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## Pharmacy Reimbursement Change

In order to meet legislatively mandated pharmacy budgetary goals, the Division of Medical Assistance submitted a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to reduce the estimated acquisition cost for drugs from WAC + 7% to WAC + 6%. The Division received approval for the state plan amendment on August 6, 2012 with an effective date of February 1, 2012. This reimbursement change impacts pharmacy claims submitted on or after August 14, 2012. Pharmacy claims reversed and resubmitted for dates of service February 1, 2012 to present will also be impacted by this reimbursement change.

## Medicaid and Health Choice Copayment Policy

### Medicaid Beneficiaries

All eligible **Medicaid beneficiaries** who receive prescribed drugs are required to make a co-payment of \$3.00 for each prescription received unless they are exempt for one of the reasons listed below. A provider may not deny services to any Medicaid beneficiary because of the individual's inability to pay a deductible, coinsurance or co-payment amount. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. The provider may open an account for the beneficiary and collect the amount owed at a later date.

Medicaid beneficiaries are exempted from co-payments if:

- The beneficiary is under 21 years of age.
- The beneficiary resides in a nursing home facility, intermediate care facility for individuals with mental retardation (ICF/MR) or a mental health hospital (adult care homes and hospice patients are responsible for co-payment).
- The beneficiary is pregnant.
- The drug is classified as family planning (birth control medication).
- The beneficiary is classified as a CAP beneficiary as indicated on the beneficiary's MID card.

### Health Choice Beneficiaries

All eligible NCHC beneficiaries who receive prescribed drugs are required to make a co-payment according to the income levels listed below:

#### Income Level Co-payment

##### Class A

<150% of Family Poverty Level AND Native American OR Alaska Native

- No Co-payment

##### Class J

<150% of Family Poverty Level

- Generic \$1.00
- Brand with no generic \$1.00
- Brand with generic \$3.00
- OTC medication \$1.00

##### Class K

151% - 200% of Family Poverty Level

- Generic \$1.00
- Brand with no generic \$1.00
- Brand with generic \$10.00
- OTC medication \$1.00

**Class S**

151% - 200% of Family Poverty Level AND Native American OR Alaska Native

- No Co-payment

**Class L (Optional Extended Coverage)**

201% - 225% of Family Poverty Level

- Generic \$1.00
- Brand with no generic \$1.00
- Brand with generic \$10.00
- OTC medication \$1.00

NCHC beneficiaries are exempted from co-payments if they are eligibility type MIC-A or MIC-S. There are no other co-payment exemptions for NCHC beneficiaries.

**Coverage of Synagis for the 2012 -2013 Season**

The clinical criteria utilized by N.C. Medicaid for the 2012/2013 RSV season are consistent with published guidelines in the 2012 Red Book. Prior approval (PA) is required for Medicaid coverage of Synagis. PA request for coverage of Synagis for the upcoming season will be submitted electronically through the Synagis web-based application at [www.documentforsafety.org](http://www.documentforsafety.org). Providers should note the new website location for Synagis PA requests.

The Synagis web-based application will accept PA requests starting in early October. A user name and password is required to access the system. Providers not currently registered should complete the registration process as soon as possible to avoid delays in submitting requests when the system opens for the season. The outpatient pharmacy program has multiple electronic programs, including A+KIDS and BRANDS. The same user name and password will access all programs available through [www.documentforsafety.org](http://www.documentforsafety.org).

The electronic PA method will approve up to five monthly doses of Synagis. Individual dose authorizations will be issued up to the maximum number of doses approved for coverage for a beneficiary. The provider should always ensure the previous dose of Synagis obtained for a beneficiary is administered before making a next dose request. It is important for the Synagis distributor to have the appropriate single dose authorization on hand prior to shipping Synagis for a beneficiary. An individual dose authorization is required for each paid Synagis claim. The claim should not exceed the quantity indicated on the authorization.

**POS Reversals**

We have had many requests from providers to reverse POS claims. Currently, neither HP nor DMA can reverse POS real time claims. If you require assistance in reversing a claim, this should be handled through your vendor or “*switch*”. If this is not an option, then claims may be adjusted or recouped using the pharmacy paper adjustment form on DMA’s website <http://www.ncdhhs.gov/dma/forms/par.pdf>

## **NPI Only – September 19, 2012**

In the June and July 2012 pharmacy newsletters, the Division of Medical Assistance communicated information regarding pharmacy providers' use of prescriber NPI when submitting prescription claims. This is another reminder that effective September 19, 2012, all pharmacy claims are required to have a prescriber NPI. Submission of a DEA number or any other identification number will result in a rejected claim. Claims submitted between now and September 19, 2012 will pay but will receive an informational notice that the claim was submitted with an incorrect prescriber identification number and that NPI must be used. Please ensure that you are using prescriber NPI numbers when submitting claims to prevent claim rejections after September 19, 2012.

The N.C. Medicaid HIPAA Companion Guide Specifications for NCPDP D.0 indicates the following information:

<b>Field #</b>	<b>Field Name</b>	<b>Format</b>	<b>Field/Type</b>	<b>Field Length</b>	<b>NC Medicaid Specifications</b>
466-EZ	Prescriber ID Qualifier	NCPDP D.0	A/N	2	01 = National Provider Identifier (NPI)

## **Payment Error Rate Measurement (PERM) in North Carolina**

In compliance with the Improper Payments Information Act of 2002, the federal Centers for Medicare & Medicaid Services (CMS) has implemented a national Payment Error Rate Measurement (PERM) program to determine the extent of improper Medicaid and State Children's Health Insurance Program (SCHIP) payments.

North Carolina was selected as 1 of 17 states required to participate in PERM reviews of Medicaid fee-for-service and managed care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010).

The SCHIP program did not participate in the 2010 PERM measurement.

CMS used two national contractors to measure improper payments. The statistical contractor – Livanta – coordinated 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 – communicated directly with providers and requested medical record documentation associated with the sampled claims. Providers were required to furnish the records requested by A+ Government Solutions within a timeframe specified in the medical record request letter.

The following are North Carolina PERM medical record documentation errors identified during federal fiscal year 2010:

- No medical record documentation provided for the review
- Diagnosis Related Group (DRG) code errors
- Incorrect number of units of service billed

- Medicaid policy violations errors (Policy violations included undated prescription and billing for services without a physician order)
- Administrative/other medical review errors (This included billing for dates of service when services were not provided, and billing for dentures prior to the date of delivery to the recipient.)

The N.C. Division of Medical Assistance (DMA), Program Integrity Section, recouped the overpayments identified by CMS. In addition, provider noncompliance led to a recommendation of Prepayment Review and possible exclusion of providers from the Medicaid program.

Providers are reminded of Social Security Act (SSA) requirements – listed in SSA Section 1902(27)(a) and [42 CFR 431.107](#) – to retain any records necessary to disclose the extent of services provided to individuals and – upon request – to furnish information regarding any payments for medical services rendered.

North Carolina will be required to participate in federal fiscal year 2013 PERM review of Medicaid fee-for-service, managed care and SCHIP program claims. This is a good time to review medical record documentation to ensure it meets program requirements.

## **Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers**

**Note to Providers:** This article originally ran in September 2011.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the [July 2011 Medicaid Bulletin](#).

**N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated.**

If providers **cannot** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who was terminated. **As a result, a lapse in the provider's eligibility may occur.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by e-mail at [NCMedicaid@csc.com](mailto:NCMedicaid@csc.com).

Termination activity occurs on a quarterly basis with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner.**

## **N.C. Medicaid Provider Direct Enrollment and Screening**

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) will implement Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

[42 CFR 455.450](#) establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months.

In addition, [42 CFR 455.410](#) requires that all ordering and referring physicians – as well as other professionals providing services under the N.C. Medicaid and NCHC programs and those providing such services under a waiver – be enrolled as participating providers. This holds true for anyone in those groupings who orders or refers Medicaid and NCHC beneficiaries for services and seeks reimbursement.

All claims for payment for ordered or referred services or items must include the National Provider Identifier (NPI) of the ordering or referring physician or other professional.

Applications for provider types and specialties that are not currently enrolled in the N.C. Medicaid and NCHC programs, but wish to continue to provide services to beneficiaries, will be available beginning October 1, 2012.

## **Updated Federal Upper Limit Reimbursement List**

There are certain drugs that have been identified for which the Federal Upper Limit (FUL) reimbursement rate does not cover the cost of the drug. Medicaid pharmacy programs are required to reference this reimbursement information when pricing drug claims. In order to receive adequate reimbursement, pharmacy providers may use the DAW1 override to override the FUL reimbursement rate for the drugs listed below until the FUL rate has been adjusted to adequately cover the cost of the drug.

A comment should be entered when the DAW1 override code is used to indicate that the FUL is too low to cover the cost of the drug. If there is an active State Maximum Allowable Cost (SMAC) rate on file, the SMAC rate should be submitted.

Pharmacy providers should report reimbursement issues to the N.C. Medicaid program at 919-855-4300. Use of the *DAWI* override code for overriding FUL rates will continue to be monitored. Pharmacy providers should also monitor the FUL rates and discontinue use of the DAW1 override code once updates to the FUL rates have occurred.

<b>NDC</b>	<b>DRUG NAME</b>
00054003721	CLARITHROMYCIN 500 MG TABLET
00054302802	ACETYLCYSTEINE 20% VIAL
00093075701	PIROXICAM 20 MG CAPSULE
00093075705	PIROXICAM 20 MG CAPSULE
00168000215	TRIAMCINOLONE 0.5% CREAM
00168000315	TRIAMCINOLONE 0.025% CREAM
00168000380	TRIAMCINOLONE 0.025% CREAM
00168000415	TRIAMCINOLONE 0.1% CREAM
00168000416	TRIAMCINOLONE 0.1% CREAM
00168000480	TRIAMCINOLONE 0.1% CREAM
00168000615	TRIAMCINOLONE 0.1% OINTMENT
00168000616	TRIAMCINOLONE 0.1% OINTMENT
00168000680	TRIAMCINOLONE 0.1% OINTMENT
00168004046	BETAMETHASONE VA 0.1% CREAM
00168005515	BETAMETHASONE DP 0.05% CRM
00168005546	BETAMETHASONE DP 0.05% CRM
00168013460	FLUOCINONIDE 0.05% SOLUTION
00168025815	CLOTRIMAZOLE-BETAMETHASONE C
00168025846	CLOTRIMAZOLE-BETAMETHASONE C
00168031002	DESONIDE 0.05% LOTION
00168031004	DESONIDE 0.05% LOTION
00168038360	METRONIDAZOLE 0.75% LOTION
00185072401	CARISOPRODOL COMPOUND TAB
00185072405	CARISOPRODOL COMPOUND TAB
00228206710	OXAZEPAM 10 MG CAPSULE
00378135501	TRIAMTERENE-HCTZ 75-50
00378135505	TRIAMTERENE-HCTZ 75-50
00378537501	DOXEPIN 75 MG CAPSULE
00472016315	NYSTAIN 100,000 UNIT/GM CREAM
00472016330	NYSTAIN 100,000 UNIT/GM CREAM
00472016615	NYSTAIN 100,000 UNIT 15GMS
00472016630	NYSTAIN 100,000 UNITS 30GMS
00472037915	CLOTRIMAZOLE-BETAMETHASONE CRM
00472037945	CLOTRIMAZOLE-BETAMETHASONE CRM
00472080302	DESONIDE LOTION 0.05%
00472080304	DESONIDE 0.05% LOTION
00527142635	OXYCODONE CONC 20 MG/ML SOLN
00527142636	OXYCODONE CONC 20 MG/ML SOLN
00591578701	NORTRIPTYLINE 25MG CAP
00591578705	NORTRIPTYLINE HCL 25 MG CAP

00591578710	NORTRIPTYLINE HCL 25 MG CAP
00603459315	METHYLPREDNISOLONE 4MG D/P
00603459321	METHYLPREDNISOLONE 4 MG TABL
00603781874	NYSTATIN 100,000
00603781878	NYSTATIN 100,000 UNIT/GM CREAM
00781100801	TRIAMTERENE-HCTZ 75-50
00781100805	TRIAMTERENE-HCTZ 75-50
00781107101	METHAZOLAMIDE 50 MG TABLET
00781196160	CLARITHROMYCIN 250 MG TABLET
00781196260	CLARITHROMYCIN 500 MG TABLET
17478028310	GENTAK 3 MG/ML EYE DROPS
24208058060	GENTAMICIN OPTH SOLN
24208058064	GENTAMICIN 3 MG/ML EYE DROPS
24208067004	SULFACETAMIDE 10% EYE DROPS
29033001301	PIROXICAM 20 MG CAPSULE
29033001305	PIROXICAM 20 MG CAPSULE
43538051012	GENADUR NAIL LACQUER
45802002146	BETAMETHASONE DP 0.05% LOT
45802004811	NYSTATIN
45802004835	NYSTATIN OINTMENT
45802006405	TRIAMCINOLONE 0.1% CREAM
45802006435	TRIAMCINOLONE 0.1% CREAM
45802006436	TRIAMCINOLONE 0.1% CREAM
45802042235	DESONIDE 0.05% CREAM
45802042237	DESONIDE 0.05% CREAM
48102010101	METHAZOLAMIDE 50 MG TABLET
49884024601	CARISOPRODOL COMPOUND TAB
49884024605	CARISOPRODOL COMPOUND TAB
50111033401	METRONIDAZOLE 500 MG TABLET
50111033402	METRONIDAZOLE 500 MG TABLET
50383026760	CLOBETASOL 0.05% CREAM
51672125301	FLUOCINONIDE 0.05% CREA
51672125302	FLUOCINONIDE 0.05% CREA
51672125303	FLUOCINONIDE 0.05% CREA
51672125304	FLUOCINONIDE 0.05% CREA
51672125903	CLOBETASOL 0.05% OINTMENT
51672126301	NYSTATIN-TRIAMCINOLONE CREAM
51672126302	NYSTATIN-TRIAMCINOLONE CREAM
51672126303	NYSTATIN-TRIAMCINOLONE CREAM
51672127201	NYSTATIN-TRIAMCINOLONE OINT

51672127202	NYSTATIN-TRIAMCINOLONE OINTM
51672127203	NYSTATIN-TRIAMCINOLONE OINTM
51672127304	FLUOCINONIDE 0.05% SOLUTION
51672128003	DESONIDE 0.05% CREAM
51672128202	TRIAMCINOLONE 0.1% CREAM
51672128901	NYSTATIN 100,000 UNIT/GM CRE
51672128902	NYSTATIN 100,000 UNIT/GM CRE
51672129201	HYDROCORTISONE VAL 0.2% OINT
51672129203	HYDROCORTISONE VAL 0.2% OINT
51672129206	HYDROCORTISONE VAL 0.2% OINT
51672404709	CARBAMAZEPINE 100 MG/5 ML SU
51672404801	CLOTRIMAZOLE-BETAMETHASONE CRM
51672404806	CLOTRIMAZOLE-BETAMETHASONE CRM
59746000103	METHYLPREDNISOLONE 4 MG DOSE
60758018805	GENTAMICIN 3 MG/ML EYE DROPS
61314063136	NEOMYC-POLYM-DEXAMET EYE OINTMENT
61314063305	GENTAMICIN 3MG/ML EYE DROPS (3%)
61314064305	TOBRAMYCIN 0.3% EYE DROPS
61314070101	SULFACETAMIDE 10% EYE DROPS
64679094901	CLARITHROMYCIN 500 MG TABLET
67405011045	METRONIDAZOLE 0.75% CREAM
68382076214	CLARITHROMYCIN 500 MG TABLET
68462034737	OXYCODONE CONC 20 MG/ML SOLN

### Changes in Drug Rebate Manufacturer

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 dates indicated below:

**Code**    **Manufacturer**  
75840    Genpak Solutions, LLC

**Date**  
08/01/2012

#### Reinstated Labeler

**Code**    **Manufacturer**  
59767    Digestive Care, Inc

**Date**  
08/07/2012

**Terminated Labeler**

The following labeler will be terminated from the Medicaid Drug Rebate Program effective January 1, 2013:

Atley Pharmaceuticals, Inc

(Labeler 59702)

**Checkwrite Schedule**

August 07, 2012	September 05, 2012	October 05, 2012
August 14, 2012	September 11, 2012	October 11, 2012
August 21, 2012	September 18, 2012	October 18, 2012
August 30, 2012	September 27, 2012	October 27, 2012

**Electronic Cut-Off Schedule**

August 02, 2012	August 30, 2012	October 30, 2012
August 09, 2012	September 06, 2012	October 06, 2012
August 16, 2012	September 13, 2012	October 13, 2012
August 23, 2012	September 20, 2012	October 20, 2012

*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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