



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

Number 183

June 2010

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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 for the month of June where 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. As a part of this effort, minor changes were made to the layout of the pharmacy RA as described below.

New fields were added to the Paid/Denied Claims Section

- Claim Adjustment Reason Code (CARC)
- Adjustment Amount

All providers who want to access and download a PDF version of their RA are required to register for this service regardless if they already have an NCECSWeb logon ID. The Remittance and Status Reports in PDF Format 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.

Offering Gifts and Other Inducements to Beneficiaries

Program Integrity increasingly fields questions regarding gift cards and transfer coupons and would like to clarify with providers what the regulations and penalties are according to the Office of Inspector General (OIG). The full OIG Special Advisory Bulletin on this topic may be found at:

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf> .

Pertinent excerpts from the OIG Special Advisory Bulletin, August 2002:

“Under section 1128A(a)(5) of the Social Security Act (the Act), enacted as part of Health Insurance Portability and Accountability Act of 1996 (HIPAA), a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties of up to \$10,000 for each wrongful act. For purposes of section 1128A(a)(5) of the Act, the statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value. (See section 1128A(i)(6) of the Act.) The statute and implementing regulations contain a limited number of exceptions. (See section 1128A(i)(6) of the Act; 42CFR 1003.101.)”

“ . . . the OIG has interpreted the prohibition to permit Medicare or Medicaid providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of no more than \$10 individually, and no more than \$50 in the aggregate annually per patient.”

“In sum, unless a provider’s practices fit within an exception (as implemented by regulations) or are the subject of a favorable advisory opinion covering a provider’s own activity, any gifts or free services to beneficiaries should not exceed the \$10 per item and \$50 annual limits.”

According to the regulation, giving a Medicaid recipient a gift card or store credit to transfer their prescriptions or to retain their business would be a violation as it may be considered a “cash equivalent” to influence their selection of provider.

Further questions or concerns should be directed to the OIG Public Call Center at 202-619-0335 or the Confidential Hot Line at 1-800-HHS-TIPS.

End-dated Coverage for Exocrine Pancreatic Insufficiency Drugs

Effective with date of service July 1, 2010, the exocrine pancreatic insufficiency drugs with the National Drug Codes (NDCs) listed below will no longer be covered by N.C. Medicaid. A notice regarding this change was mailed in May to all Medicaid recipients.

In a memo dated April 29, 2010, CMS stated “According to the FDA, these drugs do not have approved applications; therefore, CMS has determined that the NDCs do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.”

The following table lists the drugs that will be affected by this change.

National Drug Code	Product Name
00032-1205	Creon 5 Capsules
00032-1210	Creon 10 Capsules
00032-1220	Creon 20 Capsules
00091-4175	Kutrased Capsules Rx
10267-2737	Pancrelipase 8,000 Tablets
39822-9045	Pancrelipase 4,500
39822-9100	Pancrelipase 10,000
39822-9160	Pancrelipase 16,000
39822-9200	Pancrelipase 20,000
58177-0028	Pangestyme MT 16 Capsules
58177-0029	Pangestyme CN 10 (Pancrelipase) Delayed Release Cap
58177-0030	Pangestyme CN 20 (Pancrelipase) Delayed Release Cap
58177-0031	Pangestyme EC Capsules
58177-0048	Pangestyme UL 12 Capsules
58177-0049	Pangestyme UL 18 Capsules
58177-0050	Pangestyme UL 20 Capsules
58177-0416	Plaretase
58914-0002	Ultrase MT 12

National Drug Code	Product Name
58914-0004	Ultrase MT 20
58914-0018	Ultrase MT 18
58914-0045	Ultrase MS 4
58914-0111	Viokase
58914-0115	Viokase 8oz Powder
58914-0116	Viokase 16000
59767-0001	Pancrecarb MS-8
59767-0002	Pancrecarb MS-4
59767-0003	Pancrecarb MS-16

Incomplete Provider Enrollment Applications

Effective August 1, 2010, DMA has instructed CSC, the enrollment, verification, and credentialing vendor for the N.C Medicaid Program, to issue a Final Notice letter to any applicant with an incomplete provider enrollment application that has been inactive for 30 days or more.

Applicants are notified by CSC when an application is deemed to be incomplete due to documents or information that is missing at the time that the application is processed. If no response is received within 30 days, the application is considered to be inactive.

For those applicants with an inactive, incomplete application, CSC will send a final notice stating that the application will be voided. Any applicant who feels that he/she has received this notice in error (e.g., the requested documents or information have actually been submitted) should contact CSC immediately. CSC will promptly investigate and address your concerns.

We appreciate your assistance with this matter and thank you for your participation with the N.C. Medicaid Program.

Medicaid Provider Participation Agreement

The N.C. Department of Health and Human Services Medicaid Provider Administrative Participation Agreement has been revised. Those providers who deferred the completion of the Medicaid Provider Participation Agreement that was included in the verification packet mailed out as part of the 12-month verification project may now access the revised Agreement on the NC Tracks website at <http://www.nctracks.nc.gov/provider/forms/>.

Providers who included a completed Agreement with the verification packet and providers who have enrolled for participation with N.C. Medicaid within the last 12 months do not need to resubmit an Agreement. CSC, N.C. Medicaid's contractor for provider enrollment, verification, and credentialing, will contact you when a new Agreement is required.

The completed Medicaid Provider Participation Agreement should be submitted by mail, fax, or by e-mail to CSC by September 1, 2010.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Fax: 1-866-844-1382
E-mail: NCMedicaid@csc.com

State Medicaid Health Information Technology Plan

The Office of Medicaid Management Information Systems Services (OMMISS) is leading an effort to develop the State Medicaid Health Information Technology (HIT) Plan (SMHP), in collaboration with DMA, the Health and Wellness Trust Fund (HWTF), the N.C. Health Information Exchange (NCHIE), the Regional Extension Center (REC), and other stakeholders. The SMHP, along with an Implementation Advanced Planning Document (I-APD), will outline the State's plans to administer the Medicare and Medicaid Electronic Health Record (EHR) Incentive Payments for North Carolina's eligible providers and hospitals.

CMS must approve the SMHP before the I-APD will be approved. CMS has advised that two separate I-APDs may be created to secure funding for administering the Incentive Payment program; one for MMIS-related costs and one for HITECH costs. The Incentive Payments for EHR Meaningful Use may be available as early as January, 2011, if the State receives approval of the SMHP, secures funding through approved I-APDs, and is able to develop and test systems that comply with the CMS National Level Repository (NLR) interface requirements. OMMISS is currently in the planning and analysis phase to determine when North Carolina will be prepared to begin making incentive payments. Eligible providers will be able to apply for the incentive payments under Medicaid in any 5-year consecutive period during this 10-year program, which ends in 2021.

For additional information on the EHR incentive, refer to DMA's web page at <http://www.ncdhhs.gov/dma/provider/ehr.htm>.

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>
50192	Nautilus Neurosciences, Inc	06/08/2010

Terminated Labeler

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

Beta Dermaceuticals, Inc	(Labeler 53062)
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Voluntarily Terminated Labeler

The following labeler has requested voluntary termination effective October 1, 2010:

Novavax, Inc (Formerly Fielding)	(Labeler 00421)
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Checkwrite Schedule

June 08, 2010	July 07, 2010	August 03, 2010
June 15, 2010	July 13, 2010	August 10, 2010
June 24, 2010	July 22, 2010	August 17, 2010
		August 26, 2010

Electronic Cut-Off Schedule

June 03, 2010	July 01, 2010	July 29, 2010
June 10, 2010	July 08, 2010	August 05, 2010
June 17, 2010	July 15, 2010	August 12, 2010
		August 19, 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

Ann Slade, R.Ph.
Chief, Pharmacy Review Section
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
