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**North Carolina
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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 covered. Selected therapeutic drug classes are currently being 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 NDCs from CMS

The FDA has determined that the following drugs are a DESI code 5; therefore, these drugs will no longer be eligible for Medicaid coverage and rebate billing effective as of **April 8, 2010**.

NDC	Drug Name
00603478221	NITROGLYCERIN 2.5 MG CAP SA
49483022106	NITRO-TIME ER 2.5 MG CAPSULE
49483022110	NITRO-TIME ER 2.5 MG CAPSULE
49483022206	NITRO-TIME ER 6.5 MG CAPSULE
49483022210	NITRO-TIME ER 6.5 MG CAPSULE
49483022306	NITRO-TIME ER 9 MG CAPSULE
49483022310	NITRO-TIME ER 9 MG CAPSULE

Medicaid Integrity Contractors Audit

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) and dramatically increased the federal government's role and responsibility in combating Medicaid fraud, waste, and abuse. Section 1936 of the Social Security Act (the Act) requires CMS to contract with eligible entities to review and audit Medicaid claims, to identify overpayments, and to provide education on program integrity issues. Additionally, the Act requires CMS to provide effective support and assistance to states to combat Medicaid provider fraud and abuse.

CMS created the Medicaid Integrity Group (MIG) in July 2006 to implement the MIP. As a result of this action, the Medicaid Integrity Contractors (MIC) audit was developed. Section 1936 of the Act requires CMS to enter into contracts to perform four key program integrity activities:

- Review provider actions;
- Audit claims;
- Identify overpayments; and
- Educate providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

CMS has awarded contracts to several contractors to perform the functions outlined above. The contractors are known as the MICs. There are three types of MICs:

- **The Review MIC.** The Review MIC analyzes Medicaid claims data to identify aberrant claims and potential billing vulnerabilities, and provide referrals to the Audit MIC. Thomson Reuters is the Review MIC for North Carolina.
- **The Audit MIC.** The Audit MIC conducts post-payment audits of all types of Medicaid providers and identifies improperly paid claims. The Audit MIC for North Carolina is Health Integrity.
- **The Education MIC.** Education MICs work with the Review and Audit MICs to educate health care providers, State Medicaid officials and others about a variety of Medicaid program integrity issues. There are two Education MICs:
 - ◆ Information Experts; and
 - ◆ Strategic Health Solutions.

The objectives of the MIC audit are to ensure that claims are paid:

- For services provided and properly documented;
- For services billed using the appropriate procedure codes;
- For covered services; and
- In accordance with federal and state laws, regulations, and policies.

MIC Audit Process:

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.
2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.
3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the “look back” period, should mirror that of the state which paid the provider’s claims.
4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
 - identifies a point of contact within the Audit MIC.
 - gives at least two weeks’ notice before the audit is to begin.
 - includes a records request outlining the specific records that the Audit MIC will be auditing.
 - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC’s arrival at the provider’s office.

The Audit MIC schedules an entrance conference to communicate all relevant information to the provider. The entrance conference includes a description of the audit scope and objectives.

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider’s location. Providers are given specific timelines in which to produce records. Because some audits will be larger in scope than others, provider requests for time extensions are seriously considered on a case-by-case basis. The audits are being conducted according to Generally Accepted Government Auditing Standards (<http://www.gao.gov/govaud/ybk01.htm>).

6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.
7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comments. The draft report may be subject to revision based on additional information and shared again with the state.
8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state's comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.
9. **CMS issues final audit report to state, triggering the "60-day" rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR sections 433.316 (a) and (e), this action serves as CMS' official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12(2), the state must repay the federal share of the overpayment to CMS within 60 calendar days, regardless of whether the state recovers or seeks to recover the overpayment from the provider.
10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

Ten providers have had completed MIC audits in North Carolina. To date, no errors have been reported.

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, CMS implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid Program and the State Children's Health Insurance Program (SCHIP). North Carolina is 1 of 17 states required to participate in PERM reviews of Medicaid Fee-for-Service and Medicaid Managed Care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010). The SCHIP error rate will not be measured in the 2010 PERM.

CMS is using two national contractors to measure improper payments. The statistical contractor, Livanta, will coordinate efforts with the State regarding the eligibility sample, maintaining the PERM eligibility website, and delivering samples and details to the review contractor. The review contractor, A+ Government Solutions, will communicate directly with providers and

requesting medical record documentation associated with the sampled claims. Providers will be required to furnish the records requested by the review contractor within a timeframe specified in the medical record request letter.

It is anticipated that A+ Government Solutions will begin requesting medical records for North Carolina's sampled claims in June 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

Providers are reminded of the requirement listed in Section 1902(a)(27) of the Social Security Act and federal regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider rendering services.

Remittance and Status Reports in PDF Format

Effective with the June 8, 2010, checkwrite, the N.C. Medicaid Program will implement an expansion of the NC 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). There will be a transition period during the month of June when the paper RA will continue to be printed and mailed to providers. Beginning with the July 7, 2010, checkwrite, RAs will only be available through the NCECS Web Tool. The NCECS Web Tool will retain ten checkwrite versions of the PDF version of the RA. If a provider needs an RA that is older than ten checkwrites, they will 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 wish to be able to download a PDF version of their RA are required to register for this service regardless if they already have an NCECSWeb logon ID. The provider request form and instructions can be found at on DMA's website 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.

As a part of this expansion, there will be some minor changes to the layout of the RA. Some fields that are either duplicated or not used will be removed to allow room to report the HIPAA Claim Adjustment Reason Codes and Remark Codes along with the adjustment amounts. A complete list of changes will be published prior to implementation in a future bulletin article or special bulletin.

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.

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>
68405	Physician Therapeutics LLC	04/13/2010

Terminated Labeler

The following labelers will be terminated from the Medicaid Drug Rebate Program effective July 1, 2010:

Microbix Biosystems, Inc	(Labeler 24430)
Le Vista, Inc	(Labeler 42212)
Sage Pharmaceuticals, Inc	(Labeler 59243)

Voluntarily Terminated Labeler

The following labelers have requested voluntary termination effective July 1, 2010:

Blaine Company	(Labeler 00165)
Targacept Biopharmaceuticals, Inc	(Labeler 17205)
Topix Pharmaceuticals, Inc	(Labeler 58211)

Checkwrite Schedule

April 06, 2010	May 04, 2010	June 08, 2010
April 13, 2010	May 11, 2010	June 15, 2010
April 22, 2010	May 18, 2010	June 22, 2010
	May 27, 2010	June 24, 2010

Electronic Cut-Off Schedule

April 01, 2010	April 29, 2010	June 03, 2010
April 08, 2010	May 06, 2010	June 10, 2010
April 15, 2010	May 13, 2010	June 17, 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
