



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

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In This Issue...

Compounded Hydroxyprogesterone Caproate (known as 17P) Continues to be Available in the Physician's Drug Program and Outpatient Pharmacy Program

NPI Update for Pharmacy Providers

Deleted NDC's from CMS

Recipient Management Lock-In Program

Monthly Prescription Limitations and the Opt-In Program

Drug Utilization Review Early Refill Alert

Provider Verification

Quality Assurance Questionnaire

Changes in Drug Rebate Manufacturers

Compounded Hydroxyprogesterone Caproate (known as 17P) Continues to be Available in the Physician's Drug Program and Outpatient Pharmacy Program

The Division of Medical Assistance (DMA) **supports and encourages** the use of compounded hydroxyprogesterone caproate (known as 17P) for use in pregnant women with a singleton pregnancy and a prior spontaneous preterm birth (before 37 weeks of gestation) due to spontaneous preterm labor or premature rupture of the membranes.

Since Makena, the branded version of hydroxyprogesterone caproate (known as 17P), was added to the marketplace in March 2011, there has been some confusion on whether or not the compounded version of the drug continues to be covered by N.C. Medicaid. The compounded version of 17P is available in the Physician's Drug Program and based on recent guidance is once again available in the Outpatient Pharmacy Program when a rebatable hydroxyprogesterone powder is used in the compounded product. For additional assistance to outpatient pharmacies in billing the compounded product, please refer to the Outpatient Pharmacy Program policy manual at <http://www.ncdhhs.gov/dma/mp/9pharmacy.pdf>.

For Medicaid billing through the Physician's Drug Program:

- The ICD-9-CM diagnosis code required for billing 17P is V23.41 (*supervision of pregnancy with history of pre-term labor*).
- Providers must verify that the recipient's history includes a singleton preterm birth (prior to 37 weeks gestation). The recipient must be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment should continue until week 37 (through 36 weeks, 6 days) and must end at that time. It may be appropriate to start a recipient at a later gestational age if she presents late for prenatal care.
- Providers must bill 17P with HCPCS procedure code J3490 (*unclassified drugs*).
- One unit of coverage is 250 mg (weekly dose). Providers must bill their usual and customary charge. The maximum reimbursement rate for one unit is \$20.00.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form, or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>).
- Providers must use rebatable 11-digit National Drug Codes (NDCs) and appropriate NDC units when billing for 17P.
- If the drug was purchased under the 340B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Refer to articles in the April 2007 and February 2009 general Medicaid bulletins.

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 N.C. 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	NCPDP V5.1	A/N	2	01 = National Provider Identifier (NPI)

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 have been deleted from the CMS Master Drug Rebate (MDR) file of covered drugs effective as of **May 4, 2011**.

NDC	DRUG NAME
00037065504	RYNA 12 SUSP
00037067310	RYNA-12 TITRATABLE TABLETS
00095064501	LODRANE 12 D TABLETS
00095120006	LODRANE 24 EXTENDED RELEASE CAPSULES
00095129006	LODRANE 24 D EXTENDED RELEASE CAPSULES
00185130401	CPM 8MG/PSEUDO ER 120MG
00185130410	CPM 8MG/PSEUDO ER 120MG
00277016001	DALLERGY TABLETS
00277018201	DALLERGY CAPLETS
00277018301	DALLERGY-JR CAPSULES
00485005401	ED A-HIST TABS
00485005516	ED A-HIST LIQUID
00485007201	ED-CHLOR-TAN
00485007402	ED CHLORPED
00642064510	TUSSO-DMR
10122065020	ALLERX DOSEPACK
10122065060	ALLERX DOSEPACK
10122070260	ALLERX D
10122070420	ALLERX DOSEPACK DF
10122070460	ALLERX DOSEPACK DF

10122070520	ALLERX DOSEPACK PE
10122070560	ALLERX DOSEPACK PE
16477014601	DALLERGY PSE TABLET
16477081901	DALLERGY SYRUP
23359001116	DOXYTEX
23589001116	VIRAVAN-P SUSPENSION
23589001316	VIRAVAN-PDM
24839034616	RYNEZE LIQUID
28595011001	SERADEX LA 6-19 MG
50383087130	CP DEC ORAL DROPS
50991041216	POLYTAN
51991014501	COLFED A CAPSULES
51991053420	ALLERGY DN II TABLETS
51991059101	DURADRYL CHEWABLE TABLETS
54838054280	SILDEC PE SYRUP
58605027401	BROVEX ADT SUSPENSION
58605027701	BROVEX PD SUSPENSION
60258022016	DEHISTINE SYRUP
60258022116	CHLOR-MES D LIQUID
60258033516	DYPHYLLINE-GG ELIXIR
60258037116	DY-G LIQUID
60575061919	RESPAHIST 2
64376053001	PCM CHEWABLE TAB
64376054301	BPM 6MG TAB
64376054331	BPM 6MG TAB
64376054401	BPM PSEUDO 6/45MG TAB
64376054431	BPM PSEUDO 6/45MG TAB
64376054601	PSEUDO CM NF TAB
64376054631	PSEUDO CM NF TAB
64376071416	CPM PSE SYRUP
64376072116	PSE BPM LIQUID
64376072830	C PHEN DROPS
64376072916	C PHEN SYRUP
64376072940	C PHEN SYRUP
64376073716	DEXPHEN M SOLN
64543009190	RESCON MX
64543009690	RESCON TABLETS
64661005001	J-TAN D SR 100TB

66870070101	TIME-HIST QD
66992014616	LUSONAL LIQUID
66992023004	VAZOBID
68013000701	BROMPHENIRAMINE TANNATE CHEWABLE 12MG
68013000760	BROMPHENIRAMINE TANNATE CHEWABLE 12MG
68013001420	VISRX DOSE PACK
68013001460	VISRX DOSE PACK
68032032421	BROMPHENIRAMINE MALEATE 1MG DROPS
68032032521	BROMPHENIRAMINE MALEATE 1MG/PSEUDOEPHEDRINE 7.5 MG DROPS
68032032621	SONAHIST PEDIATRIC DROPS
68047016001	NOHIST
68047033001	SUDAHIST

Recipient Management Lock-In Program

The N.C. Medicaid program implemented a recipient management lock-in program to deter overutilization of certain prescription controlled substances. Recipients identified for this lock-in program are restricted to a single prescriber and pharmacy to obtain opioid analgesics, benzodiazepines and certain anxiolytics. Recipients eligible for this program meet one or more of the following criteria:

1. Recipients who have at least ONE of the following
 - a. Benzodiazepines and certain anxiolytics: > 6 claims in 2 consecutive months
 - b. Opiates: > 6 claims in 2 consecutive months
2. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from > 3 prescribers in 2 consecutive months
3. Referral from a provider, DMA or CCNC.

An enrolled Medicaid pharmacy will be reimbursed for a four-day supply of a prescription dispensed to a recipient locked into a different pharmacy and prescriber in response to an emergent situation. The provider will be paid for the drug cost only and the recipient will be responsible for the appropriate copayment. One emergency occurrence will be reimbursed per recipient during the one year lock-in period. Records of dispensing of emergency supply medications are subject to review by Program Integrity. Paid quantities for more than a four-day supply are subject to recoupment.

Monthly Prescription Limitations and the Opt-In Program

The N.C. Medicaid program has a prescription limitation of eight prescriptions per recipient per month. A pharmacist may override the monthly prescription limit with three additional prescriptions per recipient per month for recipients aged 21 and older. Overrides are available at the discretion of the pharmacist based on the assessment of the recipient's need for additional

medications during the month of service. Recipients under 21 years of age are exempt from the prescription limitation. Recipients who reside in nursing facilities, intermediate care facilities/mental retardation centers, assisted living facilities, and group homes are also exempt from the prescription limitation.

Once a recipient has a need for more than 11 unduplicated prescriptions each month, the recipient is restricted to a single pharmacy. The recipient must elect to participate in the opt-in program to receive more than 11 unduplicated prescriptions; however, written consent is not required. Every six months, recipients will be systematically removed from the opt-in program when fewer than 12 unduplicated prescriptions were dispensed in two out of the last three months or if fewer than 12 unduplicated prescriptions were dispensed in the sixth month. The recipient's primary care physician or pharmacy provider can contact HP Enterprise Services to request changes to the pharmacy opt-in provider. To reach HP Enterprise Services between 8:30 a.m. and 4:30 p.m. on weekdays, dial 919-851-8888 or 1-800-688- 6696.

Emergency fills are allowed for recipients who opt-in to a pharmacy for situations in which the recipient may not be able to get to their pharmacy. The emergency supply is limited to a four-day supply. The provider will be paid for the drug cost only and the recipient will be responsible for the appropriate copayment.

Drug Utilization Review Early Refill Alert

DMA is continuing to see a large number of claims that are denied with the early refill alert and are subsequently being rebilled by overriding the denial at the point-of-sale. In accordance with the Clinical Coverage Policy 9, Outpatient Pharmacy Program, pharmacy providers are reminded that there is no provision for payment by N.C. Medicaid for early refills on controlled substances except in the event that a recipient's therapy has changed. Providers are cautioned to carefully consider the appropriateness of overriding the Drug Utilization Review (DUR) early refill alert. When using 05 to designate a therapy change, the provider should verify that indeed a therapy change did occur.

Program Integrity will monitor the use of the early refill override codes. Claims billed with the incorrect override code, overridden for an invalid reason, or otherwise not in compliance with policy will be subject to recoupment.

Provider Verification

To comply with industry best practices, CSC's EVC Operations Call Center staff will request the caller to provide the last four digits of the provider's Tax Identification Number Social Security Number (SSN) or Employer's Identification Number (EIN) to confirm that the caller is the actual enrolled provider or an authorized agent of the enrolled provider that he/she is presenting himself/herself to be. If the caller does not have the information available, the CSA (Customer Service Agent) cannot discuss the provider file with you. Once the information is obtained, a CSA will be glad to assist you.

After greeting the caller, the CSA will ask the caller to verify the provider's NPI or MPN, name, the physical site or accounting address. The CSA will also ask for the caller's name, the caller's phone number, and the caller's e-mail address before disclosing any information. Please have your information ready for assistance regarding provider enrollment.

If you have questions regarding this notice, please contact the CSC EVC Operations Center. CSA's are available Monday through Friday, 8:00 a.m. through 5:00 p.m. eastern time, at 1-866-844-1113.

Quality Assurance Questionnaire

DMA Provider Services published the first in a series of quality assurance (QA) questionnaires to assist DMA in its efforts to improve customer service to enrolled providers and Medicaid recipients. The QA questionnaires are intended only for DMA's enrolled Medicaid providers. All enrolled providers are encouraged to complete the May 2011 QA questionnaire. Results obtained from the questionnaire will be kept confidential. Completed questionnaires may be submitted by e-mail to ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

May 2011 Medicaid Provider Quality Assurance Questionnaire			
	Question	Response	
		YES	NO
1	Does the annual Medicaid card and web-portal eligibility verification greatly improve your way of doing business?		
2	Do you regard your experience as a N.C. Medicaid provider overall to be a positive experience?		
3	Do you and your fellow colleagues enrolled in the Medicaid program view their Medicaid as a value added health plan, which improves the lives of citizens?		
4	Do you find the administrative services and education information provided by DMA on its website, bulletins, and customer service to be adequate in supporting a high level of health care for Medicaid recipients?		
5	Do you or your staff ask all Medicaid recipients to present their identification as well their Medicaid card prior to receiving services?		
6	Would a more electronically managed Medicaid program improve your ability to provide services (i.e., electronic health records, electronic billing, prior approvals, enrollment applications, etc.) to recipients		
7	Does the Medicaid bulletin adequately inform you of important Medicaid recipient, provider, and Medicaid program issues in a timely fashion?		
8	Do you believe that the North Carolina clinical policies addressing Medicaid patients are fair and meet the needs of a majority of the patients?		
9	Are patients always notified in writing of a non-covered Medicaid service?		
10	Do you find your experience in using the provider services line to be timely and at a high professional level?		
11	Do you have a formal process to measure Medicaid patient customer satisfaction in your practice?		
12	Has your business relationship (i.e., billing, payment, clinical policy, and enrollment) experience with N.C. Medicaid been at a high professional level?		

13	Do you or your staff need more training and direction (i.e. billing, payment, clinical policy, and enrollment) from DMA?		
14	Would you prefer to handle all enrollment and recertification and other communication with the Medicaid program electronically?		
15	Have you supported the development of EHR (Electronic Health Record) and electronic billing with your practice?		
16	Is contacting HP (fiscal agent) the first resource you use when you encounter an EOB that you need assistance in finding a resolution?		

Please submit your completed questionnaire to DMA Provider Services by e-mail at ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

All responses will be kept confidential.

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>
35501	Huckaby Pharmaceuticals, Inc	05/18/2011
44178	Pharmaxis, Inc	05/09/2011
50967	Women's Choice Pharmaceuticals, LLC	05/13/2011

Terminated Labelers

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

Parkedale Pharmaceuticals, Inc	(Labeler 64029)
Odyssey Pharmaceuticals, Inc	(Labeler 65473)
Novavax, Inc	(Labeler 66500)
AAI Pharma, Inc	(Labeler 66591)

Voluntarily Terminated Labelers

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

Midland Healthcare, LLC	(Labeler 15686)
Jones Pharm, Inc	(Labeler 52604)
LTC Products, Inc	(Labeler 61598)

The following labeler has requested voluntary termination effective October 01, 2011:

Hope Pharmaceuticals	(Labeler 60267)
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Checkwrite Schedule

May 03, 2011	June 07, 2011	July 06, 2011
May 10, 2011	June 14, 2011	July 12, 2011
May 17, 2011	June 23, 2011	July 21, 2011
May 26, 2011		

Electronic Cut-Off Schedule

April 28, 2011	June 02, 2011	June 30, 2011
May 05, 2011	June 09, 2011	July 07, 2011
May 12, 2011	June 16, 2011	July 14, 2011
May 19, 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.

Lisa Weeks, PharmD, R.Ph.
 Chief, Pharmacy and Ancillary Services
 Division of Medical Assistance
 Department of Health and Human Services

Clarence Ervin
 Assistant Director, Program Integrity
 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

Sharon H. Greeson, R.Ph.
 Pharmacy Director
 HP Enterprise Services

Craigan L. Gray., MD., MBA., JD.
 Director
 Division of Medical Assistance
 Department of Health and Human Services

Melissa Robinson
 Executive Director
 HP Enterprise Services
