemia, in relapse
 - C94.20 - Acute megakaryoblastic leukemia not having achieved remission
 - C94.21 - Acute megakaryoblastic leukemia, in remission
 - C94.22 - Acute megakaryoblastic leukemia, in relapse
- Providers must bill with HCPCS code: J9999 - Not otherwise classified, antineoplastic drugs
 - One Medicaid unit of coverage is: 1 vial. NCHC bills according to Medicaid units
 - The maximum reimbursement rate per unit is: \$8,370.00 per vial
 - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 68727-0745-01, 68727-0745-02, 68727-0745-05
 - 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 DMA's website.
 - Providers shall bill their usual and customary charge for non-340B drugs.
 - PDP reimburses for drugs billed for Medicaid and NCHC 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 PDP is available on DMA's [PDP web page](#).

CSRA, 1-800-688-6696

Proposed Clinical Coverage Policies

Per NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the N.C. Division of Medical Assistance's website. To submit a comment related to a policy, refer to the instructions on the [Proposed Clinical Coverage Policies web page](#). Providers without internet access can submit written comments to:

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

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

As of Nov. 1, 2017, the following policies are open for public comment on the [Proposed Clinical Coverage Policies web page](#):

| Proposed Policy | Date Posted | Comment Period End Date |
|--|-------------|-------------------------|
| 5A-1, Physical Rehabilitation Equipment and Supplies | 10/27/17 | 11/26/17 |
| 5A-2, Respiratory Equipment and Supplies | 10/27/17 | 11/26/17 |
| 5A-3, Nursing Equipment and Supplies | 10/27/17 | 11/26/17 |
| PA Criteria Opioid Dependence Therapy Agents | 10/27/17 | 11/11/17 |
| 1A-4 Cochlear and Auditory Brainstem Implants | 10/25/17 | 11/11/17 |
| PA Criteria Nuplazid | 10/23/17 | 12/09/17 |
| 2B-1, Nursing Facility Services | 10/13/17 | 11/27/17 |
| 11B-4, Kidney (Renal) Transplant | 10/11/17 | 11/25/17 |

Checkwrite Schedule

| Month | Checkwrite Cycle Cutoff Date* | Checkwrite Date | EFT Effective Date |
|----------------------|--------------------------------------|------------------------|---------------------------|
| November 2017 | 11/03/17 | 11/07/17 | 11/08/17 |
| | 11/10/17 | 11/14/17 | 11/15/17 |
| | 11/11/17 | 11/21/17 | 11/22/17 |
| | 11/24/17 | 11/28/17 | 11/29/17 |
| December 2017 | 12/01/17 | 12/05/17 | 12/06/17 |
| | 12/08/17 | 12/12/17 | 12/13/17 |
| | 12/15/17 | 12/19/17 | 12/20/17 |
| | No checkwrite week of Dec. 25 – 29 | | |

* Batch cutoff date is previous day

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