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In This Issue...

N.C. Division of Medical Assistance - Program Integrity Unit
What you need to know

N.C. Medicaid Preferred Drug List Changes – Revised Date

Health Choice Transition

Deleted NDC's from CMS

Letter of Attestation Revision

Medicaid Fraud: Protect Your Tax Dollars

HIPAA ASC X12 5010 Implementation

NCPDP Version D.0 Implementation Schedule

Subscribe and Receive Email Alerts for Medicaid Updates

Audits and Post Payment Reviews

Update to Provider Self Audit Process

Forms Required for Processing Payment of North Carolina Health Choice Claims

North Carolina Health Choice (NCHC) Proposed Clinical Coverage Policies

Changes in Drug Rebate Manufacturers

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1-800-688-6696 or 919-851-8888

N.C. Division of Medical Assistance - Program Integrity Unit

What you need to know

In 2009, Secretary Lanier Cansler launched N.C. DHHS to a new day and required all DHHS employees to work towards making DHHS the best managed agency in state government by becoming more customer focused, anticipatory, collaborative, transparent, and results-oriented. With this initiative in mind, the Program Integrity Section of DMA is broadening the lines of communication with stakeholders on efforts to ensure compliance, efficiency and accountability and prevent improper payments of Medicaid dollars. Below is an overview of Program Integrity efforts in North Carolina.

N.C. Medicaid Fast Facts

- \$1 out of every \$6 of the budget is spent on Medicaid (15%)
- Has a \$9-10 billion budget and one of the largest health care companies in the state
- Serves 1.5 million people annually (15.5% of total state population) and it is projected to increase 500,000 to 700,000 people by 2014
- Medicaid Fraud/Abuse and Misuse is a nationally recognized problem that drains taxpayers' dollars, hurts recipients and takes valuable resources right out of the system
- DMA and Program Integrity must be accountable for meeting benchmarks and achieving goals

What is the Program Integrity Section's mission?

- Ensure compliance, efficiency and accountability with the North Carolina Medicaid Program by detecting and preventing fraud, waste and program abuse.
- Prevent improper payments of Medicaid dollars through cost avoidance activities, tort recoveries, recoupments and ongoing educations/training of providers and recipients.

What are the Initiatives and Strategies of Program Integrity?

- Provide guidance to ensure the operation of the most cost-efficient health care system possible while further enhancing the quality and appropriateness of services delivered.
- Require and support efforts where health care providers are able to identify and resolve issues themselves.
- Hold provider agencies accountable for failing to have systems in place to prevent improper billing.
- Maximize technology and statistical analysis to detect providers or recipients who are outliers or illustrate aberrant patterns of utilization.
- Elevate support and use of administrative tools of payment suspension, prepayment, and post-payment review, audits, sanctions, and individual and entity exclusion when improper payments are discovered.
- Develop and communicate to the public measures of effectiveness of Program Integrity activities, which capture cost reduction and avoidance, as well as recoveries, recoupments and minimize cost imposed by reviews and investigation.
- Evaluate program activities and identify areas of vulnerabilities that adversely affect system and agency accountability and modify policies and rules accordingly.

What are Program Integrity's objectives?

- Customer service
- Bridge policy with execution & education
- Track down & eliminate Medicaid fraud, waste and abuse

What are Program Integrity's processes for recoupment?

- Detection- Identify suspicious activity
- Assignment- vette, prioritize and assign
- Investigation- open case, finalize and send tentative notice of overpayment
- Accounts Receivable & payment- collect and pay federal share

What does Program Integrity workload consist of?

- Call intake/complaint
- Claims review
- Case investigation & research
- Provider audits & edits
- Provider education

What are some of the projected benefits of Program Integrity's 2011-2012 goals?

- Enhanced provider education
- Highly scalable service delivery
- Shift to a more proactive/preventive model
- Improved guidance on reimbursement policies/provider enrollment requirements
- Improved return on investment on early detection and cost avoidance activities
- Improved detection and targeting
- Increased efficiencies
- Improved performance standards
- Reduced case time (open to close)
- Enhanced quality and auditability
- Enhanced access to modernized tools
- Improved stakeholder communications, collaboration and education

Program Integrity Partners in combating Medicaid Fraud, Waste & Abuse

IBM-Fraud Abuse Management Systems (FAMS)

IBM provides the Program Integrity Unit with two solutions for detecting Fraud, Waste and Abuse of Medicaid services in the Provider community.

- IBM Fraud & Abuse Management System (FAMS)
IBM's fraud and abuse management system (FAMS) uses advanced analytics to detect healthcare fraud and abuse by healthcare providers. This is accomplished through the use of peer group modeling and behavioral analysis to identify possible Providers of interest.
- **IBM Infosphere Identity Insight**
IBM Infosphere Identity Insight is a real-time entity resolution and analysis platform for identifying fraud.

Its identity and relationship disambiguation technology helps Program Integrity and its partners recognize and mitigate the incidence of fraud, waste & abuse.

- Who is Who – Identity Resolution
- Who Knows Who – Relationship Resolution

Public Consulting Group (PCG)

PCG is the vendor contracted by DMA to support Program Integrity in the post-payment claims review initiatives; such as:

- Determining if services billed were clinically and administratively appropriate according to generally accepted standards of care, N.C. Medicaid coverage policies, guidelines and procedures.

Health Management System (HMS)

HMS is the vendor contracted by DMA to support Program Integrity in the Third Party Liability Recoveries, Cost Avoidance and Credit Balance Review initiatives.

Ingenix – Health Spotlight, OmniAlert and DRIVE

- Health SpotLight and OmniAlert combined makes up the N.C. Fraud and Abuse Detection System provided by Optum. Health SpotLight provides browse and search capabilities of paid and denied claims for the last 6 years as well as custom analytics to identify potential fraud and/or abuse by providers and recipients.
- OmniAlert is the N.C. SUR application and allows the user to rank providers or recipients based upon a variety of user defined rules. Optum staff provides support to the DMA business users for each of these tools. In addition, Optum staff provides data mining support to DMA staff to identify providers billing units that are more than 5 times the standard deviation for services.
- DRIVE is the data warehouse maintained by Optum for DMA which contains the 6 years of paid and denied claims data upon which the Health Spotlight and OmniAlert analytics are based. Parameterized queries are provided for staff to enter dates, billing provider numbers, attending provider number, provider types and specialties, etc., to identify potential abuse, fraud, or waste.

The Carolinas Center for Medical Excellence (CCME)

CCME is the vendor contracted by DMA to support Program Integrity in the post payment Diagnosis Related Group (DRG) reviews of inpatient services to determine that appropriate DRG assignments have occurred and criteria for medical necessity of inpatient acute admissions have been met.

CCME also partners with Program Integrity in performing pre-payment claims review.

Medicaid Fraud Control Unit: (Also known as Medicaid Investigation Unit – MIU)

- While Program Integrity identifies Medicaid fraud, the Attorney General's Medicaid Investigations Unit (MIU) takes the legal action to convict a provider of criminal fraud. The MIU coordinates their efforts with the IRS, State Bureau of Investigation, FBI, Drug Enforcement Agency, U.S. Attorney, Office of Inspector General and the Medicaid Fraud Control Units in other states to resolve fraud cases. As a general rule, once a case is taken by the MIU, Program Integrity staff involvement with the provider ceases.

Summary

Program Integrity believes that an analytically-driven approach plus effective, efficient processes with enhanced governance and reporting is the formula for achieving Medicaid quality assurance and compliance. The DHHS values of being customer focused, anticipating challenges, practicing transparency in decision making, collaborating on issues and holding ourselves accountable for outcomes are the foundation for our strategic approach. Program Integrity is committed to this plan and our stakeholders.

N.C. Medicaid Preferred Drug List Changes – Revised Date

Effective with date of service **November 15, 2011**, DMA will make changes to the N.C. Medicaid Preferred Drug List. Below are highlights of some of the changes that will occur:

- Addition of N.C. Health Choice (including all clinical PA requirements)
- Addition of the tetracycline derivatives drug class
- Addition of the pancreatic enzymes drug class including grandfathering of current users
- Addition of the topical steroids drug classes
- Addition of a one-time point-of-sale override for Pradaxa and new oral anticoagulants that enter the marketplace as non-preferred to allow transition to a preferred agent
- Removal of coverage from the outpatient pharmacy program of the IV formulations Actemra, Orencia, Remicade, Boniva, pamidronate disodium, Reclast, Xgeva, and Zometa. (Coverage will continue under the Physicians Drug Program)
- Updates to the list of preferred brands (please see chart below):

Brand Name	Generic Name
Accolate	zafirlukast
Alphagan P	brimonidine
Aricept	donepezil
Astelin/Astepro	azelastine hydrochloride
Benzaclin	Clindamycin/Benzoyl Peroxide
Differin	adapalene
Exelon	rivastigmine
Lovenox	enoxaparin
Ovide	malathion

Health Choice Transition

Effective with date of service on and after October 1, 2011, N.C. Health Choice (NCHC) claims will be processed by DMA's fiscal agent, HP Enterprise Services. Providers should use the same BIN and PCN currently used to submit N.C. Medicaid claims. 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.

The Medicaid policy will apply, so all claims over \$9,999.99 will need to be billed on the Medicaid Pharmacy Claim Form located at <http://www.ncdhhs.gov/dma/forms/pharmclaim.pdf>

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 **October 04, 2011**.

NDC	DRUG NAME
66993053402	R-TANNA TABLETS
66993053757	R-TANNA S PEDIATRIC SUS 5/4.5MG

Letter of Attestation Revision

As previously announced in the September 2011 Medicaid bulletin, the Division of Medical Assistance (DMA) will no longer notify providers who received a minimum of \$5 million in Medicaid payments during the federal fiscal year (October 1, 2009 through September 30, 2010). Upon enrollment and re-enrollment in the N.C Medicaid program, providers are required to complete and sign the Letter of Attestation on the NCTracks website at <http://www.nctracks.nc.gov/provider/forms/> as a condition of participation in the Medicaid and N.C. Health Choice programs. In accordance with Session Law 2011-399, § 108C-9 requires the revised provider attestation to contain a statement that the provider:

- “has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance programs,
- does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission,
- does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and has implemented a corporate compliance program as required under federal law.”

DMA is currently modifying the Letter of Attestation to include statements regarding educating employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws, and to include additional statements as required in the Affordable Care Act and Session Law 2011-399. To avoid any delay in reimbursement, providers should review their corporate compliance programs and be prepared to submit the signed revised Medicaid Letter of Attestation. All providers will receive further guidance on completing and submitting attestations for Medicaid. Information will be available in upcoming Medicaid bulletins and on the “What’s New” page of the DMA’s website at <http://www.ncdhhs.gov/dma/provider/index.htm>.

Medicaid Fraud: Protect Your Tax Dollars

WHY IT IS IMPORTANT?

The Medicaid program is funded with state and federal tax dollars. It is designed to pay for health care and certain support services for low-income and vulnerable North Carolinians (children, pregnant women, disabled adults and seniors). Tax dollars are wasted and services are taken away from people who need them when people obtain benefits they are not entitled to or when services are delivered that don't meet the policy and requirements.

WHAT IS MEDICAID FRAUD, WASTE AND ABUSE?

- **Fraud:** Deception or misrepresentation made by a health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under Federal requirements set forth in 42 C.F.R § 455 which relates to Medicaid.
- **Waste:** The over utilization of services, or other practices that result in unnecessary costs generally not considered caused by criminal negligent actions but rather the misuse of resources.
- **Abuse:** Provider practices that are inconsistent with sound fiscal, business or clinical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet recognized standards for health care or clinical policy.

WHAT MEDICAID FRAUD LOOKS LIKE?

Most types of Medicaid fraud, waste or abuse fall into one or more of these categories:

- Billing for “phantom patients” who did not really receive services
- Billing for medical services or goods that were not provided
- Billing for old items as if they were new
- Billing for more services that could be provided in 24 hours a day
- Billing for unnecessary tests
- Paying a “kickback” in exchange for a referral for medical services or goods
- Charging Medicaid for expenses that have nothing to do with caring for a Medicaid client
- Overcharging for health care services or goods that were provided
- Concealing ownership in a related company
- Using false credentials for staff
- Double-billing for health care services or goods that were provided
- Providing services by untrained staff

To report suspected Medicaid Fraud, Waste or Abuse, please call the North Carolina DHHS Customer Service Center toll-free number at 1-800-662-7030 or the North Carolina Medicaid Program Integrity Tip-Line at 1-877-DMA-TIP1 (1-877-362-8471).

You may submit an Online Medicaid Fraud and Abuse Confidential Complaint Form using the website <http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>. Callers may request to remain anonymous.

Before making a report, try to get as much information as possible, including:

- The name of the provider/recipient you suspected of committing fraud. This might be a person receiving medical benefits or a health care professional, hospital, nursing home, or other facility that provides Medicaid services
- The Recipient Medicaid ID number
- The Provider ID number
- The date of services
- The amount of money involved, and/or
- A description of the acts that you suspect involve fraud

HIPAA ASC X12 5010 Implementation

In accordance with 45 CFR Part 162 – Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rule, HIPAA-covered entities, which include state Medicaid agencies, must adopt modifications to the HIPAA required standard transactions by January 1, 2012. The modifications are to the HIPAA named transactions to adopt and implement ASC X12 version 5010 and NCPDP Telecommunication version D.0. N.C. Medicaid will implement the HIPAA requirements for the ASC X12 5010 transactions within the legacy MMIS+ claims processing system. HPES will begin Vendor/or Trading Partner testing of the 837 transactions for compliance in October, 2011. Clearing Houses, Billing Agencies and providers using vendor software to connect to HPES, will need to update their Trading Partner Agreement – Appendix A in preparation for ASC X12 5010 testing and implementation. HPES will begin dual processing of transactions on November 4, 2011. In addition, if your Trading Partner Agreement has been updated, you will receive both the ASC X12 versions 4010 and ASC X12 versions 5010 of the 835 transaction beginning with the November 8, 2011 checkwrite. The Division of Medical Assistance will continue to notify providers through upcoming Medicaid Bulletins as the HIPAA ASC X12 5010 implementation efforts progress.

NCPDP Version D.0 Implementation Schedule

In accordance with 45 CFR Part 162 – Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rule, HIPAA-covered entities, which include state Medicaid agencies, must adopt modifications to the HIPAA required standard transactions by January 1, 2012. The modifications are to the HIPAA named transactions to adopt and implement ASC X12 version 5010 and NCPDP Telecommunication version D.0.

North Carolina Medicaid has published a companion guide for NCPDP D.0. to assist providers and trading partners in their effort to become HIPAA compliant. This companion guide is specific to N.C. Medicaid and is intended to be used in conjunction with NCPDP Standards for Retail

Pharmacy Services for complete implementation information. Consult the NCPDP website at <http://www.ncpdp.org> for the NCPDP Transaction Standards for Retail Pharmacy Services. N.C. Medicaid companion guides are now available at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm>

Medicaid will implement NCPDP Version D.0 on November 18, 2011 and will continue to support NCPDP 5.1 until December 31, 2011.

Subscribe and Receive Email Alerts for Medicaid Updates

NC Medicaid allows all providers the ability to sign up for NC Medicaid email alerts. Email alerts send notices to providers on behalf of the NC Division of Medical Assistance (DMA) and NC Health Choice (NCHC) programs. Email alerts are sent to providers when there is important information to share outside of the general Medicaid Provider Bulletins. To receive email alerts, subscribe to the Email alerts at www.hp.com/go/medicaidalert. Providers and their staff members may subscribe to the email alerts. Contact information including an email address and provider type of specialty is essential for the subscription process. You may unsubscribe at any time.

Email addresses are never shared, sold or used for any purpose other than Medicaid email alerts.

Audits and Post Payment Reviews

In accordance with Session Law 2011-399, Program Integrity authorized audits and post payment reviews conducted during the state fiscal year 2011-2012 will utilize extrapolation of findings to determine recoupment amounts.

Providers who have been designated as high or moderate risk are subject to review during this fiscal year. In addition to moderate or high risk providers, other providers may be identified for review through the use of the analytical data mining software by identifying outlier billing patterns, irregular service or referral trends.

Additional methods of identification for provider review include the receipt of complaints of credible allegation fraud or abuse and tips received through the Fraud/Abuse Tip Line. Providers who receive post payment review will be subject to review for all services and codes authorized by their participation agreement with the Division of Medical Assistance (DMA). The review or audit may take the form of a desk review of medical records or an onsite review or a combination of both. The onsite review may be announced or unannounced.

If the audit is a desk review, providers will receive a request for medical records as part of the post payment review process. The letter will outline the exact dates of medical records or claims to be reviewed, documentation being requested and the consequences for failure to comply with the request by the date identified in the letter. Based upon DMA or contractor post payment review of the submitted documentation, the desk review may lead to an onsite review or an expanded period of review.

The results of the audits will be extrapolated to determine the final overpayment amount. The time period of extrapolation may go back for 36 months from date of payment of a provider's claim or longer as allowed by federal law or regulation or in instances of credible allegations of fraud.

Update to Provider Self Audit Process

In 1999, the Division of Medical Assistance (DMA) Program Integrity started a Provider Self-Audit process, which offered Medicaid providers an opportunity to conduct internal compliance audits and have a mechanism for reporting their outcomes directly to Medicaid. This process still exists, and parts of it are being expanded and incorporated into new activities introduced through N.C. Session law 2011-399.

In the current process, a provider may request a Self-Audit packet from Program Integrity, which contains instructions and forms to be returned to DMA. Providers will be able to access the packet on our web site in the near future. The provider will submit a Notice of Intent to Conduct Self Audit form to Program Integrity, which includes a description of the intended type of audit and anticipated date of completion. This information is assigned to a Program Integrity analyst, who works with you through the process.

N.C. Session Law 2011-399 offers providers the opportunity to conduct a self audit as a method for contesting the outcome of certain Program Integrity audits. As part of a provider investigation Program Integrity and its vendors review a random sample of claims from the “universe” of claims submitted by a provider over a period of time. Errors identified in the sample may be extrapolated across the full universe of claims. In cases where a “low risk” or “moderate risk” provider is notified of tentative findings of errors that could result in extrapolation, they may contest the extrapolation by conducting a self-audit. Providers should carefully review N.C. Session Law 2011-399, N.C.G.S. § 108C-5(n) “Payment suspension and audits utilizing extrapolation” for further details.

Forms Required for Processing and Payment of North Carolina Health Choice (NCHC) Claims

As previously announced in the Medicaid bulletins, claims for N.C. Health Choice (NCHC) will be processed by Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES). DMA’s current fiscal agent, HPES will begin processing claims for NCHC. NCHC providers who are newly enrolled with Medicaid must complete and submit additional forms to HPES after they receive their N.C. Medicaid provider number. Please be advised that these forms are essential for proper and timely claim processing. After completing the Medicaid provider enrollment process and receiving an N.C. Medicaid provider number from CSC, NCHC providers should submit the Electronic Claims Submission Agreement and the Electronic Funds Transfer (EFT) Authorization Agreement to HPES. More information about the requirements for electronic claims submission can be found at <http://ncdhhs.gov/dma/provider/billing.htm#ec>.

In accordance to Session Law SL2011-145 § 10.31(b)(6) Medicaid-enrolled providers must submit claims electronically. However, certain exceptions require claims to be filed on paper. The exceptions are listed on DMA’s website at <http://ncdhhs.gov/dma/provider/ECSEExceptions.htm>. Only those claims which comply with the exceptions will be accepted on paper. NCHC providers should mail paper claims and any NCHC claims-related written correspondence to:

HP Enterprise Services
P.O. Box 300001
Raleigh, N.C. 27622-0001

The HPES mailing address for NCHC Prior Approval is:

HP Enterprise Services
 Prior Approval
 P.O. Box 322490
 Raleigh, N.C. 27622

If providers want to be able to submit their paper claims without a signature, they must complete the Provider Certification for Signature on File form and submit that to HPES.

Legislation also requires HPES to issue Remittance and Status Reports to providers electronically. The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted, along with a detailed breakdown of payment. RA's are posted in PDF format on the N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool. All providers who want to download a PDF version of their RA must register for the NCECS Web Tool and submit the Remittance and Status Reports in PDF Format and National Correct Coding Initiative Information Request Form. Refer to the **Basic Medicaid Billing Guide** for more information about NCECS Web Tool and Electronic Commerce Services (ECS).

All of the aforementioned forms and their respective instructions are located on the DMA website at: <http://ncdhhs.gov/dma/provider/forms.htm> Questions regarding the forms or NCHC claims submission for dates of service 10/1/2011 and after should be directed to the HPES Provider Services Department at 1-800-688-6696, menu option 3.

North Carolina Health Choice (NCHC) Proposed Clinical Coverage Policies

The NC Physician Advisory Group has recommended that the proposed policies listed below be covered under the N.C. Health Choice Program.

Proposed Policy	Date Posted	Comment Period End Date
NCHC Surgery for Clinically Severe or Morbid Obesity	12-Sep-11	27-Oct-11
NCHC Kidney (Renal) Transplantation	31-Aug-11	15-Oct-11
NCHC Heart (Cardiac) Transplantation	29-Aug-11	13-Oct-11
NCHC Liver Transplantation	29-Aug-11	13-Oct-11
NCHC Heart/Lung Transplantation	29-Aug-11	13-Oct-11
NCHC Islet Cell Transplantation	29-Aug-11	13-Oct-11
NCHC Pancreas Transplantation	29-Aug-11	13-Oct-11
NCHC Lung/Lobar Lung Transplantation	29-Aug-11	13-Oct-11
NCHC Small Bowel, Small Bowel/Liver and Multivisceral Transplantation	29-Aug-11	13-Oct-11
NCHC Ventricular Assist Devices	29-Aug-11	13-Oct-11
NCHC Home Health Services	26-Aug-11	10-Oct-11
NCHC Off Label Antipsychotic Monitoring in Health Choice Recipients	26-Aug-11	10-Oct-11
NCHC Wireless Capsule Endoscopy	23-Aug-11	7-Oct-11

Proposed Policy	Date Posted	Comment Period End Date
NCHC Anticonvulsants PA Criteria	23-Aug-11	7-Oct-11
NCHC Xolair PA Criteria	23-Aug-11	7-Oct-11
NCHC Botox PA Criteria	23-Aug-11	7-Oct-11
NCHC Celebrex PA Criteria	23-Aug-11	7-Oct-11
NCHC CII Narcotics PA Criteria	23-Aug-11	7-Oct-11
NCHC Suboxone PA Criteria	23-Aug-11	7-Oct-11
NCHC Topic Anti-Inflammatories PA Criteria	23-Aug-11	7-Oct-11
NCHC Quaaliquin PA Criteria	23-Aug-11	7-Oct-11
NCHC Sedative Hypnotics PA Criteria	23-Aug-11	7-Oct-11
NCHC Triptans PA Criteria	23-Aug-11	7-Oct-11
NCHC Emend PA Criteria	23-Aug-11	7-Oct-11
NCHC Growth Hormones PA Criteria	23-Aug-11	7-Oct-11
NCHC Hematinics PA Criteria	23-Aug-11	7-Oct-11
NCHC Leukotrienes PA Criteria	23-Aug-11	7-Oct-11
NCHC Lidoderm PA Criteria	23-Aug-11	7-Oct-11
NCHC Oral Inhaled Steroids PA Criteria	23-Aug-11	7-Oct-11
NCHC Provigil/Nuvigil PA Criteria	23-Aug-11	7-Oct-11
NCHC Statins and Zetia PA Criteria	23-Aug-11	7-Oct-11
NCHC Bone Mass Measurement	15-Aug-11	29-Sep-11

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>
52244	Actient Pharmaceuticals	10/07/2011
75826	Winder Laboratories, LLC	10/05/2011
76014	Eclat Pharmaceuticals, LLC	10/05/2011

Checkwrite Schedule

October 12, 2011	November 08, 2011	December 06, 2011
October 18, 2011	November 15, 2011	December 13, 2011
October 27, 2011	November 23, 2011	December 22, 2011
November 01, 2011		

Electronic Cut-Off Schedule

October 06, 2011	November 03, 2011	December 01, 2011
October 13, 2011	November 10, 2011	December 08, 2011
October 20, 2011	November 17, 2011	December 15, 2011
October 27, 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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