



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

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

North Carolina Medicaid Preferred Drug List Changes

The N.C. Medicaid Preferred Drug List (PDL) will be changed to include additional drugs that will require prior authorization. The changes are targeted for the end of June 2010. Drugs listed as “non-preferred” will require prior authorizations. Drugs listed as “preferred” will not require prior authorizations unless noted on the PDL. The prior authorization process will not change.

No additional prior authorization requirements will be added for

- Recipients who are currently stable on **second generation anticonvulsants**
- Recipients under 2 years of age using **Accuneb and its generic version**
- Recipients less than 21 years of age using **insulin pens and cartridges**
- **Mental health drugs**

For additional information, refer to DMA’s Outpatient Pharmacy Program web page at <http://www.ncdhhs.gov/dma/pharmacy.htm> for a list of the drugs on the PDL and for updates.

HP Enterprise Services

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

ACS

1-866-246-8505

End-dated Coverage for Exocrine Pancreatic Insufficiency Drugs

Effective with date of service July 1, 2010, the exocrine pancreatic insufficiency drugs with the National Drug Codes (NDCs) listed below will no longer be covered by N.C. Medicaid. A notice regarding this change was mailed to all Medicaid recipients in May.

In a memo dated April 29, 2010, CMS stated “According to the FDA, these drugs do not have approved applications; therefore, CMS has determined that the NDCs do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.”

The drugs that will be affected by this change are:

National Drug Code	Product Name
00032-1205	Creon 5 Capsules
00032-1210	Creon 10 Capsules
00032-1220	Creon 20 Capsules
00091-4175	Kutrase Capsules Rx
10267-2737	Pancrelipase 8,000 Tablets
39822-9045	Pancrelipase 4,500
39822-9100	Pancrelipase 10,000
39822-9160	Pancrelipase 16,000
39822-9200	Pancrelipase 20,000
58177-0028	Pangestyme MT 16 Capsules
58177-0029	Pangestyme CN 10 (Pancrelipase) Delayed Release Cap
58177-0030	Pangestyme CN 20 (Pancrelipase) Delayed Release Cap
58177-0031	Pangestyme EC Capsules

58177-0048	Pangestyme UL 12 Capsules
58177-0049	Pangestyme UL 18 Capsules
58177-0050	Pangestyme UL 20 Capsules
58177-0416	Plaretase
58914-0002	Ultrase MT 12
58914-0004	Ultrase MT 20
58914-0018	Ultrase MT 18
58914-0045	Ultrase MS 4
58914-0111	Viokase
58914-0115	Viokase 8oz Powder
58914-0116	Viokase 16000
59767-0001	Pancrecarb MS-8
59767-0002	Pancrecarb MS-4
59767-0003	Pancrecarb MS-16

Remittance and Status Reports in PDF Format

Effective with the June 8, 2010 checkwrite, the N. C. Medicaid Program will implement an expansion of the NC Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool to allow providers to download a PDF version of their paper Remittance and Status Report (RA). There will be a transition period for the month of June where the paper RA will continue to be printed and mailed to providers. Beginning with the July 7, 2010 checkwrite, RAs will only be available through the NCECS Web Tool. As a part of this effort, minor changes were made to the layout of the pharmacy RA as described below.

New fields were added to the Paid/Denied Claims Section

- Claim Adjustment Reason Code (CARC)
- Adjustment Amount

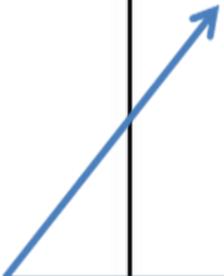
All providers who want to access and download a PDF version of their RA are required to register for this service regardless if they already have an NCECSWeb logon ID. The Remittance and Status Reports in PDF Format Request form and instructions can be found at on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>. Providers are encouraged to complete the form immediately and return it to the HP Enterprise Services Electronic Commerce Services Unit to ensure adequate time for set up.



North Carolina Medicaid - Remittance and Status Advice

PHARMACY

North Carolina Medicaid - Remittance and Status Advice											PHARMACY WAY ANYWHERE		NC 12345		
											Page: 2				
NPI 1234567890															
Provider Number: 0000000															
Date: 05/04/2010															
Name	Service Dates		Days/	Procedure/Accommodation/			Total	Non	Total	Payable	Payable	Other	Paid	Exp	
Recipient ID	From	To	Units	DrugCode and Description			Billed	Allow	Allowed	Cutback	Charge	DedChg	Amount	Codes	
PAID CLAIMS															
DRUG															
RECIPIENT ID	LAST NAME	FIRST NAME	M I	SVC DATE	RX NUM	DRUG CODE	DRUG NAME	QTY	CLAIM	NUMBER	TOTAL BILLED	TOTAL ALLOWED	CO-PAY	TOTAL PAID	EOB CODE
111111111X	LAST	FIRST	M I	04212010	111111	00555913167	OCELLA TA	84.000	0520109999999999	NCXIX	17699	16766	00	16766	3005



CARC = XXX Adjustment Amount = 1234567.89

Synagis Pharmacy Claims for 2009/2010 Season

The last accepted date of service for Synagis pharmacy claims for the 2009/2010 policy coverage period was March 31, 2010. Synagis claims processing began on October 27, 2009, for this season. All Synagis requests must be completed on criterion-specific forms, which can be found at DMA's website at <http://www.ncdhhs.gov/dma/pharmacy/synagis.htm>.

No more than five (5) monthly doses of Synagis can be obtained by using these forms. Copies of the submitted North Carolina Medicaid Synagis for RSV Prophylaxis forms should be mailed by pharmacy distributors to DMA. Please mail forms to:

N.C. Division of Medical Assistance
Pharmacy Program
1985 Umstead Drive
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Pharmacy distributors with a large volume of Synagis claims should submit scanned copies of the North Carolina Medicaid Synagis for RSV Prophylaxis forms on a diskette. Please call Charlene Sampson at 919-855-4306 to coordinate this process if you need further assistance or have questions. All diskettes must be sent to DMA by June 1, 2010.

A Notice of Approval was provided by ACS, (DMA's prior authorization vendor) for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requests for Synagis coverage outside of the policy limits. These would include requests for an April dose of Synagis. A copy of the Notice of Approval from ACS should be maintained on file at the pharmacy.

The N.C. Medicaid Program should not be billed for Synagis unless one of the following is on file at the pharmacy:

- an accurate and complete Synagis for RSV Prophylaxis form
- an ACS Notice of Approval from an EPSDT request for Synagis

Payment of Synagis claims will be reviewed and may be subject to recoupment by Program Integrity if the appropriate forms or approval notifications are not on file.

Additional Information on Prodigy Diabetic Supplies

The following additional information is provided regarding the Prodigy Diabetic Supply program:

Transition Period

The transition period for Prodigy ended on April 16, 2010. No additional overrides will be allowed for non-Prodigy brands of diabetic supplies available under the Prodigy program

Certificate of Medical Necessity/Prior Approval Form for Diabetic Supplies

The date span on the Certificate of Medical Necessity/Prior Approval Form (CMN/PA) for diabetic supplies can be valid for up to one calendar year with a corresponding valid physician prescription.

Insulin Pump Users

There is an **override** process available for recipients who, for clinical reasons, cannot use Prodigy products. In these instances, the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. The following protocol, documented in Section 5.5 of Clinical Coverage Policy 5A, *Durable Medical Equipment* (<http://www.ncdhhs.gov/dma/mp/>), should be followed: fax the denial from the remittance advice to DMA at the designated diabetic supply override fax number, 919-715-3166, along with the required medical necessity forms. Consideration will be given to the request and a written decision will be returned to the provider.

Durable Medical Equipment Limitations

Medicaid may place appropriate limits, based on medical necessity criteria, on DME items and supplies. When the prescribing physician, physician's assistant or nurse practitioner orders equipment or supplies beyond these limits, the provider must seek authorization for payment for these items from DMA. The DME provider must send a written request to DMA, along with a letter of medical necessity from the prescribing physician, physician's assistant or nurse practitioner. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

Step-by-Step Instructions

1. Send a copy of the completed CMN/PA and/or Letter of Medical Necessity indicating the type of pump being used and the brand-specific test strips that are needed and the quantity that is needed per month.
2. The CMN/PA and/or Letter of Medical Necessity must also indicate that the pump and the current glucometer communicate directly with each other. If there is any additional or other medical justification, it should also be presented.
3. All medical justification must be signed off on by the physician.
4. There must also be legible contact information for the provider and the physician.

Information can be faxed, preferably by the provider, to 919-715-3166. If there are any questions, please call 919-855-4310.

CMN/PA forms can be obtained by calling the HP Enterprise Services Provider Services Unit at 1-800-688-6696 or 919-851-8888.

DME Provider Billing for Diabetic Supplies

- There is no change in billing HCPCS units presently compared to the past.
- Calculate NDC units by multiplying the HCPCS units by the number of pieces in the package. For example, test strips HCPCS units = 1 (for 1 box) x 50 strips per box = 50 NDC units.

Provider Information Regarding Changes in NC Health Choice Copayments

Effective with date of service July 1, 2010, copayment changes are being made to the benefits for N.C. Health Choice (NCHC). Based on a child's current NCHC ID card, the following copayment changes apply.

- If **all** copayment amounts on the NCHC ID card are \$0, they are still \$0; there are no changes.

- If the emergency room (ER) copayment on the NCHC ID card is \$0 but there are other copayment amounts, the following changes apply:
 - ◆ ER copayment is changing from \$0 to \$10
 - ◆ Generic drug copayment is changing from \$1 to \$2
 - ◆ Brand drug copayment with no generic available is changing from \$1 to \$2
 - ◆ Brand Drug copayment with a generic available is changing from \$3 to \$5
- If the ER copayment on the NCHC ID card is \$20, the following changes apply:
 - ◆ ER copayment is changing from \$20 to \$25
 - ◆ Generic drug copayment is changing from \$1 to \$2
 - ◆ Brand drug copayment with no generic available is changing from \$1 to \$2
 - ◆ Brand drug copayment with a generic available will stay the same at \$10

These changes in copayments are effective for all non-emergency ER visits and for prescriptions filled starting on July 1, 2010.

Provider Information Regarding Changes in NC Health Choice Administration

Effective July 1, 2010, the administration of the N.C. Health Choice (NCHC) program will move from the State Employees Health Plan to N.C. DMA. This change will not directly impact providers or recipients of NCHC Blue Cross Blue Shield of North Carolina will continue to process claims for NCHC.

Effective July 1, 2010, the NCHC medical policies currently located on the State Employees Health Plan website will be moved to DMA's website.

Medco will continue as the pharmacy benefit manager for NCHC. However, Medco will have a new customer service number for NCHC. That number is 1-800-466-4115. Until July 1, 2010, providers and recipients should continue using the existing customer service number, 1-800-336-5933. There will also be a new Rx group number that pharmacists should use beginning July 1. That number is NCDHHS1. It will be on the new NCHC ID cards issued on and after July 1, 2010.

Provider Information Regarding Changes in NC Health Choice Benefits

Effective July 1, 2010, NCHC will cover certain over-the-counter (OTC) medications if prescribed by a doctor. The covered OTC medications follow Medicaid's policy for OTC medications.

NCHC families are receiving notices informing them of these upcoming changes. New NCHC ID cards may not arrive to families until sometime in July so these notices also serve to remind families of their new copayments, the new Medco customer service number, and the Rx group number as well as the addition of OTC medications benefit.

Maintaining the Security and Accessibility of Records after a Provider Agency Closes

All Medicaid providers are responsible for maintaining custody of the records and documentation to support service provision and reimbursement of services by N.C. Medicaid for at least six years.

See 10A NCAC 22F.0107 and section seven of the N.C. Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement. The Agreement is part of the enrollment application and may be accessed at <http://www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications>. Documentation that is required to be maintained includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). Clinical service records include, but are not limited to

- Diagnostic testing results (X-rays, lab tests, EKGs, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment and treatment
- Service or treatment plans

Billing and reimbursement records should include recipient demographic information.

Providers are **required** to arrange for continued safeguarding of the above-described records in accordance with the record retention guidelines. Failure to protect consumer or staff privacy by safeguarding records and ensuring the confidentiality of protected health information is a violation of the Health Insurance Portability and Accountability Act (HIPAA) and NCGS § 108A-80 and may be a violation of the North Carolina Identity Theft Protection Act. Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights, as applicable. The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect: \$50,000 up to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the State in monetary penalties plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain the above-described records is independent from ongoing participation in the N.C. Medicaid Program and extends beyond the expiration or termination of the Agreement or contract. See 10A NCAC 22F.0107 and section eight of the DHHS Provider Administrative Participation Agreement. Provider records may be subject to post-payment audits or investigations after an agency closes. Failure to retain adequate and accessible documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid Program and/or referral to the US DHHS

Office of Inspector General for exclusion or suspension from federal and state health care programs, at the discretion of the Department.

If another provider takes over the functions of a closing entity, maintenance of the closing entity's records for the applicable recipients may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to DMA upon request. When custody of records is not transferred, the closing providers should send copies of transitional documentation to the providers who will be serving the recipient for continuity of care. Consumer authorization should be obtained as necessary. Copies of records may be provided to the recipient directly for coordination of care.

N.C. Medicaid must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid program, as indicated on the N.C. Tracks website at <http://www.nctracks.nc.gov/provider/cis.html>. Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate how the records will be stored, the name of the designated records custodian, where the records will be located, and the process to fulfill requests for records. Information must be included on how recipients will be informed of the contact information and the process to request their records. The plan should also designate retention periods and a records destruction process to take place when the retention period has been fulfilled and there is no outstanding litigation, claim, audit or other official action. The plan should be on file with the records custodian.

Mental health, developmental disabilities, and substance abuse (MH/DD/SA) services records are subject to additional retention and management requirements, including those mandated by S.L. 2009-451 (Section 10.68A(a)(5)(j) and (k) for Community Support and Other MH/DD/SA Services and Section 10.68A(a)(7)(h) and (i) for MH Residential Services). MH/DD/SA providers should refer to guidance from Implementation Updates 72, 62, 60, and 58 for more information. Implementation Updates may be accessed at <http://www.dhhs.state.nc.us/MHDDSAS/servdefinitions/servdefupdates/>.

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.

Addition

The following labelers have entered into Drug Rebate Agreement and have joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
00941	Baxter Healthcare Corporation	04/01/2010
14550	Actavis Pharma Mfging Private Limited	04/27/2010
36800	Topco Associates LLC	04/29/2010
43351	Allaire Pharmaceuticals, LLC	04/29/2010
49685	Neurogesx, Inc	04/29/2010
50236	QLT Ophthalmics Inc	04/29/2010
52304	Gensavis, LLC	04/29/2010
50268	Avpak	04/30/2010

Checkwrite Schedule

May 04, 2010	June 08, 2010	July 07, 2010
May 11, 2010	June 15, 2010	July 13, 2010
May 18, 2010	June 24, 2010	July 22, 2010
May 27, 2010		

Electronic Cut-Off Schedule

April 29, 2010	June 03, 2010	July 01, 2010
May 06, 2010	June 10, 2010	July 08, 2010
May 13, 2010	June 17, 2010	July 15, 2010
May 20, 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.

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