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**North Carolina  
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Newsletter**

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## 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 submitted.

Pharmacy providers should report reimbursement issues to the N.C. Medicaid program at 919-855-4300. Use of the **DAWI** 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
00168000215	TRIAMCINOLONE 0.5% CREAM
00168000315	TRIAMCINOLONE 0.025% CREAM
00168000380	TRIAMCINOLONE 0.025% CREAM
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
00168004046	BETAMETHASONE VA 0.1% CREAM
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
00228206710	OXAZEPAM 10 MG CAPSULE

00378537501	DOXEPIN 75 MG CAPSULE
00378641001	DOXEPIN 100 MG CAPSULE
00378641010	DOXEPIN 100 MG CAPSULE
00472016315	NYSTAIN 100,000 UNIT/GM CREAM
00472016330	NYSTAIN 100,000 UNIT/GM CREAM
00472016615	NYSTAIN 100,000 UNIT 15GMS
00472016630	NYSTAIN 100,000 UNITS 30GMS
00472037915	CLOTRIMAZOLE-BETAMETHASONE CRM
00472037945	CLOTRIMAZOLE-BETAMETHASONE CRM
00472080302	DESONIDE LOTION 0.05%
00472080304	DESONIDE 0.05% LOTION
00527142635	OXYCODONE CONC 20 MG/ML SOLN
00527142636	OXYCODONE CONC 20 MG/ML SOLN
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
24208058060	GENTAMICIN OPTH SOLN
24208058064	GENTAMICIN 3 MG/ML EYE DROPS
24208067004	SULFACETAMIDE 10% 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
51672126301	NYSTATIN-TRIAMCINOLONE CREAM
51672126302	NYSTATIN-TRIAMCINOLONE CREAM
51672126303	NYSTATIN-TRIAMCINOLONE CREAM
51672127201	NYSTATIN-TRIAMCINOLONE OINT
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
61314063136	NEOMYC-POLYM-DEXAMET EYE OINTMENT
61314063305	GENTAMICIN 3MG/ML EYE DROPS (3%)
61314064305	TOBRAMYCIN 0.3% EYE DROPS
61314070101	SULFACETAMIDE 10% EYE DROPS
68462034737	OXYCODONE CONC 20 MG/ML SOLN

**Upcoming Policy Implementation: March 20, 2012**  
**Off Label Antipsychotic Safety Monitoring in Recipients 18 and older**

On March 20, 2012, DMA, partnering with Community Care of North Carolina, will implement a policy that creates a prior authorization process for the off label prescribing of an antipsychotic for a Medicaid recipient age 18 and older. The prior authorization process will collect information to support standards established by the Food and Drug Administration for on-label use of antipsychotics. This first phase implementation starting on March 20, 2012 is for atypical (second generation) antipsychotics only. Documentation will be requested when the atypical is prescribed for an indication that is not approved by the federal Food and Drug Administration.

Recipients with any of the following diagnoses are exempt from the requirements of the policy:

- **Schizophrenia**
- **Schizophreniform disorder**
- **Schizoaffective disorder**
- **Delusional disorder**
- **Brief psychotic disorder**
- **Shared psychotic disorder**
- **Psychotic disorder NOS**
- **Bipolar disorder**
- **Major depressive disorder with psychotic features**
- **Treatment resistant depression (antipsychotic use for TRD is adjunctive only)**
- **Tourette syndrome**
- **Other psychosis**

The exemption ensures recipients with these diagnoses are able to obtain antipsychotic medications without documentation. When any of the above diagnoses are present, the prescriber should write on the face of each new and renewal prescription in his/her own handwriting: **“Meets PA Criteria”** to authorize the exemption. **“Meets PA Criteria”** may also be entered in the comment block on e-prescriptions. The pharmacist is authorized to override the documentation requirement when **“Meets PA Criteria”** is written. The authorization is effective for the life of the prescription. If an exempted diagnosis is found in the recipient’s most recent 24 months of Medicaid claims data, an atypical claim can process successfully without any action at all by the prescriber.

For those clinical situations not exempted as described above, in accordance with the policy, a documentation request will occur for each atypical antipsychotic medication prescribed for a recipient that meets any of the below criteria. The first phase implemented on March 20, 2012 will only include indications not approved by the FDA. Generally, a dose change or change in strength only will not trigger a documentation request.

- The antipsychotic is prescribed for an indication that is not approved by the federal Food and Drug Administration.
- The antipsychotic is prescribed at a different dosage than approved for an indication by the federal Food and Drug Administration.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

When documentation is required, the information may be submitted by faxing a completed Adult Safety with Antipsychotic Prescribing (ASAP) form to ACS at 866-246-8507 or by calling ACS with the information at 866-246-8505. The form can be found on the DMA website at <http://www.ncmedicaidpbm.com> and on the Resources page of [www.documentforsafety.com](http://www.documentforsafety.com). A twelve month approval period is granted when the documentation is provided using the fax form or by phone. The information requested includes:

- drug and total daily dosage
- primary psychiatric diagnosis
- primary target symptoms
- recipient has been informed regarding the potential metabolic and neurologic adverse effects with these agents.

### **Pharmacy Override Protocol**

**A “1” in the PA field or submission clarification code “2” will override the edit when “Meets PA criteria” is written.** Two point of sale (POS) overrides per recipient per 365 rolling days are available for occurrences where the prescriber has not provided documentation or an exempted diagnosis does not exist. Each override will apply to all claims for antipsychotic medication(s) on the same date of service. The message "Safety documentation requested call ACS 866-246-8505" will return to the pharmacy for atypical antipsychotic claims for recipients without documentation. The claim will not process successfully and the information returned in the POS message should be shared with the prescriber. A POS override can be utilized for rejected claims if timely provision of information by the prescriber does not occur. **An “11” in any available submission clarification field will override the documentation requirement in these cases. This is a new submission clarification code activated for the antipsychotic overrides.** If a third override is attempted, the message “Override limit exceeded. Prescriber call ACS 866-246-8505" will return to the pharmacy. This message cannot be overridden and the pharmacy should share it with the prescriber. The alert indicates the prescriber must provide the requested documentation for the recipient in order for successful claims processing to result.

A widespread training effort about the Medicaid antipsychotic initiatives, led by Community Care of North Carolina, has been underway since early 2011. The adult initiative is known as **ASAP (Adult Safety with Antipsychotic Prescribing)**. Objectives of the initiative include improving the use of evidence based treatments, reduction of antipsychotic polypharmacy, and reduction of occurrences where the antipsychotic is prescribed in an amount differing from the FDA approved dosage for an indication.

### **A+KIDS Medicaid and Health Choice - Unlimited Overrides End on March 15, 2012**

Effective March 16, 2012, the use of an override for antipsychotic claims processing for the Antipsychotics – Keeping It Documented for Safety (A+KIDS) programs in Medicaid and Health Choice will be limited to two every 365 rolling days. The A+KIDS registry used to capture safety documentation is supported by the Medicaid policy titled “Off Label Antipsychotic Safety Monitoring in Recipients through Age 17” implemented in April 2011 and the “Off Label Antipsychotic Safety Monitoring In Health Choice Recipients” policy implemented in February 2012. The first phase implementation for Health Choice effective on February 8, 2012 is for ages 6 through 17 only.

Currently, unlimited override use by a pharmacist is allowed to obtain successful point of sale (POS) processing for an antipsychotic claim when a prescriber has not provided safety documentation for the prescribed antipsychotic therapy. The importance of ensuring recipients did not go without antipsychotic medication related to the novel initiative warranted this liberty. The unlimited override window was created as an extra medication access and availability assurance measure during the period of registry implementation and widespread educational and training effort by Community Care of North Carolina.

### **New Pharmacy Override Protocol Effective March 16, 2012**

**A POS override should be utilized for rejected claims if timely A+KIDS registration by the prescriber does not occur. An “11” in any available submission clarification field will override the PA. This is a new submission clarification code activated for the antipsychotic overrides. Each recipient is allowed two overrides per 365 rolling days. Each override will apply to all antipsychotic claims on the same date of service. If a third override is attempted, the message “Override limit exceeded. Prescriber go to [www.documentforsafety.com](http://www.documentforsafety.com) or call**

**ACS 866-246-8505" will return to the pharmacy. This message cannot be overridden and the pharmacy should share it with the prescriber. The alert indicates the prescriber must provide the requested documentation for the recipient in order for successful claims processing to result.**

Pharmacies should be aware of the following information about A+KIDS registry use and submitting information for a recipient. Prescribers not registered to submit safety documentation using the A+KIDS registry can go to the website [www.documentforsafety.com](http://www.documentforsafety.com) to complete the registration process. A user ID and password are required to access the A+KIDS registry. These are available within five business days of registering. An alternate method to provide the safety documentation is completion of the "North Carolina Medicaid and Health Choice Off Label Antipsychotic Safety Monitoring In Recipients Through Age 17" fax form. The form is found on websites [www.documentforsafety.com](http://www.documentforsafety.com) and <http://www.ncmedicaidpbm.com>. The completed form is faxed to ACS at 866-246-8507.

Pharmacies are urged to share with the prescriber each POS message that returns for a rejected antipsychotic claim when safety documentation is not found and an override is used. As a reminder, pharmacies are able to be reimbursed for a 72 hour emergency supply for recipients who have exhausted the two override opportunities and are waiting for safety documentation to be provided.

### **Photo Identification Required Prior to Dispensing Certain Controlled Substances**

The North Carolina General Assembly passed S.L. 2011-349, which requires presentation of a photo identification prior to the dispensing of certain controlled substances. The statute is an amendment to the North Carolina Controlled Substances Act (NC CSA) and codified at N.C.G.S. § 90-106.1 and is effective March 1, 2012. The NC Board of Pharmacy has developed an FAQ document which is available on the NC Board of Pharmacy's website at <http://www.ncbop.com>. Because this law is part of the NC CSA, the Drug Control Unit of the North Carolina Department of Health and Human Services also has administrative responsibilities for the statute.

### **Corrected 1099 Requests for Tax Years 2009, 2010, and 2011 -Action Required by March 1, 2012**

Each provider number receiving Medicaid payments of more than \$600 annually will receive a 1099 Miscellaneous Income Form (MISC) tax form from HP Enterprise Services. The 1099 MISC tax form generated as required by IRS guidelines will be mailed to each provider no later than January 31, 2012. The 1099 MISC tax form will reflect the tax information on file with NC Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2011.

If the tax name or tax identification number on the annual 1099 MISC you receive is incorrect, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file for each provider number with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of 28 percent for future Medicaid payments. The IRS could require HP Enterprise Services to initiate and continue this withholding to obtain correct tax data. Please note that only the provider name and tax identification number can be changed and must match the W-9 form submitted.

A correction to the original 1099 MISC must be submitted to HP Enterprise Services by March 1, 2012 and must be accompanied by the following documentation:

- Cover page outlining what information needs to be changed and for which tax year(s).
- A copy of the original 1099 MISC form(s) or the last page of the last Remittance and Status

Report(s) showing the total YTD for that specific year(s). A current signed and completed [IRS W-9 form](#) clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at <http://www.irs.gov> under the link “Forms and Publications.”) The W-9 form cannot be dated prior to one year before submission. Fax all documents to 919-816-3186, Attention: Corrected 1099 Request – Financial

## Or

Mail all documents to:  
HP Enterprise Services  
Attention: Corrected 1099 Request - Financial  
2610 Wycliff Rd. Suite 401  
Raleigh, NC 27607-3073

A copy of the corrected 1099 MISC form(s), along with a second copy of the incorrect 1099 MISC form(s) with the “Corrected” box selected, will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that tax information on file with Medicaid is accurate. Providers may be notified by phone or mail of any additional action which may be required to complete the correction information.

## Reporting Managing Relationship Changes

Providers are responsible for notifying the Division of Medical Assistance (DMA) of any change in their disclosed managing relationships. This notification must be made within thirty (30) calendar days of the change. The changes must be reported by submission of a new Provider Enrollment Packet, which can be found on the NCTracks website at <https://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>. Providers are encouraged to use the online provider enrollment application. With each submission, the provider must disclose all managing relationships in the Managing Relationship section. The entire Provider Enrollment Packet must be complete and correct upon submission to avoid delays in processing.

Below are two examples of how changes in managing relationships should be reported on the Provider Enrollment Packet:

- **Scenario 1 (Adding a managing relationship):** Upon enrollment, a provider disclosed that they had four managing relationships. A year later, the provider added one new managing relationship. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all five managing relationships.
- **Scenario 2 (Removing a managing relationship):** Upon enrollment, a provider disclosed that they had 20 managing relationships. Six months later, the provider removed one of their managing relationships. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all 19 managing relationships.



By properly notifying DMA of managing relationship changes, the provider will ensure that their Medicaid provider file is always current.

## **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 three years to ensure that all provider information is accurate and current. On November 1, 2011, the EVC Operations Center began recredentialing providers as part of a one month ramp-up project and will recredential 11,000 providers every six months after that. 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 Program participation guidelines. It will also reduce fraud by ensuring a provider's record is current and that the state is aware of any adverse actions taken against the provider.

Another benefit is the ability to electronically generate and distribute contract renewals for all enrolled Medicaid providers 75 days prior to the 3-year anniversary date of enrollment or the date of the last contract renewal. It also allows providers the chance to complete their renewals electronically. Given the volume of providers that require recredentialing, this feature will reduce processing time for staff, shorten the amount of time a provider spends completing the application, and give providers sufficient notice to remain enrolled in the Medicaid Program.

To make this process simple, CSC has pre-populated a recredentialing application with the information they currently have on file for each provider. Within 30 days of receiving the invitation letter, providers must verify their Medicaid Provider information, provide any additional information requested via the online recredentialing application and follow 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.

**Providers will be required to pay a \$100 recredentialing fee.** CSC will notify providers by mail with instructions on how to make payment of the recredentialing fee, if applicable.

## **Keeping Your Medicaid Provider Record Current**

Providers must update the information in your provider file as soon as the change occurs. Having current information allows timely response to requests and deliver correspondence to the appropriate parties and addresses. The Provider Administrative Participation Agreement and the Electronic Claims Submission Agreement that outlines your responsibilities for maintaining accurate provider records.

### **Excerpt from the Provider Administrative Participation Agreement – Disclosure -Item 6:**

- a.** At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, and Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the

Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:

1. ownership;
  2. licensure;
  3. federal tax identification number;
  4. bankruptcy;
  5. additions, deletions, or replacements in group membership; and
  6. any change in address or telephone number
- b.** The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:
1. Proof of a valid license, operating certificate, and/or certification if required by controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
  2. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
  3. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.

**Excerpt from the Electronic Claims Submission Agreement: Item 5:**

The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

**Item 13:**

Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

## **Implementation of the Patient Protection and Affordable Care Act Requirements – Credible Allegation of Fraud and Payment Suspension**

On February 2, 2011 in the Federal Register Volume 76, Number 22, the Centers for Medicare & Medicaid Services (CMS) clarified new requirements under the Patient Protection and Affordable Care Act (PPACA) regarding Medicaid Program Integrity efforts to combat fraud and abuse. The Social Security Act was amended with requirements that the State Medicaid Agency must:

- Suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity.
- Make a fraud referral to the Medicaid Fraud Control Unit (MFCU) whenever the State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part.
- Send notice of its suspension of program payments within the following timeframes:
  - a) Five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.
  - b) Thirty days if requested by law enforcement in writing to delay sending such notice, and in no event may exceed 90 days.

A provider may request, and shall be granted a reconsideration review in accordance with 10A NCAC 22F.0402.

The Social Security Act was also amended to include a definition of credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source and including but not limited to the following:

1. Fraud hotline & online form complaints
2. Claims data mining
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis. These new provisions in the Social Security Act were effective on March 25, 2011.

## **Medicaid Providers Must Screen for Individual & Entity Exclusion**

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42

CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician/pharmacist or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider/pharmacist, practitioner or supplier that is not excluded. (42 CFR Section 1001.1901(b).

Providers can look for excluded Individuals & Entities on the HHS-OIG List of Excluded Individuals and Entities (LEIE) database, which is accessible to the general public and displays information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at:  
<http://www.oig.hhs.gov/fraud/exclusions.asp>.

To further protect against payments for items and services furnished, prescribed or ordered by excluded individuals and/or entities, the Division of Medical Assistance (DMA) is advising all current providers and providers applying to participate in the Medicaid program to take the following steps:

- Provider has an **obligation** and must screen all employees and contractors to determine whether any of them have been excluded.
- DMA will require this obligation as a condition of enrollment into the Medicaid program.
- Search the HHS-OIG website monthly by the names of an individual or entity to capture exclusions and reinstatements that have occurred since the last search.
- Immediately report to the appropriate Regional Office of the OIG Office of Investigations or DMA any exclusion information discovered.

This line of defense in combating fraud, waste & abuse must be conducted accurately, thoroughly and routinely. DMA understands that providers share our commitment to combating fraud, waste & abuse. Working together will strengthen efforts to identify excluded parties. The integrity and quality of the Medicaid program will be improved which will benefit Medicaid recipients and North Carolina taxpayers.

## Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at <http://www.ncdhhs.gov/dma/mp/>:

- 6, Off Label Antipsychotic Safety Monitoring in Children through Age 17 (posted 1/1/12; eff. 12/1/11)
- A-15, Surgery for Clinically Severe Obesity (1/1/12)
- 1A-31, Wireless Capsule Endoscopy (1/1/12)
- 1A-32, Tympanometry and Acoustic Reflex Testing (1/1/12)
- 3K-1, Community Alternatives Program for Children (CAP/C) (1/1/12)
- 9, Outpatient Pharmacy Program (1/1/12)
- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers (1/1/12)
- 10D, Independent Practitioners Respiratory Therapy Services (1/1/12)
- 11A-1-Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)
- 11A-2- Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia
- 11A-3- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia
- 11A-4 - Donor Leukocyte, Donor Lymphocyte or Buffy Coat Infusion for Hematologic Malignancies that Relapse or at a High Risk for Relapse after Allogeneic Stem Cell Transplantation (Date of termination 12/31/11)
- 11A-5 - Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias
- 11A-6 - Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors
- 11A-7 - Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma

The following new or amended NC Health Choice policies are now available on DMA's website at <http://www.ncdhhs.gov/dma/hcmp/>:

- Abatacept (Date of termination 9/30/2011) Acquired Anemias
- Alefacept Injection (Date of termination 9/30/2011)
- Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Capsule Endoscopy, Wireless Cell Tumors
- Endovascular Stent Graft for Aortic Aneurysm (Date of termination 9/30/2011)
- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous
- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma
- Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ
- Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia
- Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic
- Independent Practitioners Infliximab (Date of termination 9/30/2011) Leukemia Leukemia (ALL)
- Surgery for Morbid Obesity
- Tympanometry and Acoustic Reflex Testing

These policies supersede previously published policies and procedures. Providers may contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888 with billing questions.

## 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>
18657	Halozyme Therapeutics, Inc	02/03/2012
42794	Sigmapharm Laboratories, LLC	01/27/2012
46026	Gloucester Pharmaceuticals Inc	01/31/2012
52605	Polygen Pharmaceuticals, LLC	02/17/2012
76439	Virtus Pharmaceuticals, LLC	01/31/2012

### Voluntarily Terminated Labeler

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

Orchid Pharma, Inc

(Labeler 59834)

**Checkwrite Schedule**

February 07, 2012	March 06, 2012	April 10, 2012
February 14, 2012	March 13, 2012	April 17, 2012
February 22, 2012	March 20, 2012	April 26, 2012
February 29, 2012	March 29, 2012	

**Electronic Cut-Off Schedule**

February 02, 2012	March 01, 2012	April 05, 2012
February 09, 2012	March 08, 2012	April 12, 2012
February 16, 2012	March 15, 2012	April 19, 2012
February 23, 2012	March 22, 2012	

*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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