



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

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Changes in Drug Rebate Manufacturers

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 **June 20, 2011**.

NDC	DRUG NAME
16781019796	HYLATOPIC PLUS EMOLLIENT FOA
16781019797	HYLATOPIC PLUS EMOLLIENT FOA

Affordable Care Act Implementation Updates

N.C. Medicaid will begin providing monthly updates on North Carolina's efforts to implement the Patient Protection and Affordable Care Act (ACA), also known as "health care reform".

The North Carolina Institute of Medicine (NCIOM) health care reform task forces work to provide implementation recommendations to the Department of Health and Human Services (DHHS) and the N.C. General Assembly. Task forces include workgroups on Quality, the Safety Net, Medicaid, Fraud and Abuse, Health Benefits Exchange and Insurance Oversight, Prevention, Health Professional Workforce, and New Models of Care. DMA is working closely with stakeholders and providers in the development of appropriate systems and policies required by the act, as well as exploring opportunities to improve the delivery and quality of care. DMA participates in all workgroups and chairs the workgroups on Medicaid, Fraud and Abuse, and New Models of Care.

For more information about the NCIOM task forces, please see: <http://www.nciom.org/task-forces-andprojects/current-task-forces-projects/>

For the NCIOM interim report on the "Implementation of the Patient Protection and Affordable Care Act in North Carolina", please see: <http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>

1. In addition to working to meet the requirements of ACA, DMA is pursuing several initiatives that will be discussed in more detail in future bulletins, including:
 - Health homes for Medicaid recipients with chronic health problems;
 - Family planning services through a State Plan Amendment (SPA), instead of the current waiver, to men or women of childbearing age who meet the income guidelines that would apply for pregnant women (185% FPL);
 - Medicaid Incentives for Prevention of Chronic Diseases grant to provide incentives to at risk and chronically ill patients with hypertension and diabetes to better self-manage their care; and
 - Dual Eligible's Planning grant to better coordinate care for individuals receiving health care services through both Medicare and Medicaid.

Enactment of the Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act) makes a number of changes to the Medicare and Medicaid programs and to the Children's Health Insurance Program. These changes will enhance the provider enrollment process to improve the integrity of the services through the reduction of fraud, waste, and abuse. A full copy of the final rule is available in the [Federal Register, Vol 76, No. 22, page 5862](#).

NC Medicaid and NC Health Choice Provider Screening:

The department must screen all initial applications for enrollment in NC Medicaid or Health Choice. This includes all applications for a new practice or site location, and any revalidation applications. The providers will be categorized based on a risk level. The risk levels will be limited, moderate, and high. If a provider could fit within more than one risk level, the highest level of screening will be applied.

Provider Enrollment Criteria:

Providers must submit an attestation and complete certain required training sessions prior to being granted billing privileges. The attestation shall contain a statement that the individual or entity seeking to enroll or seeking revalidation has necessary to comply with all federal and state requirements governing the Medicaid and Children's Health Insurance programs, that the individual or entity does not owe any outstanding taxes or fines to the U.S. or N.C. Departments of Revenue or Labor or the Employment Security Commission, and that the individual or entity does not owe any overpayment, assessment, or fine to any other State Medicaid or Children's Health Insurance Program.

The Department shall establish rules designating the types of training requirements based upon the level of risk. Failure to complete the required training sessions or to submit an attestation accurately may be grounds to termination.

Background screening; prohibited offenses:

All employees required by law to be screened pursuant to this section must undergo security background investigations as a condition of employment and continued employment which includes, but need not be limited to, employment history checks, electronic fingerprinting for statewide criminal history records checks, national criminal history records checks through the Federal Bureau of Investigation, and a check of the National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies. Background screening pursuant to this chapter must be conducted on each of the following persons:

- (a) All owners and operators;
- (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider;
- (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider;
- (d) Any and all other managing employees; and
- (e) Any person seeking employment or contracting with a health care provider who is expected to, or whose responsibilities may require him or her to, provide care or services directly to clients or have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the provider.

Provider Criteria Performance Bonds:

The purchase and maintenance of a performance bond or executed letter of credit shall be a condition of eligibility for non-licensed providers or non-Medicare certified providers as those terms are defined in Rule .0401 of this Subchapter. Evidence of the performance bond or executed letter of credit issued by a financial institution shall be submitted to the Division of Medical Assistance annually for five years.

- i. In the first year, the provider shall obtain a performance bond or executed letter of credit in the amount of twenty thousand dollars (\$20,000)
- ii. In subsequent years, the amount of the performance bond or executed letter of credit shall equal the actual paid claims total for the most recent calendar year of participation, not to exceed one hundred thousand dollars (\$100,000).
- iii. Each performance bond or executed letter of credit shall exist for a term of one year.

Federal Enrollment Fee:

With the exception of physicians, non-physician practitioners, physician group practices and nonphysician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application in the amount of \$505 through December 31, 2011. The amount will be adjusted by the percentage change for the consumer price index for the 12-month period ending June 30 of the prior year.

Enrollment Fee Final Notice

As the Enrollment, Verification, and Credentialing (EVC) vendor for the North Carolina Medicaid Program, CSC processes all enrollment applications, enrollment additions, and Medicaid Provider Change Forms. On September 1, 2009, DMA implemented a \$100 fee for providers enrolling for participation with the N.C. Medicaid Program. This requirement was implemented in response to legislation mandated by <http://www.ncleg.net/Sessions/2009/Bills/Senate/PDF/S202v8.pdf>.

CSC will send an invoice to the provider with instructions for payment. If the enrollment fee payment is not provided within 30 days from the date of the invoice, CSC sends a system-generated e-mail to the provider (see below) informing the provider that the application will be voided. Any applicant who feels that he/she has received this notice in error should contact the CSC EVC Call Center immediately. CSC will promptly investigate and address your concerns.

The following paragraph is the message that CSC sends to the provider when an application is voided due to CSC has not received the enrollment fee payment within 30 days.

The N.C. Medicaid Provider Enrollment Packet for the applicant referenced above has been voided due to the absence of payment of the State-required \$100 provider enrollment fee. This fee has been invoiced in writing to the address shown above, with at least one reminder notice issued via U.S. mail and/or e-mail. Our accounting system shows no receipt of any payment on the above referenced application.

If you have questions regarding the notice, please contact the CSC EVC Center and reference the Enrollment Tracking Number (ETN) featured in the final notice. Customer Service Agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1.866.844.1113.

Compounded Hydroxyprogesterone Caproate (known as 17P) continues to be Available in the Physician's Drug Program

With the addition of Makena, the branded version of hydroxyprogesterone caproate (known as 17P), to the marketplace, there has been some confusion on whether or not the compounded version of the drug continues to be covered by N.C. Medicaid. N.C. Medicaid continues to cover the compounded version and the Division of Medical Assistance **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.

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 information.
- Refer to articles in the April 2007 and February 2009 general Medicaid bulletins.

W-9

As part of the enrollment process to become a Medicaid provider in North Carolina, applicants are required to submit a Form W-9 from the IRS. CSC's Credentialing staff has determined that 60 percent of the enrollment applications contain errors related to Form W-9, which increases the amount of time it takes to process an application.

The State of North Carolina has agreed to eliminate the Form W-9 submission requirement provided that CSC add the following section to enrollment applications:

My Taxpayer Identification Number and Name (exactly as shown on my income tax return) associated with my Medicaid provider number are:

Taxpayer Name _____

Taxpayer Identification Number _____

My Taxpayer Identification Number above is (check only one):

____ *Social Security Number*

____ *Employer Identification Number (EIN)*

Under penalties of perjury, I certify that:

- 1. The payee's TIN is correct.*
- 2. The payee is not subject to backup withholding due failure to report interest.*
- 3. The payee is a U.S. person.*

Signature: _____ *Date:* _____

MMIS Financial Operations' review of IRS publications support use of substitute language for applicant (the payee) to certify as to the accuracy of the tax information and name registered with the IRS. Such language will mitigate the potential of "B" notices in the future.

If you have questions regarding the notice, please contact the CSC EVC Operations Center. Customer Service Agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1-866-844-1113.

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 labeler has entered into a Drug Rebate Agreement and has joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
51862	Libertas Pharma, Inc	06/15/2011

Terminated Labelers

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

Novartis Pharmaceuticals Corporation	(Labeler 00028)
Allan Pharmaceutical, LLC	(Labeler 13279)
Verus	(Labeler 13436)
Mylan Pharmaceuticals, Inc	(Labeler 15330)
Sun Pharmaceuticals Industries, Inc	(Labeler 14508)
Probactive Biotech, Inc	(Labeler 23110)
Dermarite Industries, LLC	(Labeler 61924)

Voluntarily Terminated Labelers

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

Watson Pharma, Inc	(Labeler 55515)
Amerifit Pharma, Inc	(Labeler 61451)

Checkwrite Schedule

June 07, 2011	July 06, 2011	August 02, 2011
June 14, 2011	July 12, 2011	August 09, 2011
June 23, 2011	July 21, 2011	August 16, 2011
		August 25, 2011

Electronic Cut-Off Schedule

June 02, 2011	June 30, 2011	July 28, 2011
June 09, 2011	July 07, 2011	August 04, 2011
June 16, 2011	July 14, 2011	August 11, 2011
		August 18, 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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