



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

Number 196

July 2011

In This Issue...

Off Label Antipsychotic Monitoring in Children through Age 17

Upcoming Changes

Affordable Care Act Implementation Updates

Termination of Inactive Medicaid Provider Numbers

Health Choice Transition

Changes in Drug Rebate Manufacturers

Off Label Antipsychotic Monitoring in Children through Age 17

Phase II Implementation: Children 13 through 17 years of age - Start Date August 24, 2011

DMA will implement Phase Two of the policy titled *Off Label Antipsychotic Monitoring in Children through Age 17* on August 24, 2011. Phase Two adds recipients ages 13 – 17. This policy known as A+KIDS creates an opportunity to gather information about antipsychotic prescribing trends within the child and adolescent Medicaid population of North Carolina.

In accordance with the policy, DMA, in partnership with Community Care of North Carolina, maintains a registry for providers to document the use of antipsychotic therapy in Medicaid-eligible children age 17 and under. Phase Two implementation will activate registry requirements for 13 – 17 year old recipients. The registry is supported by an advisory panel consisting of child psychiatrists from North Carolina's four medical universities. It encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics.

Objectives of the **A+KIDS** registry include improvement in the use of evidence-based safety monitoring for recipients prescribed antipsychotic medication; reduction of antipsychotic polypharmacy; and reduction of cases with the prescribed dose differing from the FDA approved dosage for an indication. Data elements collected within the registry reflect a generally accepted monitoring profile for the safety and efficacy follow-up of the prescribed antipsychotic pharmacotherapy. An antipsychotic medication meeting any of the below descriptions requires safety monitoring documentation by the prescriber in order for the claim to be paid.

- The antipsychotic is prescribed for an indication that is not approved by the FDA.
- The antipsychotic is prescribed at a different dosage than approved for a specific indication by the FDA.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

About the A+KIDS Registry

The process to provide documentation for the 13 – 17 aged group is the same as for the 0 – 12 year olds. The **A+KIDS** website, found at (www.documentforsafety.org) is used to register as an **A+KIDS** provider and to access the online registry. Pharmacy providers are encouraged to visit the website to understand how the policy may impact pharmacy claims processing for antipsychotic medications.

The registry captures demographics and brief clinical information. The information can be submitted electronically through the **A+KIDS** website (www.documentforsafety.org) or by completing a form to submit by fax to ACS at 866-246-8507. The form will be available on the DMA outpatient pharmacy website (www.ncdhhs.gov/dma/pharmacy) and the **A+KIDS** website (www.documentforsafety.org). Using the fax method to provide information will result always in a three-month approval period. Faxed forms missing essential information cannot be processed and will be returned to the prescriber. When information is provided electronically through the registry, approval periods from 6 to 12 months are possible depending on case specific clinical variables.

Pharmacy Override Protocol – Unlimited use extended

Point of sale (POS) overrides are available for occurrences where the prescriber has not provided registry documentation either electronically or by fax for the recipient. Each override will apply to all claims for antipsychotic medication(s) on the same date of service. The message "Safety documentation requested. Prescriber go to www.documentforsaftey.org or call ACS 866-246-8505" will return to the pharmacy for antipsychotic claims for a recipient without registry documentation. The claim will not process successfully. A POS override should be utilized for rejected claims if timely A+KIDS registration by the prescriber does not occur. **A "1" in the PA field (461-EU) or a "2" in the submission clarification field (420-DK) will override the PA edit.** Patients should not be denied their antipsychotic medication(s) in response to the safety documentation requested message. The prescriber of the antipsychotic medication should be alerted when an override is used, and the language returned in the original POS message regarding the safety documentation request should be shared with him/her.

Use of an override to successfully process a claim for an antipsychotic medication remains unrestricted. **Override limits did not go into effect on July 13, 2011 as previously communicated. The unlimited override period remains in effect.** Pharmacists are encouraged to ensure all pharmacy staff are informed about the override option. It is important to follow all antipsychotic claims until a paid status results. Denial codes or DUR alerts subsequent to use of an override should be responded to in a timely manner according to professional judgment. Such diligence will support the purpose of unrestricted overrides which is to ensure recipients don't go without needed antipsychotic medication.

Many resources are available to assist providers with understanding the policy and registry. Technical support is available to assist providers with registration and questions and can be accessed by calling the toll free number, 855-272-6576, found on the website. Community Care of North Carolina network psychiatrists and pharmacists are available to educate about the registry. Additionally, help may be obtained by calling the ACS helpline at 866.246.8505. DMA assistance with understanding the policy and registry is available by contacting the outpatient pharmacy program at 919.855.4300.

Upcoming Changes

Recent bills were passed and signed into law, which impact the North Carolina Medicaid Program. You may view the bills at www.ncga.state.nc.us/session2011. Providers will receive more detailed information in upcoming bulletins.

Affordable Care Act Implementation Updates

Section 6404 of the Patient Protection and Affordable Care Act (PPACA), implemented October 4, 2010, amends Medicare timely filing requirements for submission of Medicare fee-for-service claims. The maximum time period to file a Medicare claim was reduced to one calendar year after the date of service. Prior to PPACA, the regulations stated claims for services furnished during the first nine (9) months of the calendar year were required to be submitted on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider was required to submit the claim on or before December 31st of the next consecutive year.

The previous timely filing period gave DMA time to identify claims with dates of service during a 2-year period that were billed in error to Medicaid. DMA would send a list of these claims to the provider along with the Medicare disallowance notice, allowing the provider 60 days to respond. However, because providers must file claims with Medicare within one calendar year of the date of service, it is no longer possible to allow the 60-day response period.

In order to minimize the financial impact of the Medicare changes on the North Carolina Medicaid program, DMA and its partner, Health Management Systems, Inc. (HMS), have modified the Medicare Recovery Process—the process by which Medicaid recovers funds paid on claims that should have been submitted to Medicare first. To address the new 1-year timely filing requirement, DMA now selects paid claims going back 11 months from the date of the disallowance notice and allows the provider 30 days to submit the refund or the refuting documentation. This process helps safeguard the provider's ability to file the oldest claims with Medicare before the timely filing period expires. Please note that DMA is unable to accept Medicare "denials due to timely filing" as a reason to avoid recoupment of the original Medicaid payments.

Additionally, DMA has increased the frequency at which we will send out disallowance notices. They will be sent to providers every 2 months instead of quarterly. Other than the changes noted in this article, the Medicare Recovery Process itself remains the same. Detailed instructions regarding the process will continue to be included with the disallowance notices issued by HMS.

Termination of Inactive Medicaid Provider Numbers

In May 2002, DMA began terminating certain Medicaid provider numbers that did not reflect any billing activity within the previous 12 months. This action was necessary to reduce the risk of fraudulent and unscrupulous claims billing practices. Effective July 1, 2011, once a provider is terminated, a new application and agreement to re-enroll must be submitted. As a result, a lapse in eligibility as a Medicaid provider may occur.

The termination activity occurs on a quarterly basis with provider notices being mailed April 1, July 1, October 1, and January 1 of each year and the termination dates being effective May 1, August 1, November 1, and February 1. These notices are sent to the current mailing address listed in the provider's file.

Health Choice Transition

Effective with date of service on and after October 1, 2011, NC Health Choice (NCHC) claims will be processed by DMA's fiscal agent, HP Enterprise Services. For questions regarding claims processing, providers may contact the HP Provider Services Department at 1-800-688-6696, menu option 3. For dates of service prior to the transition date of October 1, 2011, providers will continue to submit pharmacy claims to Medco.

Active N.C. Medicaid providers that want to participate in NCHC will not need to take any action for NCHC enrollment. Any provider that is not currently enrolled in the N.C. Medicaid program that wants to provide care to NCHC members will need to complete the enrollment application on www.nctracks.nc.gov. CSC, DMA's contractor for enrollment, verification and credentialing (EVC),

is available to assist providers who want to participate in NCHC. CSC contact information is provided below.

Additional information will be provided to providers in the general N.C. Medicaid bulletin and on the NCHC webpage found on DMA's website.

Enrollment, Verification, and Credentialing Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
CSC Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
CSC Website Address	http://www.nctracks.nc.gov

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>
00407	GE Healthcare, Inc	07/05/2011
52015	Optimer Pharmaceuticals, Inc	06/22/2011
59088	Puretek Corporation	07/18/2011
64208	Bio Products Laboratory	07/01/2011

Reinstated Labeler

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
15310	Creekwood Pharmaceutical, Inc	07/12/2011

Rescindment of Termination

CMS notified the states on June 20, 2011 that Dermarite Industries, LLC. (Labeler 61924) would be terminated. The labeler will not be terminated and will remain active in the Medicaid Drug Rebate Program.

Terminated Labelers

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

World Gen, LLC

(Labeler 66814)

Checkwrite Schedule

July 06, 2011	August 02, 2011	September 13, 2011
July 12, 2011	August 09, 2011	September 22, 2011
July 21, 2011	August 16, 2011	October 04, 2011
	August 25, 2011	October 12, 2011

Electronic Cut-Off Schedule

July 30, 2011	July 28, 2011	September 01, 2011
July 07, 2011	August 04, 2011	September 08, 2011
July 14, 2011	August 11, 2011	September 15, 2011
	August 18, 2011	September 29, 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

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

Tara R. Larson
Chief Clinical Operating Officer
Interim Assistant Director for Program Integrity
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
