



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

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Syringe and Pen Needle Coverage through Pharmacy Point-of-Sale

Syringes and pen needles are covered through the pharmacy point-of-sale system as long as there is a history drug claim on file in the previous 90 days. Currently insulin, growth hormones, Byetta and Forteo are considered to be a valid history claim in order to receive either the syringes or pen needles.

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 will be deleted from the CMS Master Drug Rebate (MDR) file of covered drugs effective as of **October 21, 2010**.

NDC	Drug Name
00591094401	COLCHICINE 0.6 MG TABLET
00591094410	COLCHICINE 0.6 MG TABLET
00603305221	COLCHICINE 0.6 MG TABLET
00603305232	COLCHICINE 0.6 MG TABLET
51552099101	COLCHICINE POWDER

Requirement for Internal Claim Number on Self-Audits

DMA's Program Integrity Section strives to operate the most cost efficient health care system possible while further enhancing the quality and appropriateness of services delivered. DMA Program Integrity supports our health care providers' efforts to identify and resolve issues with overpayments and billing errors themselves.

Providers are encouraged to identify overpayments and correct potential billing errors by performing self-audit reviews. In an effort to properly track refunds of Medicaid monies, internal claim numbers (ICN) are required on all self-audit results submitted to DMA Program Integrity.

Participation in the self-audit program does not alleviate the possibility of further review by Program Integrity in this or future investigations, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies or to obtain additional damages, penalties or fines for the matters that are the subject of the self-audit.

Self-audit packets are available by calling DMA Program Integrity at 919-647-8000 or 1-877-362-8471.

Provider Enrollment Application Process

Recent reports indicate improvements in CSC's processing times for provider enrollment. DMA will continue to monitor the process and to work with CSC to identify areas for improvement.

To ensure that provider enrollment applications continue to be processed in a timely manner, applicants are reminded to complete all required fields and to fully answer all of the required disclosure questions. Please refer to the online help text when completing the application.

Complete information is critical to ensuring an accurate background check [as required by PL 111-148 Subtitle E, Section 6401(b)]. Applicants are reminded that

- Individual information requested on the application must match the applicant's federal tax form.
- If applicable, the full middle name should be indicated.
- Social Security Numbers are required.

Information about **Managing Relationships** between the applicant and any employee who exercises operational or managerial control of the provider agency or who directly or indirectly conducts the day-to-day operations of the provider agency must be disclosed (see 42 CFR 1002.3). Company officers, directors, general managers, business managers, and office administrators, as well as any personnel authorized for electronic funds transfers, are considered to be a managing relationship.

- Please enter the individual's full middle name, if applicable.
- The individual's Social Security Number and date of birth are required.
- The business relationship to the provider must be indicated.

Ownership information for any applicant that is a corporation, partnership or non-profit organization must be disclosed (see 42 CFR 1002.3). Applicants must report all **Ownership Information** for each owner/shareholder with 5% or more direct or indirect controlling interest in the applicant's organization.

- For individual owners, enter the full name (including full middle name, if applicable), Social Security Number, and date of birth.
- For corporate owners, enter the complete legal name of the business and the Employer Identification Number.

All applicants must answer each question in the **Exclusion Sanction Information** section of the application.

- For each question that is answered with a "yes," applicants must attach or submit a complete copy of the applicable criminal complaint or disciplinary action, Consent Order, documentation regarding recoupment/repayment/settlement actions, and/or final disposition clearly indicating the final resolution as applicable. A written explanation in lieu of supporting documentation is not acceptable.
- Disclosure is not time-limited; all adverse legal actions must be reported regardless of whether any records were expunged or any appeals are pending.

Disclosure of adverse legal actions may not preclude participation with the N.C. Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the N.C. Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).

Pharmacy Prior Authorization: Response Times and Emergency Supplies

All pharmacy prior authorization (PA) requests are processed at the ACS Clinical Call Center in Henderson, North Carolina. The PA Help Desk receives and responds to calls related to prior authorizations. ACS employs a sufficient number of attendant pharmacists and technicians to receive and respond to every call, but the PA Help Desk also has a voice mail system if the prescriber/provider elects not to wait for the next available PA Help Desk attendant.

PA requests should be completed **within 24 hours or less**. Turnaround time is contingent upon the accuracy of information obtained from the PA request. Please contact the DMA pharmacy program staff at 919-855-4300 for assistance if you have a PA request that has not been responded to within 24 hours from the time of request.

In addition, a 72-hour emergency supply is available to all recipients who are waiting for acknowledgement of their prior authorization request. The pharmacy will be reimbursed for the supply if the prescription is changed to an alternative medication. If the prior authorization request is approved, the emergency supply should be billed through POS as part of the original fill.

If the prior authorization request is not approved, the emergency supply should be billed on a pharmacy paper claim and mailed to:

**HP Enterprise Services
Attn: Pharmacy Claims Analyst
2610 Wycliff Rd, Suite 401
Raleigh, NC 27607**

Helpful Information:

The ACS PA Help Desk is open **7 a.m. until 11 p.m. Monday through Friday and 7 a.m. until 6 p.m. Saturday and Sunday**. Prior authorization requests may be phoned in, faxed in, emailed or sent by US mail. Please see information below:

Prior Authorization Requests by Phone: 866-246-8505

Prior Authorization Requests by Fax: 866-246-8507

Prior Authorization Requests by Email: NorthCarolinaPriorAuthorization@acs-inc.com

Prior Authorization Requests by US Mail should be mailed to the following address:

**ACS Clinical Call Center
P.O. Box 967
Henderson, NC 27536-8198
Prior Authorization Website: www.ncmedicaidpbm.com**

False Claims Act Education Compliance for Federal Fiscal Year 2009

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires providers receiving annual Medicaid payments of \$5 million or more to educate employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws.

Each year DMA will notify those providers who received a minimum of \$5 million in Medicaid payments during the last federal fiscal year (October 1 through September 30) that they must submit a Letter of Attestation to Medicaid in compliance with the DRA. (A complete list of providers who meet this requirement will be available on DMA's website at <http://www.ncdhhs.gov/dma/fcadata/default.htm>.) This minimum amount may have been paid to one N.C. Medicaid provider number or to multiple Medicaid provider numbers associated with the same tax identification number. A separate notification will be mailed for each Medicaid provider number.

Providers must complete and submit a copy of the Letter of Attestation Form within 30 calendar days of the date of notification.

Upon completion, submit the Letter to HP Enterprise Services by fax or by mail.

Mail to

HP Enterprise Services
Attn: PVS-False Claims Act
P.O. Box 30968
Raleigh NC 27622

OR

Fax to

919-851-4014
Attn: PVS-False Claims Act

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers who do not submit a signed Letter of Attestation within 30 days of the date of notification. Providers may resubmit claims once the signed Letter is submitted to and received by HP Enterprise Services.

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>
42847	Somaxon Pharmaceuticals, Inc	10/14/2010
49702	Viiv Healthcare	10/19/2010
64950	Lehigh Valley Technologies Inc	10/07/2010

Reinstated Labeler

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
11994	Lantheus Medical Imaging, Inc	10/06/2010

Checkwrite Schedule

October 05, 2010	November 02, 2010	December 02, 2010
October 13, 2010	November 09, 2010	December 07, 2010
October 19, 2010	November 18, 2010	December 14, 2010
October 28, 2010		December 22, 2010

Electronic Cut-Off Schedule

September 30, 2010	October 28, 2010	November 24, 2010
October 07, 2010	November 04, 2010	December 02, 2010
October 14, 2010	November 10, 2010	December 09, 2010
October 21, 2010		December 16, 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

Glenda Adams, PharmD.
Outpatient Pharmacy Program Manager
Division of Medical Assistance
Department of Health and Human Services

Craigan 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
HP Enterprise Services

Melissa Robinson
Executive Director
HP Enterprise Services
