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North Carolina

Medicaid Pharmacy

Newsletter

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In This Issue…

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

Clarification on the Insulin Syringe Billing

Effective date of service July 17, 2009, insulin syringes will be covered as an over-the-counter product in the N.C. Medicaid Outpatient Pharmacy Program. Recipients must have a prescription for the insulin syringes and there must be an insulin prescription on file within the last 90 days in order to bill using the pharmacy point-of-sale system. Syringes are supplies that must be billed per syringe in multiples of 10 and a National Drug Code (NDC) must be used when billing through point-of-sale. Rates apply to syringes; therefore, no co-payments or dispensing fees apply. Medicare Part D continues to cover insulin syringes for dual eligible recipients.

Syringes do not have to be purchased at the same pharmacy as the insulin unless the patient is locked into a pharmacy. Recipients identified for the Focused Risk Management (FORM) Program who require more than 11 unduplicated prescriptions each month are restricted to a single pharmacy. In these cases, the insulin syringes must be purchased at the same pharmacy.

Insulin syringes will no longer require authorization by a recipient's CCNC/CA primary care provider as long as they are billed using the pharmacy point-of-sale (POS) system. Pen needles, lancets and strips will not be paid through POS. These items will continue to require authorization by a recipient's CCNC/CA primary care provider.

Insulin syringes can continue to be billed through the DME program; the ability to bill on POS will be an additional option.

New Prior Authorization Requirements for Brand-Name Muscle Relaxants

Effective with date of service of July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for brand-name muscle relaxants. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

Medications that now require prior authorization include Amrix, Fexmid, Parafon Forte DSC, Skelaxin, Soma, Soma Compound, Soma Compound with Codeine, and Zanaflex. Generic muscle relaxants will not require prior authorization.

New Prior Authorization Requirements for Brand-Name Nasal Steroids

Effective with date of service of July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for brand-name nasal steroids. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

Medications that now require prior authorization include Beconase AQ, Flonase, Nasacort AQ, Nasarel, Nasonex, Omnaris, Rhinocort Aqua, and Veramyst. Generic fluticasone nasal spray and generic flunisolide nasal spray will not require prior authorization. Prior authorization is not required for patients under 4 years old.

New Prior Authorization Requirements for Serotonin 5-HT_1 Receptor Agonists (Triptans)

Effective with date of service of July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for high quantities (more than 12 units per class per calendar month) of serotonin 5-HT_1 receptor agonists (triptans). Prescribers can request prior authorization for patients requiring greater than 12 units per calendar month by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

Time Limit Overrides

Federal guidelines require that all Medicaid claims, except hospital inpatient and nursing facility claims, be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the remittance advice (RA) date to refile a claim.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, the provider has 180 days from the date listed on the explanation of benefits (EOB) to file the claim to Medicaid from that insurance (whether the claim was paid or denied). The provider must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third-Party or Medicare EOB in order to request a time limit override with EDS.

Claims initially received for processing within the 365-day time limit may be resubmitted to EDS on paper or electronically. The claim information must match exactly to the original claim for the recipient Medicaid identification number (MID), provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following Explanation of Benefits (EOB):

- **0018** Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.
- **8918** Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Requests for time limit overrides must be sent to EDS with documentation showing that the original claim was submitted within the initial 365-day time period.

Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA or EDS about the specific claim received that is within 365 days of the date of service
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial.

- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit.

Examples of unacceptable documentation may include, but not limited to:

- The billing date on the claim or a copy of an office ledger.
- The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

The **Medicaid Resolution Inquiry Form** is used to submit claims for Time Limit Overrides. The instructions for completing the Medicaid Resolution Inquiry Form can be found in the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/basicmed in Section Eight – Resolving Denied Claims on page nine.

When submitting inquiry forms, always attach the claim and a copy of any paper RAs related to the inquiry form, as well as any other information related to the claim (provider-generated RAs or electronic RAs are not acceptable). Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, attach only single-sided documents to the inquiry request. Do not attach double-sided documents to the inquiry request. A copy of the Medicaid Resolution Inquiry Form is on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Retro Eligibility and Retroactive Prior Approval
In some instances an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal, or a court decision. A time limit override may be needed in some cases; the county department of social services (DSS) is responsible for requesting this override base on date of approval. When a time limit override is warranted, the county department of social services will provide written notice to the recipient outlining the specific dates of service when the Time Limit Override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. When this occurs, providers can file claims for these specific dates of service outlined in the recipient letter. The provider must file these claims within six months of determination as outlined in the recipient letter.

Retroactive prior approval is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA.

Notice of Possible Medicaid Identification Card Changes

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program may begin issuance of no more than one Medicaid identification (MID) card per year to each recipient. The proposed annual cards would be printed on white stock; DMA would no longer have blue, pink, green, and buff colored MID cards. The cards would include, at a minimum, the recipient's name, MID number, and managed care primary care provider information (if applicable).

If implemented, this change would mean that the MID card will no longer serve as proof of recipient eligibility. Providers must verify the cardholder's current eligibility at each visit. Once

providers have verified eligibility during a particular month, the provider may assume that the cardholder remains eligible for the remainder of that month.
An exception to the one card per year rule would be made for those managed care recipients who change their primary care physician or change their name. A recipient would also be able to ask the county department of social services to submit a request for a replacement card, if needed.

Should the proposed legislation be implemented, providers will be notified of the change in future Medicaid Bulletins and through Remittance and Status Report banner messages, e-mail blasts, and the DMA Budget Initiative web page.

DMA Budget Initiative Web Page

DMA will implement a number of changes in response to proposed legislated budget reductions. Providers will be notified of operational changes and coverage and policy changes via the Medicaid Bulletin. These changes will also be listed on DMA's website at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

Electronic Claims Submission

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program will require all providers to file claims electronically. Providers will be notified of the implementation date for this requirement in a future Medicaid bulletin.

By submitting claims electronically, providers have the advantage of expedited claims processing and improved cash flow. Electronic claims software includes time-saving features such as automatic insertion of required claims information, retrieval of previously submitted claims from backup files, and generation of lists of commonly used billing codes. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed in the following checkwrite.

Electronic Claims Submission Agreement
Providers who did not complete an Electronic Claims Submission (ECS) Agreement at the time of their enrollment must now complete and submit an ECS Agreement. Effective with this requirement, all providers enrolling in the N.C. Medicaid Program will be required to complete and submit the ECS Agreement in their Provider Enrollment Packet. Providers who are already filing claims electronically do not need to resubmit an ECS Agreement.

The ECS Agreement must be submitted and approved prior to submitting claims electronically, regardless of how claims are submitted – through a clearinghouse, with software obtained from an approved vendor, or through the NCECS-Web Tool. Once notification of approval is received, providers must contact the EDS Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain a logon ID and password for electronic claims submission.

Group providers must submit the name and Medicaid Provider Number for each individual provider affiliated with their group for whom they will be submitting claims using their group provider number. This is required even if there is only one provider in the group. The ECS Agreement for the group must be signed by each individual provider, which authorizes the group to use the individual's National Provider Identifier to bill Medicaid for services provided.

To obtain a copy of this agreement for either a group or an individual, visit http://www.nctracks.nc.gov/provider/forms/.

Trading Partner Agreement
Providers and clearinghouses that bill HIPAA-compliant transactions directly to N.C. Medicaid are required to complete and submit a trading partner agreement (TPA) to N.C. Medicaid. The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. The form is available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Additional information regarding billing claims electronically is available in the *Basic Medicaid Billing Guide*, Section 10 (on DMA's website at http://www.ncdhhs.gov/dma/basicmed/), or from the EDS Electronic Commerce Services Unit (telephone 1-800-688-6696 or 919-851-8888, option 1).

Electronic Claim Exceptions
The following list outlines some of the situations in which a claim must be billed on paper:

- Medicare HMO (Part C) primary claims
- Medicare Part A inpatient claims submitted directly to Medicaid
- Services that require an invoice to be submitted with the claim including, but not limited to
    - Hearing aids and related items
    - Some visual aids
    - Unclassified and unlisted procedures
    - Undelivered dentures
    - Compounded injectable drugs billed with an unclassified HCPCS procedure code (for example, J3490)
      Note: 17-P compounds do not require invoices and should be billed electronically when this provision becomes effective.
- Claims submitted with a Medicaid Resolution Inquiry Form for
    - Time limit override
    - Medicare override
    - Third-party override
- **Pharmacy claims for**
    - **Charges over $9,999**
    - **Compound drugs, when the compound comprises both legend and non-legend drugs**
    - **Compound drugs, when the compound contains an over-the-counter drug**
    - **Non-covered over-the-counter drugs prior approved through EPSDT**
    - **Retroactive charges that exceed the time limit for filing**
    - **DMA-approved quantity overrides**
    - **Medicare deductibles**
    - **Synagis that does not meet the established guidelines for coverage**
    - **Depo-Provera that does not meet the established guidelines for coverage**
- Visual field exams requiring medical justification
- Any claim that requires manual review of records after the initial filing in order to make a coverage determination
- Non-covered services provided under EPSDT
- Any claim billed with one of the following ICD-9-CM diagnosis codes:

  - 584.8
  - 589
  - 593.9
  - 640 through 640.9
- Any professional claim billed with one of the following CPT procedure codes:
  - 59136
  - 59151
  - 59120
  - 59100
  - 99082
- Any dental claim billed with one of the following ADA procedure codes:
  - D0340
  - D0470
  - D7830
- Any institutional claim billed with one of the following ICD-9-CM procedure codes:
  - 66.6 through 66.9
  - 62.41 through 62.42
  - 63.81 through 63.85
  - 63.89
  - 65.51 through 65.52
  - 65.61 through 65.62
  - 66.71 through 66.79
  - 66.91
  - 66.94 through 66.99
- Claims submitted with a Provider Enrollment Packet from an out-of-state provider for reimbursement of services rendered to N.C. Medicaid recipients in response to an emergency
- Nursing home crossovers submitted directly to Medicaid

Only claims that comply with the exceptions listed above may be submitted on paper. All other claims are required to be submitted electronically. This list will be maintained on the DMA website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Providers will be notified of updates to the list through the Medicaid Bulletin.

Electronic Funds Transfers

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program will require all providers to receive payments electronically. Providers will be notified of the implementation date for this requirement in a future Medicaid Bulletin.

By receiving payments electronically, providers eliminate the possibility of their paper checks' being lost, stolen, misrouted, damaged or returned to sender. Electronic funds transfers (EFT) also eliminate delays incurred in receipt of Medicaid payment for the mailing and delivery of the check, which can take 5 to 7 business days. EFT payments are deposited through a secure transaction into the provider-designated checking or savings bank account. EFT provides payment in a timely and safe manner and supports an increased cash flow to the provider's business operation.

To initiate the automatic deposit process, providers must complete and return the **Electronic Funds Transfer Authorization Agreement for Automatic Deposit form.** A separate EFT form

must be submitted for each provider number. Providers must submit a new EFT form if they change banks or bank accounts. A copy of the form can be obtained on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm. Instructions on completing the form as well as documentation requirements can be found on the EFT form. Documentation includes attaching a voided check to confirm the provider's account number and bank transit number.

Completed forms can be returned by fax to the EDS financial unit at 919-816-3186 or by e-mail to NCXIXEFT@eds.com. Providers will continue to receive paper checks until automatic deposits begin or resume to a new bank account. When the EFT process for automatic deposits has been completed, the top left corner of the last page of the Remittance and Status Report will show "EFT number" rather than "check number."

False Claims Act Education Compliance for Federal Fiscal Year 2008

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

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

Providers must complete and submit a copy of the Letter of Attestation Form within 30 days of the date of notification. Upon completion, submit the Letter to EDS by fax or by mail.

Mail to
EDS
Attn: PVS-False Claims Act
P.O. Box 300012
Raleigh NC 27622

OR

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

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

Clarification for Completing the W-9

The Medicaid provider enrollment process includes the completion of the Internal Revenue Service's (IRS) W-9 form. The N.C. Medicaid Program must collect this information in order to correctly report income paid to the provider. The W-9 form is retained by the N.C. Medicaid Program and is not sent to the IRS. The instructions that the IRS provides with the W-9 form explain that payments you receive may be subject to backup withholding if you do not report your correct tax identification number (TIN). The instructions further explain that the TIN provided must match the name given on Line 1. Failure to provide your correct TIN may result in a penalty. (The W-9 form and instructions for completing the form are available at http://www.irs.gov/)

Some individual providers who are also associated with a group practice submitted their W-9 with the group's TIN listed instead of their social security number (SSN). Now that the N.C. Medicaid Program is aware of this issue, the IRS instructions and guidelines for completion of the W-9 form will be followed. Providers who have supplied incorrect TINs in the past may correct their W-9s at any time by sending a completed Medicaid Provider Change Form with a corrected W-9 attached to the form to the address listed below.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Earnings reported on the 1099 form are based on the provider number associated with the National Provider Identifier entered on the claim form. If incorrect earnings are reported it may be because claims are incorrectly filed without the group number, which results in income being reported to the individual (attending) provider number entered on the claim. Incorrect earnings are **NOT** reported based on the W-9. It is important that all providers carefully review the Financial Section of their Remittance and Status Report (RA) to verify that the claim is submitted properly and income is reported to the correct TIN

CSC to Initiate 12-Month Provider Verification and Credentialing Activities

CSC is ready to begin the 12-month process to verify information and credential enrolled Medicaid providers who have not been credentialed in the last 18 months. CSC will notify providers by mail when verification and credentialing activities will begin for their provider types. The notification packet will be mailed to the provider's billing/accounting address and will include a pre-printed report of information currently on file with N.C. Medicaid plus a checklist of credentialing-related documents that must be returned to CSC. (Providers may verify their billing/accounting address via the DMA Provider Services NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm or by calling the EVC Call Center.)

The pre-printed NC MMIS Verification Form includes demographic data and NPI information currently on file with N.C. Medicaid and also contains space for providers to enter license/certification numbers, type of ownership, and contact information. Providers must complete the form, attach copies of documents required for credentialing, and return the verification packet to CSC within 30 days of the date of receipt. Failure to respond to the notification may result in termination of Medicaid participation.

The verification process will take up to three weeks from the time CSC receives the correct and complete verification packet from the provider; the return of incomplete or incorrect information will prolong the verification process. CSC will review the information and conduct credentialing activities that include criminal background checks, queries of practitioner databases, and verification of licensure, certification, and endorsement.

DMA and CSC will continue to inform providers of various events and changes through the General Medicaid Bulletins, the DMA website, and the EVC Call Center website.

EVC Call Center Contact Information

EVC Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
EVC Call Center Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
EVC Call Center Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
EVC Call Center Website	http://www.nctracks.nc.gov

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.

Additions

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

Code	***Manufacturer***	***Date***
42546	Prugen, Inc	07/03/2009
63833	CSL Behring GmbH	06/12/2009
67467	Octapharma Pharmazeutikagm	06/30/2009
68209	Octapharma A.B.	06/30/2009

Voluntarily Terminated Labeler

The following labelers have requested voluntary termination effective October 1, 2009:

Deston Therapeutics, LLC	(Labeler 16881)
Provident Pharmaceutical, Inc	(Labeler 20091)
Santarus, Inc	(Labeler 68012)

Rescindment of Termination

CMS notified the states that West-Ward Pharmaceutical Corp. (Labeler 00143) has now come into compliance with CMS requirements and their termination has been rescinded. They will continue to be an active labeler code.

Checkwrite Schedule

July 07, 2009	August 11, 2009	September 09, 2009
July 14, 2009	August 18, 2009	September 15, 2009
July 23, 2009	August 27, 2009	September 24, 2009
August 04, 2009		

Electronic Cut-Off Schedule

July 02, 2009	August 06, 2009	September 03, 2009
July 09, 2009	August 13, 2009	September 10, 2009
July 16, 2009	August 20, 2009	September 17, 2009
July 30, 2009		

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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