



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

Number 201

December 2011

In This Issue...

Pharmacy Generic Dispensing Fee Change

Updated Federal Upper Limit Reimbursement List

Roche ACCU-CHEK Diabetic Supplies Under the DME and Pharmacy Programs

Requesting Roche Provider Rebates

Medical Record Requests for Program Integrity Post Payment and Prepayment Reviews

Update to Provider Self-Audit Process

Letter of Attestation

Recredentialing of Medicaid Providers

NCPDP Version D.0 Implementation Schedule

NC Health Choice Claims Processing Transition Reminder

Changes in Drug Rebate Manufacturers

Pharmacy Generic Dispensing Fee Change

The Medicaid and Health Choice dispensing fee for generic drugs will be changing effective February 1, 2012 to four tiers based on a pharmacy's quarterly generic dispensing rate. The dispensing fee for brand drugs will remain \$4.00. The dispensing fee for generic drugs will be determined according to the following tiers:

Generic Dispensing Rate	Generic Dispensing Fee
80% +	\$9.00
75% - 79.9%	\$6.50
70% - 74.9%	\$4.40
69.9% -	\$4.00

Pharmacy providers' generic dispensing rates will be posted on the Division of Medical Assistance (DMA) website at <http://www.ncdhhs.gov/dma/pharmacy/index.htm>. Changes to providers' generic dispensing fees during calendar year 2012 will occur on the first day of February 2012, May 2012, August 2012 and November 2012 based on the previous three month period.

The first reporting of generic dispensing rates will be available on the DMA website no later than January 20, 2012 for the February 1, 2012 change and will be based on a provider's average generic dispensing rate for time period October 1, 2011 – December 31, 2011.

Reporting of generic dispensing rates during the remainder of calendar year 2012 will be made available in April 2012, July 2012 and October 2012 approximately two weeks prior to changes made in May 2012, August 2012 and November 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 used.

Pharmacy providers should report reimbursement issues to the N.C. Medicaid program at 919-855-4300. The use of the DAW1 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.

NDC	DRUG NAME
00093026330	FLUOCINONIDE-E 0.05% CREAM
00093026392	FLUOCINONIDE-E 0.05% CREAM
00093075701	PIROXICAM 20 MG CAPSULE
00093075705	PIROXICAM 20 MG CAPSULE
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
00168005515	BETAMETHASONE DP 0.05% CRM
00168005546	BETAMETHASONE DP 0.05% CRM
00168013460	FLUOCINONIDE 0.05% SOLUTION
00168020230	CLINDAMYCIN PH 1% GEL
00168020260	CLINDAMYCIN PH 1% GEL
00168025815	CLOTRIMAZOLE-BETAMETHASONE C
00168025846	CLOTRIMAZOLE-BETAMETHASONE C
00168031002	DESONIDE 0.05% LOTION
00168031004	DESONIDE 0.05% LOTION
00185072401	CARISOPRODOL COMPOUND TAB
00185072405	CARISOPRODOL COMPOUND TAB
00378641001	DOXEPIN 100 MG CAPSULE
00378641010	DOXEPIN 100 MG CAPSULE
00472037915	CLOTRIMAZOLE-BETAMETHASONE CRM
00472037945	CLOTRIMAZOLE-BETAMETHASONE CRM
00472080302	DESONIDE LOTION 0.05%
00472080304	DESONIDE 0.05% LOTION
00487990401	ALBUTEROL SUL 1.25 MG/3 ML SOLN
00487990402	ALBUTEROL SUL 1.25 MG/3 ML SOLN
00487990425	ALBUTEROL SUL 1.25 MG/3 ML SOLN
00527142635	OXYCODONE CONC 20 MG/ML SOLN
00527142636	OXYCODONE CONC 20 MG/ML SOLN
00574025001	HYOSCYAMINE 0.125 MG TAB SL
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
00781107101	METHAZOLAMIDE 50 MG TABLET

00781196160	CLARITHROMYCIN 250 MG TABLET
00781196260	CLARITHROMYCIN 500 MG TABLET
17478028310	GENTAK 3 MG/ML EYE DROPS
24208034205	DESMOPRESSIN NASAL SOLN 0.01%
24208058060	GENTAMICIN OPTH SOLN
24208058064	GENTAMICIN 3 MG/ML EYE DROPS
29033001301	PIROXICAM 20 MG CAPSULE
29033001305	PIROXICAM 20 MG CAPSULE
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
50111064801	FLUOXETINE 20MG CAP
50111064802	FLUOXETINE HCL 20 MG CAPSULE
50111064803	FLUOXETINE HCL 20 MG CAPSULE
50111064844	FLUOXETINE HCL 20 MG CAPSULE
51672126201	DESOXIMETASONE 0.25% OINTMEN
51672126203	DESOXIMETASONE 0.25% OINTMEN
51672126207	DESOXIMETASONE 0.25% OINTMEN
51672126301	NYSTATIN-TRIAMCINOLONE CREAM
51672126302	NYSTATIN-TRIAMCINOLONE CREAM
51672126303	NYSTATIN-TRIAMCINOLONE CREAM
51672126402	FLUOCINONIDE 0.05% OINTMENT
51672126403	FLUOCINONIDE 0.05% OINTMENT
51672127201	NYSTATIN-TRIAMCINOLONE OINT
51672127201	NYSTATIN-TRIAMCINOLONE OINTM
51672127202	NYSTATIN-TRIAMCINOLONE OINTM
51672127203	NYSTATIN-TRIAMCINOLONE OINTM
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
52152013702	CARISOPRODOL COMPOUND TAB
52152013704	CARISOPRODOL COMPOUND TAB
59746000103	METHYLPREDNISOLONE 4 MG DOSE
59762374301	CLINDAMYCIN PH 1% GEL
59762374302	CLINDAMYCIN PH 1% GEL
60758018805	GENTAMICIN 3 MG/ML EYE DROPS
60758018805	GENTAMICIN 3 MG/ML EYE DROPS
61314064305	TOBRAMYCIN 0.3% EYE DROPS
61314070101	SULFACETAMIDE 10% EYE DROPS
68462034737	OXYCODONE CONC 20 MG/ML SOLN

Roche ACCU-CHEK Diabetic Supplies Under the DME and Pharmacy Programs

Effective November 15, 2011, Roche Diagnostics Corporation Diabetes Care is N.C. Medicaid's designated preferred manufacturer for blood glucose monitors, diabetic test strips, control solutions, lancets, and lancing devices. These products are covered under the Durable Medical Equipment and Outpatient Pharmacy Programs and will be reimbursed under the pharmacy point-of-sale system with a prescription.

The transition period has been extended from November 15, 2011 through March 14, 2012. During this period, both Roche and Prodigy diabetic supplies will be covered. Beginning on March 15, 2012, the second phase of the transition will take effect where both Roche and Prodigy diabetic supplies will be covered; however, a one-time override will be required for continued use of Prodigy products through April 14, 2012. As of April 15, 2012, only Roche diabetic supplies will be covered.

Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products. Pharmacy and DME providers need to ensure that invoices are easily retrievable in case documentation is needed to support the billing of these products. This could be requested to support the quantities being invoiced to Roche for the rebates due back to N.C. Medicaid and N.C. Health Choice.

Insulin Pump Users

Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Prior authorization requests should be submitted to HP at P.O.Box 31188, Raleigh, NC 27622.

Effective November 15, 2011, there are no designated preferred manufacturers of insulin syringes.

The following are the list of NDC's that will be covered:

Covered Products	Package Size	Unit Type	NDC - 11
ACCU-CHEK Aviva Care Kit	1 Meter Kit	1 Meter	65702-0101-10
ACCU-CHEK Compact Plus Care Kit	1 Meter Kit	1 Meter	50924-0019-01
ACCU-CHEK Aviva Test Strips	50 count	1 bottle	65702-0103-10
ACCU-CHEK Compact Test Strips	51 count	1 bottle	50924-0988-50
ACCU-CHEK Aviva Plus Test Strips	50 count	1 bottle	65702-0407-10
ACCU-CHEK Aviva Control Solution (2 levels)	1 bottle	1 bottle	65702-0107-10
ACCU-CHEK Compact Control Solution (2 levels)	1 bottle	1 bottle	65702-0369-10
ACCU-CHEK Multiclix Lancets	102 count	1 box	50924-0450-01
ACCU-CHEK Softclix Lancets	100 count	1 box	50924-0971-10
ACCU-CHEK Softclix Lancing Device (Blue)	1 count	1	50924-0957-01
ACCU-CHEK Softclix Lancing Device (Black)	1 count	1	65702-0400-10
ACCU-CHEK Multiclix Lancing Device Kit	1 count	1	50924-0446-01

Billing Instructions for Submitting Diabetic Supplies under DME

Claims for diabetic test strips, control solution, lancets and lancing devices submitted under the DME program must be billed using the NDC in addition to the HCPCS code. The NDC will be entered in the shaded area of block 24A of the CMS-1500 claim form. During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Roche NDCs listed in the chart above. As of April 15, 2012, this modifier will no longer be accepted. These requirements will not apply to private duty nursing and home health providers until April 15, 2012.

HCPCS codes and supply limits for diabetic supplies are the same as outlined in Clinical Coverage Policy 5A, Durable Medical Equipment, as indicated below:

HCPCS Code	Product Description	Quantity Limit
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	4/month – age ≥21
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	6/month – age < 21
A4259	Lancets (1 unit = 100 lancets)	2/month
A4258	Lancing device	2/year
A4256	Normal, high, low calibrator solution	4/year

Prior Authorization Instructions for Insulin Pump Users

With an effective date based on date of service of January 15, 2012 prior authorization will be required for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Claims with a prior authorization on file will need to be submitted with a NU and U9 modifier. Claims for test strips not supplied by Roche that do not have a Prior authorization on file for A4253 NU, U9 will be denied for lack of authorization. The U9 modifier will indicate that test strips **not** supplied by

Roche have been authorized for payment. Prior authorization requests should be submitted to HP at the following addresses:

NC Medicaid P.O.Box 31188 Raleigh, NC 27622.

NC Health Choice P.O.Box 322490 Raleigh, NC 27622

Billing Instructions for Submitting Diabetic Supplies under Pharmacy Point-of-Sale System

Claims for diabetic test strips, control solution, lancets and lancing devices submitted at point-of-sale must be billed using the NDC. Test strips must be billed in multiples of 50 and lancets must be billed in multiples of 100 except for the ACCU-CHEK Compact Test Strips, 51 count package size and the ACCU-CHEK Multiclix Lancets, 102 count package size. In order to accommodate the unbreakable package sizes under the pharmacy point-of-sale system, the ACCU-CHEK Compact Test Strips (NDC 50924-0988-50) can be billed up to 204 test strips per month for recipients 21 years of age and older and up to 306 test strips per month for recipients under 21 years of age will be allowed. At this time, test strip quantities over 204 per month must be requested through the DME program; however, point-of-sale system changes are underway to accommodate the higher quantity limits for pediatric recipients. Additional information will be provided when this system change has been completed. The same rules apply for the ACCU-CHEK Multiclix Lancets (NDC 50924-0450-01). For Medicaid billing, 1 lancing device = 1 unit. Rates apply to these diabetic supplies; therefore, no copayments and no dispensing fees apply.

During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, pharmacy providers can place a “1” in the prior authorization type code field (461-EU) or a “2” in the submission clarification field (420-DK) to override the requirement to bill for Roche NDCs. As of April 15, 2012, this override will no longer be available and only the Roche NDCs referenced above will be covered. Diabetic supply limits will be the same as under the DME program. Prior authorization requests for additional quantities or for non-Roche diabetic supplies must go through the DME program.

Blood Glucose Monitors

ACCU-CHEK Aviva and Compact Plus blood glucose monitors are free to N.C. Medicaid and N.C. Health Choice recipients through the DME and Outpatient Pharmacy Programs. DME providers will have access to free blood glucose monitors to supply to recipients. Pharmacy providers can dispense free blood glucose monitors to recipients by submitting the following information to Roche Diagnostics:

Rx GRP (Carrier Group): MAX26266

ID#: 1ACCUCHEK

Suffix (Dependent) Code: 01

Rx BIN#: 610415

PCN: PCS

COB: Primary

Other Coverage Code: Blank

For additional information, providers may call ACCU-CHEK Customer Care, 1-877-906-8969 or DMA Clinical Policies and Programs at 919-855-4310 (DME) or 919-855-4300 (Pharmacy).

Requesting Roche Provider Rebates

NC Medicaid and NC Health Choice pharmacy providers can obtain the provider rebates on Roche diabetic supplies through one of the following Roche-approved Medicaid switch vendor partners:

- EZ DME
- eRX Network
- QS1 (Powerline)
- Relay Health

If a pharmacy utilizes a Roche-approved switch vendor, the switch vendor will submit claims directly to Roche for payment. If the pharmacy does not use an approved switch vendor, the pharmacy will be required to submit electronic claims data to Roche for validation and payment. Upon receipt of the data, Roche will process payment within 30-60 days of receipt. Paper claims are not part of the rebate process.

Visit <https://rxvp.accu-chek.com> for more information and instructions on how to sign up for the rebates.

Medical Record Requests for Program Integrity Post Payment and Prepayment Reviews

The Division of Medical Assistance (DMA) is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR §431.107 to access patient medical records for purposes directly related to the administration of the Medicaid Program. In addition, when applying for Medicaid benefits, each recipient signs a release which authorizes access to his/her Medicaid records by DMA and other appropriate regulatory authorities. Therefore, no special recipient permission is necessary for release of records to DMA for post-payment reviews. Federal regulations and provider agreements with the DMA require the provider to keep any records necessary to disclose the extent of services furnished including but not limited to all information contained in recipient financial and medical records, agency personnel records and other agency administrative records.

A Provider on post payment review will receive an initial medical record request that requires copies of recipient records be sent to DMA or its agents within ten (10) business days of the provider's receipt of the initial letter. If records are not received by DMA or its agents within the allotted time, a final request will be sent, which states that the provider is required to provide the requested records by the end of the 5th business day from receipt of the final request letter. Failure to comply with this final request may result in a determination that the provider agency was improperly paid for all services under review for the requested dates of service. In addition, failure to produce records will be considered a credible allegation of fraud and subject the provider to immediate payment suspension and possible termination from Medicaid participation.

A Provider on prepayment review will receive medical record requests as noted above, for all recipients where they submit a claim for payment to Medicaid. With prepayment review, the initial medical records request allows five (5) business days for response. If records are not received within the allotted time, a final request will be sent that requires records to be received within five (5) business days of receipt of the letter. Payment of the claims will be denied if the documentation is not received.

Update to Provider Self-Audit Process

In 1999, 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. The Provider Self-Audit process is noted in NC Session law 2011- 399. With the expanding use of self-audits, providers will now be able to access DMA’s forms and instructions on the DMA website.

NC 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 DMA and its agents review a random sample of claims from the “universe” of claims submitted by a provider from a selected 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 NC Session Law 2011-399, N.C.G.S. § 108C-5(n) “Payment suspension and audits utilizing extrapolation.” for further details.

Providers may obtain Provider Self Audit forms and instructions at <http://www.ncdhhs.gov/dma/piletters.htm>.

Letter of Attestation

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).

As a condition of participation in the Medicaid and N.C. Health Choice programs, all providers are required to complete and sign the Letter of Attestation, irrespective of the amount received in Medicaid payments during the fiscal year.

The letter of attestation will be required initially from newly enrolling and re-enrolling providers; once enrolled all providers will be required to submit the letter of attestation annually.

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>.

Recredentialing of Medicaid Providers

As the Enrollment, Verification, and Credentialing (EVC) vendor for North Carolina’s Medicaid program, CSC must recredential existing Medicaid providers a minimum of every 3 years to ensure that all provider information is accurate and up-to-date. Effective November 1, 2011, the EVC Operations Center began recredentialing 100 providers as part of a 1-month project and will recredential 11,000 providers every 6 months thereafter. This process includes a thorough examination of a provider’s background, credentials, and qualifications to ensure the provider continues to meet North Carolina’s Medicaid participation guidelines. It will also reduce fraud by ensuring a provider’s record is current and accurately reflects all adverse actions taken against the provider.

Providers will be able to complete their renewals electronically, which will;

- reduce processing time for staff,
- shorten the amount of time a provider spends on completing the application, and
- give providers sufficient notice to remain enrolled in the Medicaid program.

Contract renewals will generate electronically for all enrolled Medicaid providers 75 days prior to the 3-year anniversary date of enrollment or the date of the last contract renewal.

To make this process as simple as possible, CSC has pre-populated a recredentialing application with the information currently on file for each provider. Within 30 days of receiving the invitation letter, providers must verify their Medicaid Provider information and submit any additional information requested via the online recredentialing application, following the instructions in the letter. **CSC will not mail recredentialing applications to providers.**

It is critical that providers verify and/or provide all information required in the recredentialing application. Failure to complete this application and provide all requested information within 30 days from the date of the re-enrollment letter will result in termination from the NC Medicaid program.

In accordance with NC Session Law 2009-451, Section 10.58.A, CSC must charge a recredentialing fee of \$100. CSC will notify providers by mail with instructions on how to make payment of the recredentialing fee, if applicable. Providers will also be charged a \$505 application fee required by Section 6401(a) of the Affordable Care Act (ACA), as amended by section 10603 of the ACA, amended section 01866 (j), to cover the costs of screening and to carry out screening and other program integrity efforts.

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.ncdp.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 22, 2011 and will continue to support NCPDP 5.1 until December 31, 2011.

NC Health Choice Claims Processing Transition Reminder

All claims with effective dates of service on and after October 1, 2011, for NC Health Choice (NCHC) will be processed by the Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES). For dates of service prior to the transition date of October 1, 2011, providers will continue to submit medical and pharmacy claims to BCBSNC and Medco.

Providers must file all claims for dates of service through September 30, 2011 with BCBSNC and Medco by February 29, 2012.

As of the transition date of October 1, 2011, active NC Medicaid providers who want to render service to NCHC recipients may do so without taking any action for NCHC enrollment. Providers who are not NC Medicaid-enrolled providers but who want to begin or continue serving NCHC recipients must complete the Medicaid provider enrollment application on www.nctracks.nc.gov. Computer Sciences Corporation, Inc. (CSC), DMA's agent for enrollment, verification, and credentialing (EVC), will process the applications. Any questions regarding provider enrollment for NCHC should be directed to the CSC EVC Center at 866-844-1113.

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>
24658	Blu Pharmaceuticals	12/11/2011
50881	Incyte Corporation	12/08/2011
76204	Ritedose Pharmaceuticals, LLC	12/14/2011

Voluntarily Terminated Labelers

The following labeler has requested voluntary termination effective April 1, 2012:

Cephazone Pharma, LLC (Labeler 68330)

HAPPY HOLIDAYS

Checkwrite Schedule

December 06, 2011
December 13, 2011
December 22, 2011

Electronic Cut-Off Schedule

December 01, 2011
December 08, 2011
December 15, 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

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
