



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy**

Newsletter

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Changes in Drug Rebate Manufacturers

North Carolina Medicaid Preferred Drug List

DMA established a N.C. Medicaid Preferred Drug List (PDL) on March 15, 2010. The N.C. General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)] authorized DMA to establish the PDL in order to obtain better prices for covered outpatient drugs through supplemental rebates. All therapeutic drug classes for which the drug manufacturer provides a supplemental rebate are considered for inclusion on the list with the exception of medications used for the treatment of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Initially there will **not** be any changes in the drugs that are currently covered. **In the future**, selected therapeutic drug classes will be reviewed by DMA and the Pharmacy and Therapeutics Committee of the N.C. Physicians Advisory Group. Specific drug products within the selected therapeutic drug classes will be “preferred” based on therapeutic effectiveness, safety and clinical outcomes. Generally these drugs will not require prior authorization (PA) unless there are other clinical PA requirements such as step therapy or quantity limits.

“Non-preferred” drugs (drug products not included in the therapeutic drug classes listed on the PDL) will be available if prior authorization criteria are met. The prior authorization process will be the same process as it is today. If a prescriber deems that the patient’s clinical status necessitates therapy with a “non-preferred” drug, the prescriber will be responsible for initiating a prior authorization request.

For therapeutic drug classes that do not appear on the PDL, nothing has changed. Prescribers can prescribe drugs in these classes as in the past, unless existing prior authorization criteria exists.

The PDL is posted on DMA’s Outpatient Pharmacy Program’s website (<http://www.ncdhhs.gov/dma/pharmacy/>).

Deleted NDC’s from CMS

The following products do not meet the definition of a covered outpatient drug and are not rebate-eligible. Therefore, these drugs will be deleted from the CMS Master Drug Rebate (MDR) file of covered drugs effective as of **March 11, 2010**.

NDC	Drug Name
13279010030	ALLANENZYME OINTMENT
13279010130	ALLANFILLENZYME OINTMENT
13279010233	ALLANENZYME SPRAY
13279010333	ALLANFILLENZYME SPRAY
58177080402	ETHEZYME OINTMENT
58177081602	ETHEZYME 830 OINTMENT
58980071111	KOVIA OINTMENT
58980071135	KOVIA OINTMENT
58980072211	KOVIA 6.5 OINTMENT
58980076511	ZIOX OINTMENT
58980076535	ZIOX OINTMENT
58980077611	ZIOX 405 OINTMENT

HP Mailing Address Changes

Effective immediately, the following HP Enterprise Services mail box addresses have been changed.

Old Mail Box Address	Current Mail Box Address	City, State, Zip*
300011	30968	Raleigh, NC 27622
300010	30968	
300001	30968	
300012	30968	

*Please note the city, state and zip code have not changed.

The **pharmacy claim form** has been updated with the new address and is located under forms on DMA’s website: <http://www.ncdhhs.gov/dma/provider/forms.htm> . The new form should be used going forward.

When appropriate, providers are instructed to continue to list any departmental information for routing purposes. For example:

HP Enterprise Services
 ATTN: Pharmacy Claims
 PO Box 30968
 Raleigh, NC 27622

2010 Census

The Department of Health and Human Services (DHHS) is partnering with the U.S. Census Bureau and the N.C. Complete Count Committee to support the 2010 Census. Please help us spread the word about the 2010 Census to achieve a complete and accurate count of North Carolina’s population.

Accurate census data guides decision-makers on where to build roads, hospitals, housing, schools, and senior centers and will ensure that North Carolina gets its fair share of federal funding. Every year, the federal government distributes more than \$400 billion for improvements to public health, education, transportation, and more. These funds are distributed to state, local, and tribal governments based on census data. For each person who is not counted, North Carolina will lose approximately \$10,000 over the next 10 years.

Every person counts in the Census. DMA encourages our providers and partners to promote Census awareness and participation by reminding consumers that

- You don’t count unless you’re counted.
- It’s quick, easy, and safe.
- It’s a patriotic duty.

For more information on the 2010 Census and to find out how you can get involved, visit the North Carolina Census website at <http://2010census.nc.gov>.

Reporting Fraud, Waste, and Program Abuse

DMA's Program Integrity (PI) section is devoted to carrying out its mission, which is to ensure compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately. You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous. However, sometimes in order to conduct an effective investigation, staff may need to re-contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

To report suspected Medicaid fraud, waste or program abuse by a Medical provider:

- Contact DMA by calling the CARE-LINE Information and Referral Service at 1-800-662-7030 (English or Spanish) and ask for the DMA Program Integrity Section; or
- Call DMA's Program Integrity Section directly at 1-877-DMA-TIP1 (1-877-362-8471); or
- Call the State Auditor's Waste Line at 1-800-730-TIPS; or
- Call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS; or
- [Complete and submit a Medicaid fraud and abuse confidential online complaint form](http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm) via this link: <http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>.

Examples of Medicaid Fraud and Abuse by Medical Providers (list is not all-inclusive)

- Medicaid recipient failed to report other insurance when applying for Medicaid
- non-recipient uses a recipient's Medicaid card with or without recipient's knowledge
- provider's credentials/qualifications are not accurate
- provider bills for services that were not rendered
- provider performs and bills for services not medically necessary
- provider alters claim forms and recipient records

Clarification on the Provider Enrollment Fee

On September 1, 2009, DMA implemented a \$100 fee for providers enrolling for participation with the N.C. Medicaid Program. This requirement was implemented in response to legislation mandated by Session Law 2009-451 (<http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf>).

The enrollment fee applies to the initial enrollment of a provider (in other words, an in-state or border-area provider who has never before enrolled to participate in the N.C. Medicaid Program). The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled. The enrollment fee also applies to currently enrolled providers at 3-year intervals when the provider is re-credentialed.

Providers should not submit payment with their enrollment applications or with their verification packets. Once a provider is approved for enrollment or has been re-credentialed, the CSC EVC Call Center will send an invoice to the provider with instructions for payment.

The enrollment fee does not apply to requests for changes to a provider's status even if a new enrollment application is required in order for the CSC EVC Call Center to complete the change. For example, a

new provider application is required for group name changes. But, the enrollment fee does not apply because the provider is currently enrolled.

Medicaid Provider Payment

DMA shall immediately suspend payment to all NC Medicaid Providers that currently have outstanding (i.e. thirty days or more past due) balances owed as a result of DMA actions to recoup assessments, overpayments or improper payments until such outstanding balances are either paid in full or the Provider enters into an approved payment plan, in accordance with N.C. Session Law 2009-451, Section 10.73A.(a) (b) (c), which states:

SECTION 10.73A.(a) The Department of Health and Human Services may suspend payment to any North Carolina Medicaid provider against whom the Division of Medical Assistance has instituted a recoupment action, termination of the NC Medicaid Administrative Participation Agreement, or referral to the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office. The suspension of payment shall be in the amount under review and shall continue during the pendency of any appeal filed at the Department, the Office of Administrative Hearings, or State or federal courts. If the provider appeals the final agency decision and the decision is in favor of the provider, the Department shall reimburse the provider for payments for all valid claims suspended during the period of appeal.

SECTION 10.73A.(b) Entering into a Medicaid Administrative Participation Agreement with the Department does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid program.

SECTION 10.73A.(c) The Department shall not make any payment to a provider unless and until all outstanding Medicaid recoupments, assessments, or overpayments have been repaid in full to the Department, together with any applicable penalty and interest charges, or unless and until the provider has entered into an approved payment plan.

For additional information on a repayment plan, please contact DMA Budget Management at (919) 855-4140.

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): <http://www.ncdhhs.gov/dma/basicmed/>
- *Health Check Billing Guide*: <http://www.ncdhhs.gov/dma/healthcheck/>
- EPSDT provider information: <http://www.ncdhhs.gov/dma/epsdt/>

Changes in Drug Rebate Manufacturers

The following change has been made in manufacturers with Drug Rebate Agreements. It is listed by manufacturer's code, which are the first five digits of the NDC.

Addition

The following labeler has entered into Drug Rebate Agreement and has joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
50222	Leo Pharma Inc	02/23/2010

Checkwrite Schedule

March 02, 2010	April 06, 2010	May 04, 2010
March 09, 2010	April 13, 2010	May 11, 2010
March 16, 2010	April 22, 2010	May 18, 2010
March 25, 2010		May 27, 2010

Electronic Cut-Off Schedule

February 25, 2010	April 01, 2010	April 29, 2010
March 04, 2010	April 08, 2010	May 06, 2010
March 11, 2010	April 15, 2010	May 13, 2010
March 18, 2010		May 20, 2010

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.

Lisa Weeks, PharmD, R.Ph.

Chief, Pharmacy and Ancillary Services
Division of Medical Assistance
Department of Health and Human Services

Glenda Adams, PharmD.

Outpatient Pharmacy Program Manager
Division of Medical Assistance
Department of Health and Human Services

Craig L. Gray, MD., MBA., JD

Director
Division of Medical Assistance
Department of Health and Human Services

Ann Slade, R.Ph.

Chief, Pharmacy Review Section
Division of Medical Assistance
Department of Health and Human Services

Sharon H. Greeson, R.Ph.

Pharmacy Director
HP Enterprise Services

Melissa Robinson

Executive Director
HP Enterprise Services
