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Published by EDS, fiscal agent for the North Carolina Medicaid Program
1-800-688-6696 or 919-851-8888

Deleted NDC's from CMS

The FDA has determined that the following drug is a DESI code 5; therefore, this drug will no longer be eligible for Medicaid coverage and rebate billing effective as of **September 10, 2009**.

NDC	Drug Name
00496082904	ANALPRAM HC 2.5% LOTION

The following product does not meet the definition of a covered outpatient drug and is not rebate-eligible. Therefore, this drug will be deleted from the CMS Master Drug Rebate (MDR) file of covered drugs effective as of **September 18, 2009**.

NDC	Drug Name
24338062016	XYLAREX 3.3 GM/5 ML SOLUTION

Pharmacy Reimbursement Changes

Effective October 5, 2009, the reimbursement methodology for pharmacy claims will change. The Average Wholesale Price (AWP) minus 10% pricing methodology will change to Wholesale Acquisition Cost (WAC) plus 7%. The cost of a drug will continue to be calculated from the lowest of the costs on file (currently utilizing First Data Bank). The pricing methodologies that will be available include the following: WAC plus 7%, the federal upper limit, the state maximum allowable cost, the enhanced specialty discount or the usual and customary charge. The enhanced specialty discount drug list will continue to use Average Wholesale Price as the basis for reimbursement.

State Maximum Allowable Cost (SMAC) Change

N.C. Medicaid utilizes a state maximum allowable cost (SMAC) list for reimbursement of drugs under the outpatient pharmacy program. The SMAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. The reimbursement has been based on 150 percent of the lowest priced generic prior to October 5, 2009. Effective with dates of service October 5, 2009, the reimbursement methodology will change so that the reimbursement will be based on 190 percent of the lowest priced generic in order to encourage generic utilization.

In cases where 190 percent results in a price less than the cost of the second lowest generic product, at least an additional ten percent margin is added to the cost of the second lowest drug to establish the SMAC price. The additional margin is variable due to the wide range of differences in cost from product to product. For established generic drugs with only one supplier, the SMAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, SMAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product.

Drugs subjected to SMAC pricing must be in adequate supply. Drug shortage information is verified through national pharmacy websites as well as through information provided by national drug wholesalers. The lowest price at any given time will be the current reimbursement for a N.C. Medicaid claim.

Prior Authorization for Short-Acting Inhaled Beta Agonists

Effective with date of service September 21, 2009, the N.C. Medicaid Outpatient Pharmacy Program began requiring prior authorization for Short-Acting Inhaled Beta Agonists. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. Proventil HFA, Ventolin HFA, and generic albuterol do not require prior authorization.

N. C. pharmacists are allowed to substitute equivalent drug products when such substitution is authorized by the prescriber. Please refer to G.S. 90-85.28 through G.S. 90-85.31 for how North Carolina law defines an equivalent drug product.

2009/2010 Procedures for Prescribing Synagis for RSV Season

Effective with date of service November 2, 2009, N.C. Medicaid reimburses for respiratory syncytial virus (RSV) immune globulin (Synagis) **only** through the Outpatient Pharmacy Program. Synagis is not covered when billed through the Physician Drug Program or when billed on institutional claims by outpatient hospitals. This does not include an outpatient hospital pharmacy billing through point of sale.

The clinical criteria utilized by N.C. Medicaid for the 2009/2010 RSV season are consistent with currently published Red Book guidelines (on the Web at <http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110>; or in *Red Book: 2009 Report of the Committee on Infectious Diseases, 28th Edition*). Prescribers and pharmacists are responsible for ensuring the appropriate usage of Synagis.

The Synagis for RSV Prophylaxis form is used for recipients who meet the clinical criteria for coverage. Please ensure that the person completing the Synagis for RSV Prophylaxis form has verified that the conditions exist and are accurately reported. If a recipient does not meet the clinical criteria for coverage but you still wish to prescribe Synagis, submit your request for coverage as described below.

A medical necessity review for Synagis will be conducted for all requests for recipients under the age of 21 who do not meet the criteria listed on the Synagis for RSV Prophylaxis form. The medical necessity review will follow Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines. Please use the N.C. Medicaid Prior Authorization Synagis Drug Request form (PA Synagis Drug Request form) for a medical necessity review for Synagis under EPSDT guidelines. Prescribers may request coverage of Synagis doses exceeding policy or coverage outside of the defined seasonal period using the Non-covered State Medicaid Plan Services Request form for Recipients under 21 Years of Age, available online at <http://www.ncdhs.gov/dma/provider/forms.htm> (under Prior Approval).

N.C. Medicaid will begin coverage of Synagis on November 2, 2009. During the season, N.C. Medicaid will cover up to five monthly doses of Synagis. Pharmacies shall bill N.C. Medicaid in accordance with policy and shall adjust the number of doses billed if an infant received the first dose prior to a hospital discharge. Delays in request processing can occur if the recipient does not have a N.C. Medicaid identification number or if the form is not complete.

- The prescriber shall complete the Synagis for RSV Prophylaxis form and submit it to the pharmacy distributor of choice.
- If the recipient does not meet the criteria for coverage, complete the PA Synagis Drug Request form and fax it to ACS at (866) 246-8507.
- N.C. Medicaid does not participate in RSV Connection. Do not submit N.C. Medicaid forms to RSV Connection for review.
- Before billing N.C. Medicaid for Synagis, the pharmacy shall have on file evidence of a complete and accurate Synagis for RSV Prophylaxis form or a PA notice of approval.
- Please refer to the guidelines below when submitting a request for Synagis.

Requesting Synagis for RSV Prophylaxis When Criteria Are Met

Submit the Synagis for RSV Prophylaxis form. (If the recipient does **not** meet the criteria, please refer to **Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met** below.)

Criteria for a Maximum of Five Doses

For the following two diagnoses, date of birth (DOB) shall be on or after November 3, 2007.

- Chronic lung disease of prematurity (bronchopulmonary dysplasia): Infants and children younger than 24 months of age who have received treatment (supplemental oxygen, bronchodilator, diuretic, or chronic corticosteroid therapy) in the six months before the start of the season.
- Hemodynamically significant congenital heart disease: Infants younger than 24 months of age who are most likely to benefit include those receiving medication to control congestive heart failure (CHF), moderate to severe pulmonary hypertension, or cyanotic heart disease.
 - Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery unless the infant continues on medication for CHF, or mild cardiomyopathy for which the infant is not receiving medical therapy.

In addition to the two conditions listed above, a premature infant may qualify for five doses of Synagis as follows. Prematurity shall be counted to the exact day.

- Born at an estimated gestational age (EGA) of ≤ 28 weeks 6 days and DOB is on or after November 3, 2008
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 3, 2009
- Born at an EGA of ≤ 34 weeks 6 days **and** DOB is after March 31, 2009 and has either severe neuromuscular disease or congenital abnormalities of the airways, either of which compromises handling of respiratory secretions

Criteria for a Maximum of Three Doses; Last Dose Administered at 3 Months of Age (90 Days of Life)

Born at an EGA of 32 weeks 0 days to 34 weeks 6 days, and DOB is on or after August 3, 2009, and has at least one of the two following defined risk factors:

- Attends child care (defined as a home or facility where care is provided for any number of infants or young toddlers [toddler age is up to the third birthday]).
- Has a sibling younger than 5 years of age in the home.

The Red Book includes a detailed chart (shown for beginning prophylaxis on November 1) of the maximum number of Synagis [palivizumab] doses for RSV prophylaxis for preterm infants without chronic lung disease, on the basis of birth date, gestational age, and presence of risk factors (American Academy of Pediatrics. Respiratory Syncytial Virus. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2009 Report of the Committee on Infectious Diseases. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009: 560-569; Table 3.61). The chart is available online at <http://aapredbook.aappublications.org/cgi/content-nw/full/2009/1/3.110/TABLE3-61>. With the exception of following a November 2, 2009 season start date, NC follows guidance the chart provides, accordingly, on the recommended number of doses.

Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met

Prior approval (PA) will be required for Synagis when criteria are not met. Submit prior approval requests on the PA Synagis Drug Request Form by faxing it to ACS at (866) 246-8507. This PA form is to be used for recipients who do not explicitly meet the criteria on the Synagis for RSV Prophylaxis form.

Generally, the following conditions do not singularly justify medical necessity for Synagis prophylaxis:

- an RSV episode during the current season
- repeated pneumonia
- sickle cell disease
- being one member of a multiple birth, another member of which is approved for Synagis
- apnea or respiratory failure of newborn

Please use the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age to request Synagis doses exceeding policy or for Synagis administration outside the defined seasonal period. A medical review will be done to consider a request for Synagis under EPSDT (refer to <http://www.ncdhhs.gov/dma/epsdt/>). If the information provided justifies medical need, an approval notification will be faxed to the provider and pharmacy.

Submitting Synagis Request Using N.C. Medicaid Forms and Point of Sale Override

The North Carolina Medicaid Synagis for RSV Prophylaxis form and the PA Synagis Drug Request form are available on the DMA website at <http://www.ncdhhs.gov/dma/pharmacy/>. The PA Synagis Drug Request form is available, also, on the ACS website at <http://www.ncmedicaidpbm.com/>. The forms will be available on the websites prior to October 5, 2009. For further information about EPSDT or a copy of the Non-

covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age, go to <http://www.ncdhhs.gov/dma/epsdt/>.

The North Carolina Medicaid PA Synagis Drug Request form can be submitted to ACS starting on October 5, 2009. Please call the ACS Prior Authorization help desk at (866) 246-8505 for questions about the form. NC Medicaid will allow Synagis claims processing to begin on October 27, 2009, to allow sufficient time for pharmacies to provide Synagis by November 2, 2009. Payment of Synagis claims prior to October 27, 2009 and after March 31, 2010 will not be allowed. Point of sale (POS) claims billed for recipients requesting Synagis using the N.C. Medicaid Synagis for RSV Prophylaxis form require an override code. A "1" in the PA field (461-EU) will override the PA edit. The override code should be used only in instances where the form is complete and the recipient meets N. C. Medicaid criteria. Inappropriate use of the override will result in recoupment of payment for Synagis claims. These overrides will be monitored by Program Integrity.

Pharmacy providers shall always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths shall be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims shall be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of Synagis records by DMA Program Integrity.

Pharmacy Distribution Information

The pharmacy distributor shall maintain the **Synagis for RSV Prophylaxis** form on site. This form is required to support the use of the POS override code. The pharmacy distributor shall mail a copy of the submitted forms **weekly** to DMA. Please mail submitted forms to
N.C. Division of Medical Assistance
Pharmacy Program
2501 Mail Service Center
Raleigh NC 27699-2501

Pharmacy distributors who fill a large volume of Synagis claims are asked to submit information from the forms on a compact disk. Please call Charlene Sampson at 919-855-4300 to coordinate this process.

The pharmacy distributor shall also maintain on site a copy of the approval notification for recipients evaluated under the PA Synagis Drug Request form or the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age.

Suppliers of Medicare Durable Medical Equipment

Medicaid requires that durable medical equipment (DME) providers be enrolled with Medicare. Suppliers of Medicare DME must meet the DME accreditation standards by September 30, 2009, are required to obtain a Surety Bond by October 2, 2009, and should amend their CMS-855S application in order to retain the ability to continue to bill Medicaid. Suppliers not meeting these requirements risk having their Medicare and Medicaid billing privileges revoked (some exceptions to the accreditation requirement for pharmacies are listed below).

As a pharmacy, you may choose to provide DME drugs that do not require accreditation (such as those items listed below) and other Part B drugs that are covered by Medicare Part B. In these instances, accreditation is NOT required but a pharmacy will still need to possess a **surety bond**. This applies to the following covered drugs under Medicare Part B (that only require a surety bond):

1. Epoetin
2. Immunosuppressants
3. Infusion drugs
4. Nebulizer drugs
5. Oral anticancer drugs
6. Oral antiemetic drugs (replacement for IV antiemetics)

To continue to bill Medicare for these Part B medications **without accreditation**, as a pharmacy, you will need to update your status by submitting an **amended CMS-855S application** to the NSC. Therefore, if you choose to forgo accreditation, you must still obtain a surety bond, and the CMS-855S application must be amended in order to bill Medicare properly.

For more information on **accreditation**, visit MLN article SE0903:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf>.

For more information on **surety bonds**, visit MLN article MM6392:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6392.pdf>
<http://www.cms.hhs.gov/transmittals/downloads/R287PI.pdf>

Provider Enrollment and Re-credentialing Fee

Session Law 2009-451 mandated that DMA begin collecting a \$100 enrollment fee from providers upon initial enrollment with the N.C. Medicaid Program and at 3-year intervals when the provider is re-credentialed. This process will begin on September 1, 2009, and will apply to applications received on or after that date.

Electronic Funds Transfer

The N.C. Medicaid Program will no longer issue paper checks for claims payments. All payments will be made electronically by automatic deposit to the account specified in the provider's Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits.

Providers who are currently receiving paper checks for claims payment must complete and submit an EFT Authorization Agreement for Automatic Deposits (<http://www.ncdhhs.gov/dma/provider/forms.htm>) immediately to ensure that there is no disruption to payments.

Pharmacy claims submitted via point of sale on or after September 11, 2009, without an EFT Authorization Agreement on file and processed by the N.C. Medicaid Program will be denied. For all **other providers**, claims submitted after 5:00 p.m. on September 10, 2009, will suspend if an EFT Authorization Agreement for Automatic Deposit has not been submitted to and processed by the N.C. Medicaid Program.

Below are fax numbers available for providers to send EFT Authorization Agreements to EDS:

- 919-816-3186
- 919-816-3181
- 919-816-4399

Notice of Medicaid Identification Card Changes

On September 8, 2009, the N.C. Medicaid Program will begin issuance of one Medicaid identification (MID) card per year to each recipient. Currently, the N.C. Medicaid Program issues each recipient a new MID card each month. The new annual cards will be printed on gray card stock. DMA will phase out the blue, pink, green, and buff-colored MID cards. The new cards will include the case head name, recipient's name, MID number, issue date, and CCNC/CA primary care provider information (if applicable). The new cards do not indicate dates of eligibility. Recipients who are issued new cards may have been approved for prior months only, the current month only, or an ongoing period of up to 12 months. (See new card sample below.)

Because the new card no longer serves as proof of eligibility, it is essential that at each visit providers verify the recipient's

- Identity (if an adult)
- Current eligibility
- Medicaid program (benefit category)
- CCNC/CA primary care provider information
- Other insurance information

Current recipients and individuals approved for Medicaid prior to September 8, 2009, will be issued an old version of the monthly MID card. Providers will continue to see the blue, pink, green, and buff-colored cards and the new gray-colored cards during the month of September 2009. Old monthly cards with September or earlier eligibility dates continue to serve as proof of eligibility for the months shown on the card.

It is anticipated that a web-based recipient eligibility verification tool will be available in September (refer to the article titled *Electronic Recipient Eligibility Verification Tool* on page 5 for additional information). Instructions for using the tool are available in the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>. For additional information about verifying recipient eligibility refer to the *Basic Medicaid Billing Guide* (<http://www.ncdhhs.gov/basicmed/>).

Cut along dotted lines

ANNUAL MEDICAID IDENTIFICATION CARD

CASEHEAD NAME
CASEHEAD ADDRESS LINE 1
CASEHEAD ADDRESS LINE 2
CASEHEAD ADDRESS LINE 3
CASEHEAD ADDRESS LINE 4
CASEHEAD ADDRESS LINE 5

Recipient Signature _____
(Not valid unless signed)

USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD
AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

FOLD HERE

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

RECIPIENT I.D.	RECIPIENT NAME	ISSUE DATE
000.00.0000.N	JONNXXXXX Q. PUBLIC	SEPT. 8, 2009

PRIMARY CARE PROVIDER NAME
PRIMARY CARE PROVIDER ADDRESS LINE 1
PRIMARY CARE PROVIDER ADDRESS LINE 2
PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

For questions about your Medicaid coverage and/or to report
Medicaid fraud, waste or program abuse, please contact
CARE-LINE at 1-800-662-7030 or locally call 919-855-4400.

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Cut along dotted lines

NOTICE TO PROVIDERS

The Medicaid Identification card is not proof of Medicaid eligibility. It is the responsibility of the medical provider to verify the identity of the individual, the Medicaid covered services, medical home/primary care physician with whom the recipient is enrolled, and to obtain authorization from the primary care physician as required. Refer to the Basic Medicaid Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/> for information on how to verify eligibility for Medicaid covered services and to obtain authorization.

Eligible Provider: A provider must be enrolled in the NC Medicaid program to be paid for services rendered to NC Medicaid recipients. If not enrolled, go to www.netracks.nc.gov to find enrollment information and forms or call the CSC Enrollment Verification and Credentialing (EVC) Center at 1-866-844-1113.

FOLD HERE

- **Prior Approval:** Some Medicaid services must be approved in advance. Refer to the Basic Medicaid Billing Guide for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins.
- <http://www.ncdhhs.gov/dma/bulletin/>.
- Out of state providers must obtain approval prior to delivering Medicaid services unless there is a medical emergency as defined in the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii). In cases of medical emergency that result in patient hospitalization, out of state providers must notify North Carolina Medicaid within 72 hours (three business days) of the admission date.
- **Claim Filing:** Bill other insurance first; Medicaid is last payor. Medicaid payment is full payment even if charges exceed the payment. Refer to the Basic Medicaid Billing Guide for additional information regarding claim filing.

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Electronic Claim Submission Exceptions

As a cost-saving measure and to increase efficiency, beginning October 2, 2009, the N.C. Medicaid Program will require all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Information on the electronic claim mandate was originally published in the June 2009 Medicaid Bulletin.

The list of exceptions (originally published in the July 2009 Medicaid Bulletin) to the requirement for electronic claim submissions has been revised and is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>. Only claims that comply with these exceptions may be submitted on paper. All other claims are required to be submitted electronically. Providers will be notified of updates to the list through the Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin/>).

Electronic Recipient Eligibility Verification Tool

In September, the N.C. Medicaid Program will implement an electronic recipient eligibility verification tool. This tool will allow providers to access electronic recipient eligibility via the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool (<https://webclaims.ncmedicaid.com/ncecs/>).

Use of this tool will allow providers to immediately verify recipient information such as

- Current eligibility
- Medicaid program (benefit category)
- Medicare participation
- CCNC/CA (Carolina ACCESS) participation
- Transfer of asset information
- Other insurance information

This will be the same information that providers receive today through the Automated Voice Response (AVR) system but the Recipient Eligibility Tool will be quicker and easier to use. In order to use this tool, providers must have access to the Web Tool. DMA encourages you to begin immediately the process of obtaining this access.

Providers who currently have a Web logon ID and password can utilize this same logon information to access recipient eligibility verification. You do not need to take any further action.

Providers who do not currently have access to the Web Tool must take the following action.

Step One:

Submit a completed and signed Electronic Claims Submission (ECS) Agreement to CSC. (Refer to the NC Tracks website at <http://www.netracks.nc.gov/provider/forms/> for a copy of the form and instructions.)

Note: Providers who have previously submitted the ECS Agreement do not need to resubmit the form.

Step Two:

Contact the EDS Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain instructions and a logon ID and password for the Web Tool.

For additional information on verifying recipient eligibility refer to the *Basic Medicaid Billing Guide* on DMA's website at <http://www.ncdhhs.gov/dma/basicmed/>. For detailed information on the Web Tool, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): <http://www.ncdhhs.gov/dma/basicmed/>
- *Health Check Billing Guide*: <http://www.ncdhhs.gov/dma/healthcheck/>
- EPSDT provider information: <http://www.ncdhhs.gov/dma/epsdt/>

Federal MAC List Changes

Effective September 25, 2009, the following changes will be made to the Medicaid Drug Federal Upper Limit list:

FUL DeletionsGeneric Name

Erythromycin
0.5%, Ointment, Ophthalmic, 3.5 gm

Metoprolol Succinate
EQ 100 mg, Tartrate, Tablet, Extended Release, Oral, 100
EQ 200 mg, Tartrate, Tablet, Extended Release, Oral, 100

FUL Decreases

<u>Generic Name</u>	<u>FUL Price</u>
Amiodarone Hydrochloride 200 mg, Tablet, Oral, 60	\$0.7375 R
Benzonatate 100 mg, Capsule, Oral, 100	\$0.1403 B
200 mg, Capsule, Oral, 100	\$0.2460 B
Betamethasone Dipropionate; Clotrimazole EQ 0.05% Base/1%, Cream, Topical, 15	\$0.8230 B
Citalopram Hydrobromide EQ 10 mg Base/5 ml, Solution, Oral, 240	\$0.3124 B
EQ 10 mg Base, Tablet, Oral, 100	\$0.1673 B
EQ 20 mg Base, Tablet, Oral, 100	\$0.1725 B
EQ 40 mg Base, Tablet, Oral, 100	\$0.1755 B
Clarithromycin 500 mg, Tablet, Oral, 60	\$0.8625 B
Clobetasol Propionate 0.05%, Cream, Topical, 30	\$0.1825 B
Methylphenidate Hydrochloride 5 mg, Tablet, Oral, 100	\$0.2253 R
10 mg, Tablet, Oral, 100	\$0.3006 R
20 mg, Tablet, Oral, 100	\$0.3309 R

FUL Decreases (cont.)

<u>Generic Name</u>	<u>FUL Price</u>
Naproxen	
250 mg, Tablet, Oral, 100	\$0.1032 B
375 mg, Tablet, Oral, 100	\$0.0761 B
500 mg, Tablet, Oral, 100	\$0.0824 B
Ofloxacin	
0.3%, Solution/Drops, Ophthalmic, 5	\$3.4500 B
Tizanidine Hydrochloride	
EQ 2 mg Base, Tablet, Oral, 150	\$0.2600 R
EQ 4 mg Base, Tablet, Oral, 150	\$0.3200 R

FUL Additions

<u>Generic Name</u>	<u>FUL Price</u>
Amoxicillin; Clavulanic Acid	
600 mg/5ml; EQ 42.9 mg Base/5 ml, Suspension, Oral, 75	\$0.4500 R
500 mg; EQ 125 mg Base, Tablet, Oral, 20	\$2.1158 B
875 mg; EQ 125 mg Base, Tablet, Oral, 20	\$2.5320 B
Clobetasol Propionate, Emollient Base	
0.05%, Cream, Topical, 30	\$0.4465 B

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.

Terminated Labelers

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

Blansett Pharmacal Co., Inc (Labeler 51674)

Voluntarily Terminated Labeler

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

Multi-Pak Packaging (Labeler 66789)

Checkwrite Schedule

September 09, 2009	October 06, 2009	November 10, 2009
September 15, 2009	October 14, 2009	November 19, 2009
September 24, 2009	October 20, 2009	December 01, 2009
	October 29, 2009	
	November 03, 2009	

Electronic Cut-Off Schedule

September 03, 2009	October 01, 2009	November 05, 2009
September 10, 2009	October 08, 2009	November 12, 2009
September 17, 2009	October 15, 2009	November 25, 2009
	October 22, 2009	
	October 29, 2009	

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

Acting Chief, Pharmacy and Ancillary Services
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
EDS

Melissa Robinson

Executive Director
EDS
