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Drug Utilization Review Intervention Letters

The North Carolina Medicaid Drug Use Review (DUR) Board reviews prescription claims billed through the Outpatient Pharmacy Program. These reviews enhance the quality and appropriateness of patient care by educating prescribers and pharmacists on common drug therapy problems with the aim of improving prescribing and dispensing practices. Periodically, the DUR Board recommends sending letters to prescribers or pharmacies regarding a drug therapy concern. These letters help providers identify patients who are potentially at risk for adverse outcomes. Each letter explains the concern and contains pertinent recipient information as well as an intervention feedback form. Feedback from providers in this process helps DMA and the Board to evaluate the intervention and assess outcomes. Feedback also assists in developing future relevant clinical issues. If you receive a letter from the DUR Board, please review and fax the completed intervention feedback form back as instructed in the letter.

Transition Period for Oral Inhaled Corticosteroids, Leukotrienes, and Statins

The six-month transition period for oral inhaled corticosteroids and corticosteroid combination products, leukotrienes, and statins which includes Zetia will end on March 15, 2011.

This transition period has been in place to allow prescribers time to complete the necessary prior approval form if it was determined that the patient met the clinical criteria for that drug or to allow time to transition the recipient to a preferred product that does not have clinical criteria.

No Copayments for Family Planning Recipients

For the past several months, DMA has experienced a significant increase in telephone calls from Family Planning Waiver (FPW) recipients stating they have received bills from their providers for services under the program. As a reminder, under North Carolina Medicaid's FPW Program there is **no copayment for recipients for any covered services** received through the FPW Program. Therefore, providers should refrain from billing recipients for any medical, lab, pharmacy or any other covered services provided under the Waiver program. In addition, providers should not send bills to recipients for unreimbursed claims for any covered services provided under the Family Planning Waiver.

When a **non-covered service** is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the FPW Program and, therefore, will be the financial responsibility of the recipient. This must be done prior to rendering the service. A provider may refuse to accept an FPW recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for the payment.

Questions about FPW claims should be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888. When billing for services provided through the Family Planning Waiver, please refer to the North Carolina Medicaid Special Bulletin (Revised May 2006) *Family Planning Waiver "Be Smart,"* which can be found on DMA's website at <http://www.ncdhhs.gov/dma/services/familyplanning.htm>.

PDF Format Remittance and Status Reports

In June 2010, the N. C. Medicaid Program implemented an expansion of the N.C. Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool to allow providers to download a PDF version of their paper Remittance and Status Report (RA). The NCECS Web Tool retains ten checkwrite versions of the PDF version of the RA. Providers are encouraged to print the RAs or save an electronic copy to assist in keeping all claims and payment records current. Printed RAs should be kept in a notebook or filed in chronological order for easy reference. If a provider needs an RA that is older than ten checkwrites, the provider can follow the current procedure of requesting a copy through HP Enterprise Services Provider Services and will continue to be assessed a fee.

All providers who want to download a PDF version of their RA are required to register for this service regardless if they already have an NCECS Web logon ID. The Remittance and Status Reports in PDF Format Request form and instructions can be found on DMA's Provider Forms web page at <http://www.ncdhhs.gov/dma/provider/forms.htm>. Providers are encouraged to complete the form immediately and return it to the HP Enterprise Services Electronic Commerce Services Unit to ensure adequate time for set up. Providers who are new to billing or providers without an RA cover page must submit a letter on company letterhead with the form stating the Medicaid Provider Number, NPI, address, and the reason why an RA has not been received.

Medicare Crossover Claims

For crossover claims to process correctly, the National Provider Identifier (NPI) submitted on the Medicare claim must match the NPI on file with N.C. Medicaid. Claims submitted to Medicare with an NPI that is not on file with Medicaid will not cross over to Medicaid and cannot be processed.

Only one NPI number is collected for each Medicaid provider number. If a provider has multiple NPIs, but only one Medicaid provider number, the provider must select the NPI to be reported to Medicaid. All NPI changes must be submitted on the Medicaid Provider Change Form. The form is available online at <http://www.nctracks.nc.gov/provider/cis.html>.

Submitting Claims on Paper: Optical Character Recognition Technology

To meet the budget reductions mandated in SL 2009-451, DMA implemented new requirements for paperless commerce. Beginning October 2, 2009, all providers were required to file claims electronically. Institutional, professional and pharmacy claims that comply with the exceptions listed on DMA's website (<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>) may be submitted on paper.

Paper claims are electronically read using industry standard Optical Character Recognition (OCR) technology. OCR technology requires that institutional and professional paper claims be submitted on standardized red and white claim forms, pharmacy on a white North Carolina Medicaid Pharmacy claim form, with the appropriate data fields completed. Refer to claim-specific manuals for standardized guidelines. Paper claims submitted on non-standard claim forms **may be denied in processing**. Examples of non-standard claim forms include forms that have been individually created and printed by a provider, fax copies, scan copies, carbon copies

or photocopies. When completing the paper claim form, use black ink only. Do not submit scan copies, carbon copies or photocopies, and do not highlight any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at <http://www.ncdhhs.gov/dma/mp/>. N.C. Medicaid programs and policies are addressed separately and maintained by authorized sections of DMA.

Corrected 1099 Requests for Tax Years 2008, 2009, and 2010: Action Required by March 1, 2011

Each provider number receiving Medicaid payments of more than \$600 annually will receive a 1099 MISC tax form from HP Enterprise Services. The 1099 MISC tax form, generated as required by IRS guidelines, will be mailed to each provider no later than January 31, 2011. The 1099 MISC tax form will reflect the tax information on file with N.C. Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2010.

If the tax name or tax identification number on the annual 1099 MISC you receive is incorrect, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file for each provider number with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of 28 percent of future Medicaid payments. The IRS could require HP Enterprise Services to initiate and continue this withholding to obtain correct tax data. Please note that only the provider name and tax identification number can be changed and must match the W-9 form submitted.

A correction to the original 1099 MISC must be submitted to HP Enterprise Services by March 1, 2011, and must be accompanied by the following documentation:

- Cover page from you outlining what information needs to be changed and for which tax year(s)
- A copy of the original 1099 MISC form(s) or the last page of the last Remittance and Status Report(s) showing the total YTD for that specific year(s)
- A current signed and completed IRS W-9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at <http://www.irs.gov> under the link “Forms and Publications.”) The W-9 form cannot be dated prior to a year before submission.

Fax all documents to 919-816-3186, Attention: Corrected 1099 Request – Financial

OR

Mail all documents to:

HP Enterprise Services
Attention: Corrected 1099 Request – Financial
2610 Wycliff Rd., Suite 401
Raleigh, NC 27607-3073

A copy of the corrected 1099 MISC form(s), along with a second copy of the incorrect 1099 MISC form(s) with the “Corrected” box selected, will be mailed to you for your records. All

corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure the tax information on file with Medicaid is accurate. Providers may be notified by phone or mail of any additional action that may be required to complete the correction information.

Office of Medicaid Management Information System Services Website

The N.C. Office of Medicaid Management Information System Services (OMMISS) provides oversight and manages activities for the procurement and implementation of support systems and services for the Replacement Medicaid Management Information System (MMIS). The OMMISS also coordinates system-critical services for MMIS Reporting and Analytics and the information technology infrastructure and systems for the Division of Health Service Regulation (DHSR).

The Replacement MMIS will expand claims payment functionality to N.C. Department of Health and Human Services' (DHHS') divisions beyond DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) to include the Division of Public Health (DPH) and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC).

The OMMISS website (<http://ncmmis.ncdhhs.gov/>) provides information about the Replacement MMIS (called NCTracks) the status of the development project, and information that providers can use to prepare their operations for NCTracks when it goes live in the fall of 2012.

Providers can expect periodic releases of useful information, topics of interest for the provider community related to the Replacement MMIS, and answers to frequently asked questions (FAQs). Providers can also submit questions through the OMMISS website about the new system and receive timely responses from appropriate DHHS personnel. All appropriate questions and responses will be published in the FAQs. All questions regarding current or emerging Medicaid policy or Medicaid claims should be directed to the appropriate DMA staff per the DMA website at <http://www.ncdhhs.gov/dma/contactus.htm>.

For questions about the Replacement MMIS, contact OMMISS Provider Relations at ommiss.providerrelations@dhhs.nc.gov.

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/>:

- 1A-12, *Breast Surgeries* (posted 12/6/10; eff. 12/1/10)
- 1C-1, *Podiatry Services* (posted 12/6/10; eff. 12/1/10)
- 1C-2, *Medically Necessary Routine Foot Care* (posted 12/6/10; eff. 12/1/10)
- 4A, *Dental Services* (posted 1/1/11; eff. 12/1/10)
- 9, *Outpatient Pharmacy Program* (12/15/10)

These policies supersede previously published policies and procedures. Providers may contact HP Enterprise Services 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. 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>
45945	CNS Therapeutics Inc	12/28/2010
52246	Parapro, LLC	01/18/2011

Terminated Labeler

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

Family Pharmacy – Amerisource/Bergen	(Labeler 52735)
Idec Pharmaceuticals – Biogen Idec	(Labeler 64406)
Vatring Pharmaceuticals, Inc.	(Labeler 65199)
Rx Elite Holdings, Inc. DBA RxElite	(Labeler 66794)
Cura Pharmaceutical Co., Inc	(Labeler 66860)

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

Sirion Therapeutics, Inc	(Labeler 42826)
Tri Med Laboratories, Inc	(Labeler 55654)

Checkwrite Schedule

January 11, 2011	February 01, 2011	March 03, 2011
January 19, 2011	February 08, 2011	March 08, 2011
January 27, 2011	February 15, 2011	March 15, 2011
	February 24, 2011	March 24, 2011

Electronic Cut-Off Schedule

January 06, 2011	January 27, 2011	February 24, 2011
February 13, 2011	February 03, 2011	March 03, 2011
February 20, 2011	February 10, 2011	March 10, 2011
	February 17, 2011	March 17, 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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