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**North Carolina
Medicaid Pharmacy
Newsletter**

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NPI Update for Pharmacy Providers

Effective immediately, pharmacy providers should start submitting the prescriber NPI on all prescriptions. The DEA number should no longer be submitted.

The NC Medicaid HIPAA Companion Guide Specifications for NCPCP 5.1 will be updated with the following information:

Field #	Field Name	Format	Field/Type	Field Length	NC Medicaid Specifications
466-EZ	Prescriber ID Qualifier	NCPD P V5.1	A/N	2	01 = National Provider Identifier (NPI)

Electronic Billing of the Prior Authorization 72-Hour Emergency Supply

Effective with date of service April 21, 2011, N.C. Medicaid began allowing electronic billing of the federally mandated 72-hour emergency supply for medications that require prior authorization. The system will bypass the prior authorization requirement if an emergency supply is indicated. A “3” in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill. The claims will not be counted toward the global limits and will only allow a 72-hour supply. Co-payments will apply and only the drug cost will be reimbursed.

Edit 383 has also been developed which will prevent the days supply edit 907 from being overridden for prior authorization emergency fills. The new edit 383 indicates the following message to the provider: “CANT USE OVERRIDE WITH A PA EMER FILL”.

DHHS/DMA Program Integrity Contract with Public Consulting Group

Medicaid services are provided to recipients in all 100 North Carolina counties. In accordance with 42 CFR 455, which sets forth requirements for a state fraud detection and investigation program, DMA’s Program Integrity Section investigates Medicaid providers when clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activity.

Program Integrity is charged with initiating these reviews to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. In accordance with 10A NCAC 22F.0202, a Preliminary Investigation shall be conducted on all complaints received or aberrant practices detected, until it is determined that there are sufficient findings to warrant a full investigation; or there is sufficient evidence to warrant referring the case for civil and/or criminal fraud action; or there is insufficient evidence to support the allegation(s) and the case may be closed.

Effective June 2010, Public Consulting Group (PCG), contracted with DMA’s Program Integrity to conduct post payment reviews for all Medicaid provider types. Program Integrity identifies

provider claims for review and assigns cases to PCG, which handles the full scale of operations including

- the receipt of a case file
- conducting the clinical review
- establishing a statistically valid claim review sample
- extrapolating these findings to calculate the recoupment

PCG responsibilities include:

- initiating contact with the provider
- informing the provider of the post payment review process requirements
- working closely with the provider and DMA
- advising the provider where and how to submit records for the review
- addressing provider questions regarding the post payment review process

If the provider's claims are determined to be out of compliance, a Tentative Notice of Overpayment letter will be sent to the provider in the amount of the overpayment. In accordance with 10A NCAC 22F.0402, reconsideration and appeal rights will be offered to the provider if the provider does not agree with the findings of the review. Instructions for the reconsideration review and appeal rights are included with the Tentative Notice of Overpayment letter.

If the preliminary investigation supports the conclusion of possible fraud, as defined in NCGS 108A-63, the case shall be referred to the appropriate law enforcement agency for a full investigation, in accordance with 10A NCAC 22F.0203.

Changes in Drug Rebate Manufacturers

The following changes have 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 labelers have entered into a Drug Rebate Agreement and have joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
43598	Dr. Reddy's Laboratories, Inc	04/18/2011
50816	New American Therapeutics	04/25/2011
51224	Tagi Pharma	04/07/2011
52609	Apo-Pharma, Inc	04/07/2011
57902	EUSA Pharma (USA), Inc	04/27/2011

Terminated Labelers

The following labelers will be terminated from the Medicaid Drug Rebate Program effective April 1, 2011:

Rosemont Pharmaceuticals	(Labeler 13632)
Oncology Therapeutics Network Joint Vent	(Labeler 15210)
Sirion Therapeutics, Inc	(Labeler 42826)
American Red Cross	(Labeler 52769)
Tri-Med Laboratories	(Labeler 55654)
Advanced Vision Research	(Labeler 58790)
Digestive Care, Inc	(Labeler 59767)
Boudreaux's Butt Past	(Labeler 62103)
Synthon Pharmaceuticals, Inc	(Labeler 63672)
Cebert Pharmaceuticals, Inc	(Labeler 64019)
Avanir Pharmaceuticals, Inc	(Labeler 64597)
Genzyme Corporation	(Labeler 64894)
Azur Pharma	(Labeler 68322)

The following labeler will be terminated from the Medicaid Drug Rebate Program effective July 1, 2011:

Merck & Co, Inc	(Labeler 59930)
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Voluntarily Terminated Labeler

The following labelers have requested voluntary termination effective July 01, 2011:

Perrigo Pharmaceuticals	(Labeler 00414)
Actelion Pharmaceuticals U.S., Inc	(Labeler 10148)
Graceway Pharmaceuticals, LLC	(Labeler 13453)
Ipsen Pharmaceuticals	(Labeler 16887)
Bristol-Myers Squibb Company	(Labeler 19810)
Kylemore Pharmaceuticals, LLC	(Labeler 49769)
Valeant Pharmaceuticals	(Labeler 65234)

Checkwrite Schedule

April 06, 2011	May 05, 2011	June 06, 2011
April 13, 2011	May 11, 2011	June 15, 2011
April 22, 2011	May 18, 2011	June 24, 2011
	May 27, 2011	

Electronic Cut-Off Schedule

April 01, 2011	April 29, 2011	June 03, 2011
April 08, 2011	May 06, 2011	June 10, 2011
April 15, 2011	May 13, 2011	June 17, 2011
	May 20, 2011	

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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