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1-800-688-6696 or 919-851-8888

Tusso-DMR Coverage

The FDA has determined that the following drug is DESI code 2; therefore, this drug will be eligible for Medicaid coverage and rebate billing effective as of **January 29, 2009**.

NDC	DRUG NAME
00642064510	TUSSO-DMR CAPSULE

Over-the-Counter Medications for Skilled Nursing Facility Recipients

Recipients who reside in skilled nursing facilities should be receiving all over-the-counter medications (OTCs), excluding insulin, under the SNF’s per diem rate. In March 2009, the pharmacist will begin to be notified via the POS system if a claim is submitted for an OTC when the recipient’s living arrangement code indicates they are residing in a skilled nursing facility (SNF). Providers will receive a denial that states “OTC drugs are not paid for SNF”.

DHHS Awards Contract for Replacement MMIS

The N.C. Department of Health and Human Services (DHHS) has awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a Replacement Medicaid Management Information System (MMIS) in support of healthcare administration for multiple DHHS agencies.

Initially, the Replacement MMIS will be used by DMA; the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH); the Division of Public Health (DPH); the Migrant Program for the Office of Rural Health and Community Care (ORHCC); and the Division of Health Service Regulation (DHSR). DMA will assume the administration of the N.C. Health Choice Program in 2010, and Health Choice claims processing and operational support will be part of the Replacement MMIS multi-payer environment at start-up in 2011.

CSC will run the system and serve as the fiscal agent for DHHS and its divisions, providing operational support to manage provider and recipient call centers, prior authorization reviews, claims processing, pharmacy operations, medical policy reviews, and other administrative activities. CSC will be the fiscal agent for four years with one 1-year option.

The DHHS Office of MMIS Services (OMMISS) will provide contract oversight and management for the implementation of the multi-payer Replacement MMIS. OMMISS, together with staff from other DHHS divisions, will work closely with CSC on the total overall design, development, and installation of the system.

As part of the contractual agreement, responsibilities for Medicaid provider enrollment, credentialing, and verification, along with retrospective drug utilization review (Retro-DUR) functions, will be assumed by CSC within 120 days.

DHHS and CSC recognize the importance of early and continued interaction with the provider community and are moving to facilitate that interaction as quickly as possible.

More information on early implementation activities and replacement system development will appear in future Medicaid bulletins.

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2009. These seminars are intended to educate all providers on the basics of billing for N.C. Medicaid. Information presented at these seminars is a general review of N.C. Medicaid and is applicable to all provider types. The seminar sites and dates will be announced in the March 2009 general Medicaid bulletin.

The April 2009 Basic Medicaid Billing Guide will be used as the training document for the seminars and will be available on DMA's website prior to the seminars.

The April 2009 Basic Medicaid seminars will begin with a morning session and will have break-out sessions in the afternoon to address particular claim submission types. Pre-registration will be required for each individual session. Due to limited seating, registration will be limited to two staff members per office, per session. Unregistered providers are welcome to attend if space is available.

Upcoming Medicaid Integrity Program – CMS Provider Audits

The Medicaid Integrity Program has announced that it will be contacting Medicaid providers in North Carolina in early February 2009 regarding provider audits. The following audit fact sheet is provided for your information.

Medicaid Integrity Program Provider Audit Fact Sheet November 2008 Background

The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP) and directed the Centers for Medicare & Medicaid Services (CMS) to enter into contracts to review Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

Who are the “Audit MICs?”

Audit Medicaid Integrity Contractors (Audit MICs) are entities with which CMS has contracted to perform audits of Medicaid providers. The overall goal of the provider audits is to identify overpayments and to ultimately decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the Audit MICs will audit Medicaid providers throughout the country. The audits will ensure that Medicaid payments are for covered services that were actually provided and properly billed and documented. Audit MICs will perform field audits and desk audits. Audits have begun in CMS Regions III & IV and will be expanded to all States and Territories. The audits are being conducted under Generally Accepted Government Auditing Standards.

Which providers will be subject to audit?

Any Medicaid provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional, as well as managed care entities.

How are providers selected?

Providers usually will be selected for audits based on data analysis by other CMS contractors. They also will be referred by State agencies. CMS will ensure that its audits neither duplicate State audits of the same providers nor interfere with potential law enforcement investigations.

What should a provider do if it receives a Notification Letter that it has been selected for audit?

Gather the requested documents as instructed in the letter. CMS contractors have the authority to request and review copies of provider records, interview providers and office personnel, and have access to provider facilities. Requested records must be made available to the Audit MICs within the requested timeframes. Generally, providers will have at least two weeks before the start of an audit to make their initial production of documents to the Audit MICs. In obtaining documents, Audit MICs will be mindful of state-imposed requirements concerning record production. Moreover, Audit MICs may accommodate reasonable requests for extensions on document production so long as neither the integrity nor the timeliness of the audit is compromised. The Audit MICs will also contact the provider to schedule an entrance conference. Notification Letters will identify a primary point of contact at the Audit MIC if there are specific questions about the Notification Letter or the audit process.

What process will follow the completion of the audit?

The Audit MIC will prepare a draft audit report, which will first be shared with the State and thereafter with the provider. The State and the provider each will have an opportunity to review and comment on the draft report's findings. CMS will consider these comments and prepare a revised draft report. CMS will allow the State to review the revised draft report and make additional comments. Thereafter, CMS will finalize the audit report, specify any identified overpayment, and send the final report to the State. The State will pursue the collection of any overpayment in accordance with State law. Providers have full appeal rights under State law. The Audit MICs will be available to provide support and assistance to the States throughout the State adjudication of the audit.

Who are the Audit MICs?

Umbrella contracts have been awarded to: Booz Allen Hamilton, Fox & Associates, IPRO, Health Management Solutions (HMS), and Health Integrity, LLC. Booz Allen Hamilton was awarded the task order to conduct audits in CMS Regions III & IV. HMS was recently awarded a task order for CMS Regions VI & VIII.

For information on the Medicaid Integrity Program, please e-mail Medicaid_Integrity_Program@cms.hhs.gov.

Provider Enrollment Packet Updates

DMA's provider enrollment packets have been updated to reflect current requirements for participation with the N.C. Medicaid Program. Applicants should obtain the January 2009 version of the provider enrollment packets from DMA's website at <http://www.ncdhhs.gov/dma/provenroll.htm>.

The Provider Services Unit will accept either the December 2007 version or the January 2009 version of the enrollment packets until March 1, 2009. Previous versions of the enrollment packets submitted to the Provider Services Unit on or after March 1, 2009, will not be processed and will be returned to the provider.

If an applicant submits the December 2007 version of an enrollment packet prior to March 1, 2009, and it is returned to the applicant because it is incomplete or invalid, the applicant will be required to resubmit the corrected enrollment packet using the January 2009 version.

The new version of the provider enrollment packets should also be used when re-enrolling for participation with N.C. Medicaid Program and to report

- changes of ownership
- tax number changes
- group name changes
- tax name changes

Refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/changematrix.htm> for additional information on the types of changes that must be reported to DMA using the provider enrollment packet.

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>:

- A-2, *Over-the-Counter Medications*
- 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*
- 5A, *Durable Medical Equipment*
- 5B, *Orthotics and Prosthetics*
- 9, *Outpatient Pharmacy Program*

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Changes in Drug Rebate Manufacturers

The following changes have been made in manufacturers with Drug Rebate Agreements. They are listed by manufacturer's code, which are the first five digits of the NDC.

Additions

The following labelers have entered into Drug Rebate Agreements and have joined the rebate program effective on the dates indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
11383	Weeks & Leo Co., Inc	02/23/2009
39328	Patrin Pharma, Inc	02/23/2009
42211	Iroko Pharmaceuticals, LLC	01/27/2009
44523	Biocomp Pharma, Inc	01/20/2009
67457	Bioniche Pharma	02/05/2009

Reinstated Labeler

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
66814	World Gen, LLC	01/26/2009

Checkwrite Schedule

February 10, 2009	March 10, 2009	April 07, 2009
February 18, 2009	March 17, 2009	April 14, 2009
February 26, 2009	March 26, 2009	April 23, 2009
March 03, 2009		May 05, 2009

Electronic Cut-Off Schedule

February 05, 2009	March 05, 2009	April 02, 2009
February 12, 2009	March 12, 2009	April 09, 2009
February 19, 2009	March 19, 2009	April 16, 2009
February 26, 2009		April 30, 2009

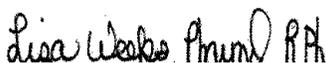
Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day of the electronic cut-off date to be included in the next checkwrite.



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