



N.C. Medicaid Bulletin January 2018

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*Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**NCTracks Training Available in January 2018****Provider Training Available in January 2018**

Registration is open for several instructor-led training courses for providers that will be held in January 2018. 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.

Jan. 16, 2018**Prior Approval Institutional (On-site) 9:30 a.m. - 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 inquiries to check on the status of a PA request.

Submitting an Institutional Claim (On-site) 1- 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

Jan. 17, 2018**Prior Approval Medical (On-site) 9:30 a.m. – 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) 1- 4:30 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

Jan. 22, 2018

Provider Web Portal Applications (WebEx) 1- 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal.

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

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal
- Complete processes for provider enrollment, Manage Change Requests (MCR), reenrollment, recertification and maintaining eligibility, and,
- Track and submit applications using the NCTracks Status and Management web page

Jan. 24, 2018

Provider Recredentialing/Reverification 1 - 2:30 p.m. (WebEx)

This course serves as a refresher for the steps taken by the provider to complete the reverification process through NCTracks. It also covers the steps to enter information and submit a Manage Change Request (MCR) in the event the user is prompted to complete an MCR during reverification/recredentialing. (The terms recredentialing and reverification are used interchangeably in NCTracks.)

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

- Explain what provider reverification is and why it is required
- Explain each phase of reverification
- Complete the reverification process in NCTracks
- Complete an MCR for invalid or missing provider data

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

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 N.C. 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 N.C. Medicaid and Health Choice services. **By June 1, 2019**, all other Medicaid and state-funded providers must be connected, including the 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 host “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](#) that 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, Jan. 29, 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 Electronic Health Record Incentive Program Announcement****Program Reminders**

There are only four 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 attestation 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 Electronic Health Record (EHR) Incentive Program in Program Year 2016 must successfully attest each remaining year of the program, through Program Year 2021, to receive their full incentive payment. Even if denied in a previous program year, providers who successfully attested at least once by Program Year 2016 are encouraged to return now and attest to have the opportunity to earn the full incentive payment.

As a reminder, if the provider was 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.

- [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 are encouraged to use the updated attestation guide every year they attest. The attestation guides may be found on the right-hand side of the [NC Medicaid EHR Incentive Payment System \(NC-MIPS\)](#) portal. To see the current Modified Stage 2 MU Attestation Guide, please [click here](#). To see the current Stage 3 MU Attestation Guide, please [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 in Program Year 2018:

- Stage 3 MU is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU;
- Providers may use a 2014 edition Certified EHR Technology (CEHRT), 2015 edition CEHRT, or a combination of 2014 edition and 2015 edition CEHRT;
- Providers will select six CQMs from a list of 53 (applicable in Program Year 2017); and,
- Providers may 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

Kidney (Renal) Transplantation Policy Revision

Clinical Coverage Policy (CCP) 11B-4, *Kidney (Renal) Transplantation*, has been revised. The revisions, which will become effective Feb. 1, 2018, will remove the prior authorization requirement from live donor kidney transplants and reflect coverage based on glomerular filtration rate (GFR) and age, rather than diagnosis.

Practitioners, Facilities and Policy Development
DMA, 919-855-4320

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 DMA's [clinical coverage policy web pages](#):

- 1A-21, *Endovascular Repair of Aortic Aneurysm* – Jan. 1, 2018
- 1A-41, *Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone* – Jan. 1, 2018
- 1H, *Telemedicine and Telepsychiatry* – Jan. 1, 2018
- 1L-2, *Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)* – Jan. 1, 2018
- 5A-1, *Physical Rehabilitation Equipment and Supplies* – Dec. 1, 2017
- 5A-2, *Respiratory Equipment and Supplies* – Dec. 1, 2017
- 5A-3, *Nursing Equipment and Supplies* – Dec. 1, 2017
- 10A, *Outpatient Specialized Therapies* – Dec. 15, 2017

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**P**ostpartum Depression Screening

Appropriate maternal depression screening is necessary to ensure that postpartum depression is addressed and care is administered in a timely manner to improve quality of care and long-term outcomes for both mother and child. Maternal depression screening identifies mothers who may be suffering from depression and may lead to treatment or discussion of referral strategies for appropriate treatment.

Obstetric providers may be reimbursed for three units of CPT code 96127 – brief emotional/behavioral assessment [e.g., depression inventory, attention-deficit hyperactivity disorder (ADHD) scale], with scoring and documentation, per standardized instrument – during the first year after the delivery date or until the recipient’s eligibility ends, in addition to global obstetrics and postpartum package services.

Note: Medicaid for Pregnant Women (MPW) eligibility ends the last date of the month in which the 60th post-delivery day occurs.

Total reimbursable units for the first year after delivery or until the mother’s eligibility ends should be three units. If a problem is identified, the mother should be referred to their primary care provider or other appropriate providers. Providers performing this postpartum depression screening will be required to bill diagnosis Z13.89 (encounter for screening for other disorder) in combination with the CPT code 96127.

For more information, providers should refer to [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

'Be Smart' Family Planning Clarification on Sterilization and Eligibility

Background on Family Planning Medicaid

The provision of family planning services and family planning-related services has been the sole purpose of the "Be Smart" Family Planning Medicaid program since it started in October 2005, and continued with the CMS approval of the State Plan Amendment in 2014.

"Be Smart" Family Planning Medicaid, listed as MAFDN eligibility category in NCTracks, provides limited coverage to eligible beneficiaries. Family Planning Medicaid serves eligible beneficiaries, regardless of age or gender, but covers family planning and family planning related services **only**, as described in [Clinical Policy 1E-7, Family Planning Services](#). Therefore, beneficiaries with MAFDN eligibility are not eligible for any other Medicaid program or categories of service.

Be Smart and Sterilization

Providers have been seeking clarification from N.C. Medicaid about sterilization and eligibility under the "Be Smart" program. The Centers for Medicare and Medicaid Services (CMS) notified N.C. Medicaid that it is **not** acceptable to ask questions related to a beneficiary's sterilization status during the Medicaid application process. Therefore, some beneficiaries will be approved for Family Planning Medicaid who have no need for family planning services.

Though Department of Social Services (DSS) staff cannot ask beneficiaries questions about sterilization status during the application process, providers **must** do so before rendering services. It is imperative that providers determine if Medicaid beneficiaries need family planning services prior to providing any other services under the program (e.g., annual or physical exams). Providers shall **not** bill Medicaid for **any service** rendered under Family Planning Medicaid for a beneficiary who does not have family planning needs. Claims may be subject to audit to ensure proper billing.

Additional information about the "Be Smart" program and eligibility for services is found in the next section.

Guidance for Providers of 'Be Smart' Services

General Medicaid eligibility and Family Planning Medicaid ("Be Smart") are **separate and distinct**. Family Planning Medicaid ("Be Smart") encompasses the need for family planning services (contraceptive or birth control services), because the beneficiary wants to prevent or delay having children. **However, there is no indication on the Medicaid identification card that the beneficiary is eligible for family planning services only.**

The following guidance will prevent providers from rendering family planning services to beneficiaries for which the provider cannot be reimbursed.

1. Providers shall verify each beneficiary's type of coverage prior to each visit. Though DSS workers cannot ask beneficiaries questions about their ability to bear children during the application process, providers **must** do so before rendering services. (Beneficiaries do receive a letter with their card that informs them of the limitations of their coverage.)

2. Eligible beneficiaries are entitled to receive one annual exam each year and six inter-periodic visits per 365 days, thereafter. All services covered under this program must be related to family planning or family planning-related reasons. Providers shall confirm that the beneficiary is seeking family planning services.
3. Providers shall screen and inform beneficiaries that the Family Planning Medicaid program is strictly for family planning services, as indicated in Clinical Policy 1E-7, *Family Planning Services*. Policy states that the beneficiary is no longer eligible to receive services under the program once they have been determined to be permanently sterilized.
4. A beneficiary who is sterilized under this program can receive all related follow up to the surgery, per policy. Once follow up is complete, they should be informed that they are no longer eligible for services under Family Planning Medicaid.
5. If it is discovered during screening that the beneficiary has no need for Family Planning Services (permanently sterilized, post-menopausal, sterile, post-hysterectomy, not capable of having children, etc.), Medicaid shall not be billed for the service. Providers should inform the beneficiary that the visit can continue but that the beneficiary would be responsible for the cost of the services provided on that day. The beneficiary should be informed of the cost of the visit and be told that they can choose to leave at that point and not be charged for the appointment.
6. Comprehensive screening prior to exam should prevent the discovery – during the exam – that the beneficiary does not need family planning services. However, if the discovery does occur during the exam, the provider cannot bill the beneficiary or Medicaid. The provider should inform the beneficiary that future visits will not be covered under Family Planning Medicaid because they are not eligible for family planning services. The beneficiary will be responsible for payment of any future services. If the provider is seeking payment from the beneficiary, the provider shall inform the beneficiary prior to rendering the service (see [10A NCAC 22J. 0106](#)). The provider shall not bill Medicaid for family planning visits, when the beneficiary has no need for family planning services.
7. Available options for the beneficiary may include:
 - The beneficiary may contact the Department of Social Services to determine whether they are eligible for another Medicaid program.
 - The beneficiary can request services for which they would be asked for payment, in whatever manner the provider usually seeks private payment (sliding scale, payment plan, etc.).

Clinical Policy and Programs
DMA, 919-855-4260

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

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 reverification process.

If an out-of-state provider chooses to enroll using the full-enrollment application, the \$100 fee will apply. Out-of-state (OOS) 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 resubmission 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 \$569 for calendar year 2018, 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, reenrollment, and five-year reverification.

Currently, the fee collection is a manual process for CSRA. On Jan. 28, 2018, system modifications in NCTracks will be made to automate the fee collection for a more efficient processing time for enrollment, reenrollment, MCR and reverification applications. Because of the changes, all enrollment, reenrollment, MCR and reverification applications currently in “saved draft” status will be deleted on Jan. 28, 2018. To prevent these applications from being deleted, the draft must be submitted. Applications created on or after Jan. 29, 2018, 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 providers will see “N/A” under the “Select” column of the Records Results.

APPLICATION TYPE	NC FEE \$100	ACA FEE (currently \$569)	ACA SITE VISIT	ACA TRAINING
Enrollment	Always required when provider applied for Medicaid and/or NCHC Exclusion: OOS Lite	ACA fee is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	ACA site visit is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Always required when provider applied for Medicaid and/or NCHC
Reenrollment	Never required	ACA fee is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	ACA site visit is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Never required
Manage Change Request	Only required when an OOS lite provider upgrades to OOS full provider	ACA fee is required per newly added/reinstated location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	ACA site visit is required per newly added/reinstated location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid/NCHC plans only	Never required
Reverification	Always required when provider is active in Medicaid and/or NCHC	ACA fee is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are active. Note: Medicaid/NCHC plans only	ACA site visit is required per location when one or more ACA taxonomy codes (as identified on the Permission Matrix) are active. Note: Medicaid/NCHC plans only	Never required
Abbreviated MCR	Never required	Never required	Never required	Never required
Change Office Administrator	Never required	Never required	Never required	Never required
Maintain Eligibility	Never required	Never required	Never required	Never required
Fingerprinting	Never required	Never required	Never required	Never required

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

Attention: All Providers**A**ffordable Care Act Fee Increase for Provider Enrollment

The Centers for Medicare & Medicaid Services (CMS) announced an increase in the Affordable Care Act (ACA) provider enrollment application fee. The application fee has increased to \$569 for calendar year (CY) 2018 for applications received starting on Jan. 1, through Dec. 31, 2018.

The fee is required for **any institutional providers** who are newly enrolling in Medicaid or N.C. Health Choice, re-enrolling, re-credentialing or adding a new practice location. It does not apply to individual physicians or non-physician practitioners.

After the submission of the enrollment application, an invoice of the fee will occur. Providers are requested to wait for their invoice before submitting payment. The Federal Register published the fee notice on [Dec. 4, 2017](#). For additional information about the application fee, visit the [ACA Application Fee FAQ web page](#) on the NCTracks Provider Portal.

Provider Services
DMA, 919-855-4050

Attention: All Providers**M**aintain Eligibility Process

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

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 in NCTracks 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

CPT Code Update: 2018

The American Medical Association (AMA) publishes an annual *Current Procedural Terminology (CPT)* manual each fall outlining new, revised, and deleted procedural codes effective January 1 of the following calendar year. (For complete information regarding all code and description changes, refer to the 2018 edition of *Current Procedural Terminology*.) N.C. Medicaid reviews these codes changes to determine clinical coverage for the Medicaid program.

The state and CSRA are in the process of completing NCTracks system updates to align our policies with CPT code changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that claims billed with the new codes will process and pay correctly.

Until this process is completed, claims submitted with new codes will pend for “no fee on file.” These pending claims will recycle and pay when the system work is completed. No additional action will be required by providers to ensure that claims process and pay correctly after the system work is completed. This process will also be applicable to the Medicare crossover claims.

To maintain cash flow, providers may wish to split claims and bill new codes on a separate claim. This will ensure that only claims billed with the new procedure codes are pending for processing.

New CPT codes that are covered by N.C. Medicaid are effective with date of service Jan. 1, 2018. Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2018. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

Providers should note the full descriptions as well as all associated parenthetical information published in this edition when selecting a code for billing services to N.C. Medicaid.

New CPT Codes Covered by N.C. Medicaid (effective Jan. 1, 2018)									
00731	00732	00811	00812	00813	15730	15733	19294	20939	31241
31253	31257	31259	31298	34701	34702	34703	34704	34705	34706
34707	34708	34709	34710	34711	34712	34713	34714	34715	34716
36465	36466	38222	38573	43286	43287	43288	55874	58575	71045
71046	71047	71048	74018	74019	74021	86008	86794	87634	87662
94617	94618	96573	97763						

New HCPCS Codes Covered by N.C. Medicaid (effective Jan. 1, 2018)									
D5511	D5512	D5611	D5612	D5621	D5622	D9222	D9239	J0565	J1555
J1627	J1726	J1729	J3358	J7210	J7211	J7296	J9022	J9023	J9203
J9285	D7979	D9995							

New CPT Codes Not Covered by N.C. Medicaid									
32994	33927	33928	33929	36482	36483	64912	64913	81105	81106
81107	81108	81109	81110	81111	81112	81120	81121	81175	81176
81230	81231	81232	81238	81247	81248	81249	81258	81259	81269
81283	81238	81334	81335	81346	81361	81362	81363	81364	81448
81520	81521	81541	81551	0001U	0002U	0003U	0004U	0005U	0006U
0007U	0008U	0009U	0010U	0011U	0012U	0013U	0014U	0015U	0016U
0017U	90587	90756	93792	93793	95249	96574	97127	99483	99484
99492	99493	99494	90682	90750					

End-Dated CPT Codes (effective Dec. 31, 2017)									
00740	00810	01180	01190	01682	15732	29582	29583	31320	34800
34802	34803	34804	34805	34806	34825	34826	34900	36120	36515
55450	69820	69840	71010	71015	71020	71021	71022	71023	71030
71034	71035	74000	74010	74020	75658	75952	75953	75954	78190
83499	84061	86185	86243	86378	86729	86822	87277	87470	87477
87515	88154	94620	97762						

End-Dated HCPCS Codes (effective Dec. 31, 2017)									
D5510	D5610	D5620	G0202	G0204	G0206	J1725	J9300	Q9984	Q9985
Q9986	Q9989								

Note: Category II and III Codes are not covered.

A bulletin article will be released listing the new codes that will be separately reimbursable by Ambulatory Surgery Centers (ASC) when that information is released by the Centers for Medicare & Medicaid Services (CMS) in January 2018.

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

Attention: All Providers**New Coverage, Implementing Balloon Sinus Ostial Dilation**

Effective Feb. 1, 2018, N.C. Medicaid will cover balloon sinus ostial dilatation (BOD) surgery. The BOD policy will outline the new coverage of the following CPT procedure codes:

- CPT 31295 – Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium e.g. Balloon dilation, transnasal or via canine fossa)
- CPT 31296 – Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium), and,
- CPT 31297 – Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium).

N.C. Medicaid will cover each procedure once per sinus during the beneficiary's lifetime. Prior approval for these procedures is required.

Providers will indicate whether the service is being performed unilaterally or bilaterally using modifier -LT (left), -RT (right), or -50 (bilateral). These procedures will be covered in:

- Inpatient hospitals,
- Outpatient hospitals,
- ambulatory surgical center, and,
- Office settings

For more information, providers should refer to policy 1A-42, *Balloon Ostial Dilation*, which will be posted Feb. 1, 2018.

Clinical Policy and Programs
DMA, 919-855-4260

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 (837 D, P, and I - Loop 2010AA / ADA Dental – box 48, CMS-1500 block 33 and UB04 – Form Locator 1) 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, and then refile the claim

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](#). This is the final Medicaid Bulletin publication.

‘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 for fingerprinting services](#). 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 fingerprinting 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**Re-credentialing Due Dates for Calendar Year 2018**

Note: This article is being republished monthly. It was originally published in the December 2017 Medicaid Bulletin with revisions.

List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in the first quarter (January through April) of 2018 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.

Note: The terms re-credentialing and re-validation are synonymous.

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/re-verification. If the provider does not complete the process within the allotted 45 days, payment will be suspended until the process is completed. If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, participation in the N.C. Medicaid and Health Choice programs will be terminated. Providers must submit a re-enrollment application to be reinstated.

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. When it is necessary to submit a full Managed Change Request (MCR), the provider must submit the full MCR prior to the 45th day and the 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 re-verification application by the re-verification 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: Dental Providers**New American Dental Association Procedure Codes**

Effective with date of service Jan. 1, 2018, the following dental procedure codes were added for the N.C. Medicaid and Health Choice Dental Programs. These additions are a result of updates to the *Current Dental Terminology (CDT) 2018 American Dental Association (ADA) Code*. Clinical Coverage Policy 4A, *Dental Services*, will be updated to reflect these changes.

CDT 2018 Code	Description and Limitations	PA Indicator
D5511	Repair broken complete denture base, mandibular <ul style="list-style-type: none"> • Reimbursement rate – same as D5510 	N
D5512	Repair broken complete denture base, maxillary <ul style="list-style-type: none"> • Reimbursement rate – same as D5510 	N
D5611	Repair resin partial denture base, mandibular <ul style="list-style-type: none"> • Reimbursement rate – same as D5610 	N
D5612	Repair resin partial denture base, maxillary <ul style="list-style-type: none"> • Reimbursement rate – same as D5610 	N
D5621	Repair cast partial framework, mandibular <ul style="list-style-type: none"> • Reimbursement rate – same as D5620 	N
D5622	Repair cast partial framework, maxillary <ul style="list-style-type: none"> • Reimbursement rate – same as D5620 	N
D7979	Non-surgical sialolithotomy <ul style="list-style-type: none"> • Not allowed on the same date of service as D7980 (surgical sialolithotomy) • Reimbursement rate (to be determined) 	Y
D9222	Deep sedation/general anesthesia – first 15 minutes <ul style="list-style-type: none"> • Allowed once per date of service • Allowed only in an office setting • Deep sedation/general anesthesia performed in the dental office must include documentation in the record of pharmacologic agents, monitoring of vital signs, and complete anesthesia time • Reimbursement includes all drugs and/or medicaments necessary for adequate anesthesia • Reimbursement includes monitoring and management • Reimbursement rate – same as D9223 	N

CDT 2018 Code	Description and Limitations	PA Indicator
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes <ul style="list-style-type: none"> • Allowed once per date of service • Allowed only in an office setting • Intravenous conscious sedation performed in the dental office must include documentation in the record of pharmacologic agents, IV site, monitoring of vital signs, and complete anesthesia time • Reimbursement includes all drugs or medicaments necessary for adequate anesthesia • Reimbursement includes monitoring and management • Reimbursement rate – same as D9243 	N
D9995	<ul style="list-style-type: none"> • Teledentistry – synchronous; real-time encounter • Reported in addition to other procedures delivered on the same date of service • The originating site is the facility in which the beneficiary is located • The distant site is the facility from which the provider furnishes the teledentistry service • All service sites/providers must be Medicaid or Health Choice enrolled • Consultation must take place by an <u>encrypted</u> two-way real-time interactive audio and video telecommunications system • Reimbursement rate (to be determined) 	Y

The following procedure codes were end-dated effective with date of service Dec. 31, 2017.

Procedure Code	Description
D5510	Repair broken complete denture base
D5610	Repair resin denture base
D5620	Repair cast framework

The following procedure codes descriptions were revised effective with date of service Jan. 1, 2018.

Procedure Code	Description
D1354	Interim caries arresting medicament application – per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (excluding final restoration)
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit
D7111	Extraction, coronal remnants – primary tooth
D7980	Surgical sialolithotomy
D9223	Deep sedation/general anesthesia – each subsequent 15-minute increment
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15-minute increment

The following procedure code criteria was updated due to the description revision effective Jan. 1, 2018.

Procedure Code	Description
D1354	<p>Interim caries arresting medicament application – per tooth</p> <ul style="list-style-type: none"> • Interim caries arresting medicament application • Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure • Limited to beneficiaries ages 1 to 5 • Allowed once every six calendar months per tooth • Limited to a total of four applications per tooth prior to age 6 • Valid tooth numbers (A-T, AS-TS, 03, 14, 19, 30) • Recommended for beneficiaries who are deemed to be at risk for progression of disease to pulpal infection • Since the potential for staining of carious enamel and dentin exists, providers must obtain informed consent from the beneficiary’s parent or caregiver prior to rendering the service • Reapplication of the caries arresting medicament at recall visits is only indicated if the carious lesions do not appear arrested • Treated carious lesions can be restored after treatment with a caries arresting medicament • Reimbursement rate of \$10 for the first tooth and cutback to 50 percent or \$5 for three additional teeth for a total of four teeth reimbursed per date of service (maximum reimbursement of \$25 per date of service)

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, refer to [Clinical Coverage Policy 4A, Dental Services](#), on the N.C. Medicaid website.

**Dental Program,
DMA, 919-855-4280**

Attention: Freestanding Birth Centers
Freestanding Birth Center Fee Update

The Freestanding Birth Center fee for CPT Code 59409 has been updated to \$1,510.97 effective Jan. 1, 2018.

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

Attention: Hospice Providers

Corrections to N.C. Medicaid Bulletin December 2017- Hospice Policy Updates

Correction under General Requirements

The correct fax number for the N.C. Division of Medicaid Assistance (DMA) is 919-715-9025.

Clarification under Certification PA Requirements

With **each prior approval (PA) entry** beginning with the third and subsequent benefit periods, providers must fax a copy of the Approval Status Inquiry Form, or the NCTracks Web Submitted Request for Hospice Prior Approval Confirmation Page, to DMA at 919-715-9025. DMA requests that providers include their name and e-mail address on the above forms.

Update Hospice Document Type Designation Within NCTracks

Hospice providers shall upload all required documents in the NCTracks Provider Portal using the attachment type that corresponds with the documents below:

Document Name	Attachment Type
Election Statement	CONTREAT
Face-To-Face Encounter	PHYSICAN
Physician Plan of Treatment - Order for care and services	TREATPLAN
<ul style="list-style-type: none"> • NC Medicaid Hospice Prior Approval Authorization Form (NC DMA-3212) • Hospice Recertification of Terminal Illness • Physician Plan of Treatment - Order for care and services • Supporting clinical documentation (e.g., medical history, nurses’ notes, IDG notes, prognosis; Tools such, as but not limited to, Fictional Assessment Scales, Palliative • Performance Scales, Hospice Card, New York Heart Association Functional Classification Tool, Palmetto Eligibility Scale Tool, and Local Coverage Determination. • Ensure all health and other records that support the beneficiary have met the specific criteria in Subsection 2.0 of this policy. 	MEDREC

**Home Care Services/Community Based Services
DMA, 919-855-4380**

Attention: Nurse Practitioners Physicians and Physician's Assistants**Meropenem and Vaborbactam for Injection, for Intravenous Use (Vabomere)
HCPCS Code J3490: Billing Guidelines**

Effective with date of service Oct. 23, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover meropenem and vaborbactam for injection, for intravenous use (Vabomere) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. Vabomere 2 grams for injection is supplied as a sterile powder for constitution in single-dose vials containing meropenem 1 gram (equivalent to 1.14 grams of meropenem trihydrate) and vaborbactam 1 gram.

Vabomere is indicated for the treatment of patients 18 years and older with complicated urinary tract infections (cUTI) including pyelonephritis caused by designated susceptible bacteria. To reduce the development of drug-resistant bacteria and maintain the effectiveness of Vabomere and other antibacterial drugs, Vabomere should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria.

The recommended dose for Vabomere is 4 grams (meropenem 2 grams and vaborbactam 2 grams) every eight hours by intravenous infusion for up to 14 days. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing are:
 - N10 - Acute pyelonephritis;
 - N11.0 - Nonobstructive reflux-associated chronic pyelonephritis;
 - N11.1 - Chronic obstructive pyelonephritis;
 - N11.8 - Other chronic tubulo-interstitial nephritis;
 - N11.9 - Chronic tubulo-interstitial nephritis, unspecified;
 - N12 - Tubulo-interstitial nephritis, not specified as acute or chronic;
 - N13.6 - Pyonephrosis;
 - N16 - Renal tubulo-interstitial disorders in diseases classified elsewhere;
 - N30.00 - Acute cystitis without hematuria;
 - N30.01 - Acute cystitis with hematuria;
 - N30.20 - Other chronic cystitis without hematuria;
 - N30.21 - Other chronic cystitis with hematuria;
 - N30.80 - Other cystitis without hematuria;
 - N30.81 - Other cystitis with hematuria;
 - N30.90 - Cystitis, unspecified without hematuria;
 - N30.91 - Cystitis, unspecified with hematuria;
 - N34.0 - Urethral abscess;
 - N34.1 - Nonspecific urethritis;
 - N34.2 - Other urethritis;
 - N39.0 - Urinary tract infection, site not specified
 - B96.1 - *Klebsiella pneumoniae* [K. pneumoniae] as the cause of diseases classified elsewhere;
 - B96.20 - Unspecified *Escherichia coli* [E. coli] as the cause of diseases classified elsewhere;

- B96.21 - Shiga toxin-producing *Escherichia coli* [E. coli] (STEC) O157 as the cause of diseases classified elsewhere;
 - B96.22 - Other specified Shiga toxin-producing *Escherichia coli* [E. coli] (STEC) as the cause of diseases classified elsewhere;
 - B96.23 - Unspecified Shiga toxin-producing *Escherichia coli* [E. coli] (STEC) as the cause of diseases classified elsewhere;
 - B96.29 - Other *Escherichia coli* [E. coli] as the cause of diseases classified elsewhere.
-
- Providers must bill with HCPCS code: J3490 - Unclassified drugs.
 - One Medicaid unit of coverage is 1 vial. NCHC bills according to Medicaid units.
 - The maximum reimbursement rate per unit is \$178.20.
 - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 65293-0009-01, 65293-0009-06.
 - The NDC units should be reported as "UN1."
 - For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
 - For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on the N.C. Medicaid 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 Physician's Drug Program is available on N.C. Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians, and Physician's Assistants**Galsulfase Injection for Intravenous Use (Naglazyme) HCPCS Code J1458: Billing Guidelines**

Effective with date of service June 2, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover galsulfase injection for intravenous use (Naglazyme) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J1458 - Injection, galsulfase, 1 mg. Naglazyme is available as an injection of 5 mg per 5 mL vial.

Naglazyme is indicated for patients with Mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome). Naglazyme has been shown to improve walking and stair-climbing capacity.

The recommended dose of Naglazyme is 1 mg per kg of body weight administered once weekly as an intravenous infusion. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are: E76.29 - Other mucopolysaccharidoses.
- Providers must bill with HCPCS code: J1458 - Injection, galsulfase, 1 mg.
- One Medicaid unit of coverage is 1 mg.
- The maximum reimbursement rate per unit is \$380.50. NCHC bills according to Medicaid Units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 68135-0020-01.
- 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 Physician's Drug Program is available on N.C. Medicaid's [PDP web page](#).

CSRA 1-800-688-6696

Attention: Physicians, Physician's Assistants, and Nurse Practitioners**Triamcinolone Acetonide Extended-Release Injectable Suspension, for Intra-Articular Use (Zilretta) HCPCS Code J3490: Billing Guidelines**

Effective with date of service Oct. 15, 2017, the NC Medicaid Program covers triamcinolone acetonide extended-release injectable suspension, for intra-articular use (Zilretta) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. Zilretta is currently commercially available as a single-dose kit containing one vial of Zilretta microsphere powder (32 mg of triamcinolone acetonide), one vial of 5 mL diluent, and one sterile vial adapter.

Zilretta is indicated as an intra-articular injection for the management of osteoarthritis pain of the knee. Zilretta is not intended for repeat administration. The recommended dose of Zilretta is 32 mg administered as a single intra-articular injection in the knee. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is/are:
 - M17.0 - Bilateral primary osteoarthritis of knee;
 - M17.11 - Unilateral primary osteoarthritis of knee, right knee;
 - M17.12 - Unilateral primary osteoarthritis of knee, left knee;
 - M17.2 - Bilateral post-traumatic osteoarthritis of knee;
 - M17.31 - Unilateral post-traumatic osteoarthritis, right knee;
 - M17.32 - Unilateral post-traumatic osteoarthritis, left knee;
 - M17.4 - Other bilateral secondary osteoarthritis of knee;
 - M17.5 - Other unilateral secondary osteoarthritis of knee.
- Providers must bill with HCPCS code: J3490 - Unclassified drugs.
- One Medicaid unit of coverage is 1 kit.
- The maximum reimbursement rate per unit is \$615.60.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is/are: 70801-0003-01.
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on 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 Physician's Drug Program 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 Jan. 1, 2018, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
3A, Home Health Services	12/14/17	01/28/18
5A-2, Respiratory Equipment and Sales	12/11/17	01/25/18
5B, Orthotics & Prosthetics	12/11/17	01/10/18

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
January 2018	01/04/18	01/09/18	01/10/18
	01/11/18	01/17/18	01/18/18
	01/18/18	01/23/18	01/24/18
	01/25/18	01/30/18	01/31/18
February 2018	02/01/18	02/06/18	02/07/18
	02/08/18	02/13/18	02/14/18
	02/15/18	02/21/18	02/22/18
	02/22/18	02/27/18	02/28/18

* Batch cutoff date is previous day

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

Paul Guthery
 Executive Account Director
 CSRA