INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Pharmacy Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA, OptumRx, and HPE
1.1	Policies and procedures as of April 1, 2016 Published: June 23, 2016	Scheduled update	FSSA, OptumRx, and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	*Core*MMIS update	FSSA, OptumRx, and HPE
2.0	Policies and procedures as of April 1, 2017 Published: July 13, 2017	Scheduled update: • Edited and reorganized text throughout the module • Changed *HIP Link* references to *HIP Employer Link* • Changed Hewlett Packard Enterprise references to DXC • Added references to the Pharmacy Supplements Formulary where appropriate • Updated the *Introduction* section to reflect that pharmacy benefits are no longer carved out of Hoosier Healthwise • Updated Tables 1 and 2 and added Table 3 in the *Introduction* section • Added the *Medically Accepted Indication* section • Added NDC information to the *Federal Rebate Program* section • Updated Table 7 in the *Tamper-Resistant Prescriptions* section • Replaced the *Legend Drug Reimbursement* and *Nonlegend (Over-the-Counter) Drug Coverage and Reimbursement* sections with the new *Legend and Nonlegend Product Reimbursement* section	FSSA, OptumRx, and DXC

Version	Date	Reason for Revisions	Completed By
		• Updated the *Professional Dispensing Fee* section • Updated the *Medical Supplies (Including Preferred Diabetic Supplies) and Durable and Home Medical Equipment* section • Updated the *Coverage of Drug Products for Treating Tobacco Dependence* section • Added the *Pharmacy Claims for Hepatitis C Drugs* section • Added note regarding Package E to the *POS Transaction* section • Updated the *Common Billing Errors* section • Added the *Patient Gender Code and Pregnancy Indicator* section • Updated contact information for the TPL Unit in the *Third-Party Liability, Coordination of Benefits, and Cost Avoidance* section • Updated the *IHCP Policy Regarding the 340B Program* section • Added a documentation requirement to the *Returned Medications* section • Updated the *Prospective Drug Utilization Review* section • Added the *Self-Audits* section • Added the *Invoice Reconciliation Audits* section • Updated the *On-Site Audits* section • Updated the *Proof of Delivery* section • Updated the *Emergency Supply* section regarding prior authorization	

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Section 1: Introduction

The Indiana Health Coverage Programs (IHCP) is administered by the Indiana Family and Social Services Administration (FSSA), with policy and operational oversight provided through the FSSA Office of Medicaid Policy and Planning (OMPP). This document provides relevant information about the IHCP pharmacy benefit:

- OptumRx® serves as the pharmacy benefit manager (PBM) and pharmacy claim processor for IHCP fee-for-service (FFS) programs.
- PBMs contracted with each of the four managed care entities (MCEs) serving Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members manage pharmacy benefits and process pharmacy claims for IHCP managed care programs.

> *Note:* *Before January 1, 2017, pharmacy services and certain drug-related medical supplies and medical devices were carved-out from the Hoosier Healthwise program. For dates of service before January 1, 2017, pharmacy benefits for Hoosier Healthwise members were managed by the FFS PBM, OptumRx rather than the member's MCE. See the Drug-Related Medical Supplies and Medical Devices Reimbursed as Fee for Service table in Durable and Home Medical Equipment and Supplies Codes on the Code Sets page at indianamedicaid.com for a list of medical supplies and devices that were covered under the medical FFS benefit for Hoosier Healthwise members for dates of service before January 1, 2017.*
>
> *For dates of service on or after January 1, 2017, for **all** managed care programs, including Hoosier Healthwise, providers are required to file pharmacy claims with, and obtain any required prior authorization from, the PBM contracted by the MCE in which the member is enrolled. Additionally, for dates of service on or after January 1, 2017, drug-related medical supplies and medical devices previously carved out from the Hoosier Healthwise program must be billed to the MCE in which the member is enrolled.*

Pharmacy providers can verify a member's program assignment and the appropriate PBM for claim submission through the Eligibility Verification System (EVS) options – the Provider Healthcare Portal at indianamedicaid.com, the Interactive Voice Response (IVR) system at 1-800-457-4584, or the 270/271 electronic transactions. The PBM information may also be listed on the member's ID card.

Pharmacy providers can contact the MCE or its PBM for questions about managed care pharmacy services and claim submission. See the *IHCP Quick Reference Guide* at indianamedicaid.com for contact information. For HIP, Hoosier Care Connect, and Hoosier Healthwise MCE pharmacy claim processing information, see Table 1. (*HIP Employer Link* is an FFS benefit plan; for these claims, see the *Billing Procedures for HIP Employer Link* section).

Table 1 – MCE Pharmacy Claim Processing Information for HIP, Hoosier Care Connect, and Hoosier Healthwise

Anthem	CareSource	Managed Health Services (MHS)	MDwise
BIN: 003858 PCN: MA Group: WKXA Help Desk: 1-844-520-2680	BIN: 004336 PCN: MCAIDADV Group: RX6421 Help Desk: 1-844-607-2829	BIN: 008019 PCN: Not required Group: Not required Help Desk: 1-855-772-7121	BIN: 003585 PCN: ASPROD1 Group: MDW Help Desk: 1-844-336-2677

> *Note:* *For more information on IHCP programs, see the Member Eligibility and Benefit Coverage module.*

See Table 2 for FFS pharmacy-related contact information. OptumRx hosts technical and clinical help desks via a call center (referred to as the OptumRx Clinical and Technical Help Desk). The OptumRx Clinical and Technical Help Desk is open 24 hours a day, seven days a week and can be contacted toll-free at 1-855-577-6317. All pharmacy and member calls directly related to FFS pharmacy claim processing or pharmacy-related inquiries, including clinical inquiries or requests for FFS pharmacy prior authorization, should be directed to OptumRx. Calls related to provider enrollment, physician-administered drugs, the Provider Healthcare Portal (Portal), and all other nonpharmacy calls are handled by DXC Technology, which can be contacted toll-free at 1-800-457-4584.

OptumRx manages all aspects of the administration of the Indiana Medicaid Maximum Allowable Cost (State MAC) program for federal legend drugs and blood factors and establishes Over-the-Counter (OTC) Drug Formulary and Pharmacy Supplements Formulary MAC rates. OptumRx is responsible for the development and ongoing maintenance of all State MAC rates, as well as for the day-to-day administration of the State MAC program. All inquiries related to the State MAC program should be directed to the OptumRx MAC Provider Relations, which can be contacted toll-free at 1-800-880-1188 or by email at MAC@Optum.com.

The IHCP pharmacy benefit is a dynamic program and, as such, this document does not contain all applicable information. A significant amount of program information is available and maintained in an up-to-date format under the Pharmacy Services quick link at indianamedicaid.com. See Table 4 for a list of pharmacy-related websites.

Updates to this document are issued periodically. In the interim, providers should read and retain the bulletins and banner pages published by the IHCP. Current and archived copies of these publications are available at the *News, Bulletins, and Banner Pages* page at indianamedicaid.com. These publications advise providers of program changes that occur between published updates to this document.

Table 2 – Fee-for-Service Pharmacy Contact Information

Pharmacy Benefit Manager Contact Information	
OptumRx Clinical and Technical Help Desk Telephone: 1-855-577-6317 Fax: 1-855-678-6976 PA Fax: 1-855-577-6384	All pharmacy and member calls directly related to FFS pharmacy claim processing or pharmacy-related inquiries, including clinical inquiries or requests for pharmacy prior authorization (PA)
OptumRx – MAC Rate Review Requests Telephone: 1-800-880-1188 Fax: 1-877-293-1845 Email: MAC@Optum.com	All State MAC rate review request documentation
OptumRx electronic funds transfer (EFT) Fax: 1-866-244-8543	For submitting the completed *Electronic Funds Transfer (EFT) Request Form*
OptumRx Pharmacy Audit Department Telephone: 1-866-618-6853 Fax: 1-866-244-9066 Email: Rxaudit.INM@Optum.com	Questions regarding documentation for audit purposes

Pharmacy Benefit Manager Mailing Address	
OptumRx P.O. Box 44085 Indianapolis, IN 46244-0085	State MAC correspondence should be sent to the OptumRx Indianapolis office.
OptumRx Manual Claims Department #620 P.O. Box 968022 Schaumburg, IL 60173-6801	The following should be sent to the OptumRx corporate address: • Paper claims • Claim reimbursement adjustments • Administrative reviews
Provider Refund Lock Boxes: First Class Mail: OptumRx Claims 26594 Network Place Chicago, IL 60673-1265 Courier Mail: OptumRx Claims LBX 26594 JP Morgan Chase 131 South Dearborn – 6th floor Chicago, IL 60603	The following should be sent to either of the Provider Refund lock boxes: • Refunds • Payments • Overpayments
State of Indiana OptumRx Pharmacy Audit Department P.O. Box 44085 Indianapolis, IN 46244-0085 Fax: 1-866-244-9066 Email: Rxaudit.INM@Optum.com	Pharmacy audit documentation should be sent to the OptumRx Pharmacy Audit Department.
Rebate Payments: First Class Mail: State of Indiana Rebates 26593 Network Place Chicago, IL 60673-1265 Courier Mail: State of Indiana Rebates LBX 26593 JP Morgan Chase 131 South Dearborn – 6th Floor Chicago, IL 60603	Rebate payments should be sent to either address.
OptumRx Indiana Drug Rebate 3025 Windward Plaza, Suite 200 Alpharetta, GA 30005 Email: indiana.rebates@Optum.com	Rebate correspondence should be sent to this mailing or email address.

Table 3 – IHCP Pharmacy Benefit Utilization Contact Information

Right Choices Program (RCP) Contact Information				
Cooperative Managed Care Services (CMCS) – FFS 1-800-784-3981	Anthem 1-866-902-1690 Option 3	CareSource 1-844-607-2831	MHS 1-877-647-4848	MDwise 1-800-356-1204
Prior Authorization for Drugs and Drug-Related Medical Supplies Billed on a Professional Claim (*CMS-1500* Claim Form Electronic Equivalent)				
CMCS – FFS Medical PA 1-800-269-5720 Fax: 1-800-689-2759	Anthem Healthy Indiana Plan 1-866-398-1922 Fax: 1-866-406-2803 Hoosier Care Connect and Hoosier Healthwise 1-866-408-7187 Fax: 1-866-406-2803	CareSource 1-844-607-2831 Fax: 1-844-432-8924	MHS 1-877-647-4848 Fax: 1-866-912-4245	MDwise *Quick Contact Guide*
Note: For PA mailing addresses and additional MCE contact information, see the IHCP Quick Reference Guide at indianamedicaid.com.				

Table 4 – Pharmacy-Related Websites

Name	Description	Address
IHCP Pharmacy Services Provider Website	The official website for IHCP providers that includes forms, publications, Preferred Drug List (PDL), drug rebate labelers, Over-the-Counter (OTC) Drug Formulary, Pharmacy Supplements Formulary, prior authorization (PA) request forms, pharmacy frequently asked questions (FAQs) for providers and members, Drug Utilization Review (DUR) Board, Therapeutics Committee, Mental Health Quality Advisory Committee (MHQAC) meeting agendas and minutes, and the Indiana State MAC lists	inm.providerportal.catamaranrx.com (available from the Pharmacy Services quick link at indianamedicaid.com)
Indiana Administrative Code (IAC)	Regulations pertaining to the Indiana Medicaid benefit	in.gov/legislative/iac See Title 405, Office of the Secretary, FSSA
National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) Lookup Tool	This site provides access to provider NPIs at no charge	npiregistry.cms.hhs.gov

Name	Description	Address
NPI Number Lookup Tool	This site provides access to provider NPIs at no charge	npinumberlookup.org
Centers for Medicare & Medicaid Services (CMS)	The official website for CMS	cms.gov
Medicaid	The official U.S. government website for people with Medicaid	medicaid.gov
Medicare	The official U.S. government website for people with Medicare	medicare.gov

Table 5 – Roles of Contractors for FFS Medicaid

Contractor	Responsibilities
OptumRx	Pharmacy benefit manager (PBM) for the fee-for-service pharmacy benefit. Primary responsibilities include: • Prior authorization and related clinical call center operations • PDL development and maintenance • DUR Board and Therapeutics Committee and MHQAC support functions • Federal and State supplemental drug rebate program administration • Required federal and State reporting • Stakeholder communications • Retrospective Drug Utilization Review (retro-DUR) • OTC Drug Formulary and Pharmacy Supplements Formulary maintenance • Adjudication of and payment for pharmacy claims • Pharmacy benefit systems support • Pharmacy-related provider and member assistance functions • Administration and maintenance of the State MAC program, including development of State MAC rates • Development and maintenance of OTC Drug Formulary and Pharmacy Supplements Formulary MAC rates • Real-time audits, desk audits, and on-site audits
DXC	Fiscal agent for the IHCP. Primary pharmacy responsibilities include: • Member eligibility data source • Primary third party liability (TPL) data source • Provider enrollment functions • Provider communications

Section 2: Pharmacy Coverage and Reimbursement

Overview

The Indiana Health Coverage Programs (IHCP) fee-for-service pharmacy benefit program operates under the following basic parameters. Providers must be aware of and abide by these provisions:

- The scope of coverage and reimbursement methodologies is as set out in the IHCP rule at *Indiana Administrative Code 405 IAC 5-24*.
- All covered drugs require a prescriber's order or prescription, as defined in Indiana Board of Pharmacy law.
- The program is a payer of medically necessary covered services provided in accordance with applicable law. The program is jointly funded by federal and State monies and, as such, is subject to federal and State requirements.
- Although the program strives to have system edits in place whenever feasible and possible to enforce program policy and parameters, ***it is not systematically possible to have edits for each and every dispensing situation. Therefore, the pharmacy provider must ensure that services rendered are covered by the program, rendered in accordance with pharmacy practice law and all other applicable laws, and do not exceed any established program limits.*** Payments that may result from a pharmacy provider's failure to exercise due diligence in this regard are subject to recoupment.

Legend Drug Coverage

The program covers legend drugs in accordance with the IHCP rule *405 IAC 5-24-3 Coverage of legend drugs*, which, at the time of publication of this document, is as follows:

***405 IAC 5-24-3* Coverage of legend drugs**

Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2*
Affected: *IC 12-13-7-3; IC 12-15*

Sec. 3. (a) A legend drug is covered by Indiana Medicaid if the drug is:

(1) approved by the United States Food and Drug Administration;

(2) not designated by the Health Care Financing Administration (HCFA)* as less than effective, or identical, related, or similar to a less than effective drug;

(3) subject to the terms of a rebate agreement between the drug's manufacturer and the HCFA; and

(4) not specifically excluded from coverage by Indiana Medicaid.

(b) The following are not covered by Indiana Medicaid:

(1) Anorectics or any agent used to promote weight loss.

(2) Topical minoxidil preparations.

(3) Fertility enhancement drugs.

(4) Drugs when prescribed solely or primarily for cosmetic purposes.

** Currently known as Centers for Medicare & Medicaid Services (CMS).*

Medically Accepted Indication

Based on federal law Sec. 1927 [*42 U.S.C. 1396r-8*], a state may exclude or otherwise restrict coverage of a covered outpatient drug if the prescribed use is not for a medically accepted indication. The term "medically accepted indication" means any approved use for a covered outpatient drug under the *Federal Food, Drug, and Cosmetic Act*, or the use is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United Status Pharmacopeia-Drug Information (or its successor publications), the DRUGEX Information System, as well as peer-reviewed medical literature.

Federal Rebate Program

Federal law requires that, for a legend or nonlegend drug to be covered by state Medicaid programs, the manufacturer must have a drug rebate agreement in effect with the Centers for Medicare & Medicaid Services (CMS).

The drug rebate program was created by the federal *Omnibus Budget Reconciliation Act of 1990* (OBRA-90) and applies to *covered outpatient drugs.* In accordance with that law, a manufacturer that holds legal title to the National Drug Code (NDC) for a prescription drug, nonprescription drug, or biological product, must have a rebate agreement with the federal government in effect to ensure coverage of its products by state Medicaid agencies. By signing the rebate agreement, a manufacturer agrees to pay each state, in the form of a rebate, a portion of the expenditure the state paid to providers for that manufacturer's covered outpatient drugs. Each calendar quarter, an invoice is produced by the state and sent to each rebating manufacturer, detailing the utilization for each NDC and the amount due the state in the form of a rebate. A complete list of manufacturers by labeler code (the first five digits of the NDC) that have entered into a rebate agreement with the federal government is available under Manufacturer Information using the Pharmacy Services quick link at indianamedicaid.com.

It is essential that pharmacies check this list for the status of a drug manufacturer before dispensing and submit the exact 11-digit NDC (which includes the last two digits [package size]) from the package from which the product was dispensed. Claims submitted with incorrect NDCs are subject to financial recovery. If the labeler code of the manufacturer of any given drug does not appear in the list, the drug is not covered by the IHCP, and providers are not entitled to reimbursement for such products.

Federal Drug Efficacy Study and Implementation Program

The *Federal Food, Drug, and Cosmetics Act of 1938* established the requirement that a manufacturer prove the safety of a drug before the drug could be marketed in the United States. In 1962, this act was amended to require that drugs sold in the United States be regulated more closely. All new drugs must demonstrate, via adequate studies, safety and efficacy before introduction into the market. The Drug Efficacy Study and Implementation (DESI) Program was established to ensure that drugs that did not have proven efficacy were ultimately removed from the market and not reimbursed by state Medicaid programs in the interim.

Federal law prohibits state Medicaid agencies from reimbursing for so-called less-than-effective (LTE) drugs, commonly called DESI drugs, or any drug that the federal government has determined to be identical, related, or similar (IRS) to such a drug. These drugs are not covered by the IHCP, and providers are not entitled to reimbursement for them. If providers have a question about a specific drug's DESI status, they can contact OptumRx toll-free at 1-855-577-6317.

Dispense-as-Written Codes

For purposes of the IHCP pharmacy benefit, only dispense-as-written (DAW) codes 0, 1, 5, 8, and 9 should be submitted by providers. Incorrect use of these codes may result in full or partial recoupment. Table 6 shows general information about these codes:

Table 6 – DAW Codes

DAW Code	Code Description
0	No product selection indicated
1	Substitution not allowed by prescriber
5	Substitution allowed-brand drug dispensed as a generic
8	Substitution allowed-generic drug not available in marketplace
9	Substitution allowed by prescriber but plan requests brand – Patient's plan requested brand product to be dispensed

Mandatory Generic Substitution and Brand Medically Necessary

Generic substitution under the program is mandatory, as set out by statute at *Indiana Code IC 16-42-22-10 Substitution Prohibited*. The Preferred Drug List quick link can be accessed at the Pharmacy Services link at indianamedicaid.com for exceptions.

Pharmacy providers must be aware of the mandatory substitution law and dispense wholly in accordance with that law. Failure by the provider to do so can result in Medicaid payment that is out of accord with program policy, with the risk of recoupment. In particular, pharmacy providers must be fully aware of and dispense in accordance with the *brand medically necessary* provisions of Medicaid rule *405 IAC 5-24-8 Prior Authorization; Brand Name Drugs* and state statute *IC 16-42-22 Drugs: Generic Drugs*.

Brand Medically Necessary

A prescriber's specification of *brand medically necessary (BMN), DAW code=1*, requires PA. The following medications do not require PA for BMN but are subject to all other BMN requirements as specified in *405 IAC 5-24-8*:

- Dilantin
- Coumadin
- Lanoxin
- Premarin
- Tegretol
- Provera
- Synthroid

Tamper-Resistant Prescriptions

All handwritten or computer-generated prescriptions processed by the IHCP pharmacy benefit must be fully compliant with CMS and State guidance for prescription tamper resistance. These prescriptions must contain *at least one* industry recognized feature *from each of the three* categories of tamper resistance:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms

The Family and Social Services Administration (FSSA) suggests that prescribers consider using Indiana Board of Pharmacy security prescriptions to facilitate compliance with this mandate. Computer-generated prescriptions *may be printed on plain paper* and be fully compliant with all three categories of tamper resistance – provided they contain at least one feature from each of the three categories. See Table 7 for the three categories and their descriptions.

Table 7 – Three Categories of Tamper Resistance

Category	Feature	Description
1. Copy Resistance	A) Void/Illegal/Copy Pantograph with or without Reverse Rx	The word "Void," "Illegal," or "Copy" appears when the prescription is photocopied.
	B) Microprint signature line for prescriptions generated by an electronic medical record (EMR) if they cannot produce Void/Illegal/Copy Pantograph with or without Reverse Rx	Very small font, which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied
2. Erasure or Modification Resistance	A) An erasure revealing background (resists erasures and alterations) for written prescriptions, or printed on "toner-lock" paper for laser-printed prescriptions and on plain bond paper for inkjet-printed prescriptions	Erasure revealing background consists of a solid color or consistent pattern that has been printed onto the paper; this feature will inhibit a forger from physically erasing written or printed information on a prescription form. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. *Note: This paper is **not** necessary for inkjet printers, because the ink from inkjet printers is absorbed into normal "bond" paper.*
	B) Quantity check-off boxes, refill indicator (circle number of refills or "NR"), or border characteristics (dispense and refill # bordered by asterisks and optionally spelled out) for prescriptions generated by an EMR	In addition to the written quantity on the prescription, quantities are indicated in ranges. Quantities and refill # are surrounded by special characters, such as asterisks, to prevent modification. For example, QTY **50**.

Category	Feature	Description
3. Counterfeit Resistance	A) Security features and descriptions listed on the prescription	A complete list of the security features on the prescription paper aids pharmacists in identification of features and determines compliance.
	B) Printing vendor is registered with the State Board of Pharmacy	A listing of approved security-feature-prescription-pad vendors may be found on the Indiana Board of Pharmacy *Security Feature Prescription Pad Provider Information* page of the Professional Licensing Agency website at in.gov/pla.

In an emergency situation, a prescription written on a non-tamper-resistant pad is permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled.

Prescriptions that are telephoned, faxed, or electronically prescribed (e-prescribed) are exempt from tamper-resistant prescription requirements.

For questions about tamper-resistant prescriptions, please contact OptumRx toll-free at 1-855-577-6317.

Legend and Nonlegend Product Reimbursement

For claims submitted with dates of service on or after April 1, 2017, covered legend and nonlegend products are reimbursed at the lowest of the following:

- The National Average Drug Acquisition Cost (NADAC) as published by the CMS pursuant to *42 U.S.C 1396r-8(f)*, as of the date of dispensing, plus any applicable professional dispensing fee.
- The state maximum allowable cost (MAC) as determined by the State as of the date of dispensing, plus any applicable professional dispensing fee.
- The provider's submitted charge, representing the provider's usual and customary charge for the service, as of the date of dispensing.
- The federal upper limit (FUL) as determined by the CMS pursuant to *42 CFR 447.514*, as of the date of dispensing, plus any applicable professional dispensing fee.
- The wholesale acquisition cost (WAC) according to the State's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, minus a percentage as determined by the State through analysis of the dispensing cost survey or other methodology approved by the CMS, as of the date of dispensing, plus any applicable professional dispensing fee. The purpose of the percentage is to ensure that the applicable WAC rate sufficiently reflects the actual acquisition cost of the provider. The WAC shall only be considered if there is no applicable NADAC, FUL, or state MAC rate.

State Maximum Allowable Cost Program

The State uses MAC rates for many drugs reimbursed under the IHCP. OptumRx is responsible for the development and ongoing maintenance of all such rates, as well as for the day-to-day administration of the State MAC program. State MAC rates are calculated for drug groups using acquisition cost data, with a multiplier applied to ensure that the applicable State MAC rate is sufficient to allow reasonable access by providers to the drug at or below the established State MAC rate. As a condition of participation in the IHCP, pharmacies are required to provide acquisition cost data, if so requested by the FSSA or its contractor. Acquisition cost data is obtained from a small group of pharmacies on a monthly basis.

Only pharmacy acquisition cost observations that are within 90 days of the current month are used in the State MAC rate-setting process. On a semiannual basis, a sample of at least 150 pharmacy providers is surveyed for acquisition cost data. This sample has chain/independent and urban/rural characteristics reflective of the overall Medicaid provider population, but excludes the providers that submit data on a monthly basis.

OptumRx maintains the State MAC rates. Providers may access the Indiana SMAC quick link after selecting the Pharmacy Services quick link at indianamedicaid.com.

Professional Dispensing Fee

As of April 1, 2017, the IHCP selected a single professional dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to IHCP members, inclusive of both specialty and nonspecialty pharmacies. The professional dispensing fee that is reimbursed to pharmacy providers is determined based on a *Cost of Dispensing* survey that is performed every two years. The survey identifies costs associated with the dispensing function of prescription services, regardless of product or setting. A provider is entitled to dispensing fees in accordance with the IHCP rule at *405 IAC 5-24-6 Dispensing Fee.* A maximum of one professional dispensing fee per month is allowable per member per drug order for legend products provided to Medicaid recipients residing in Medicaid certified long-term care facilities. A maximum of one professional dispensing fee is allowable per member per prescription per 28 days for legend drugs provided to Medicaid members residing in Medicaid certified long-term care facilities. Providers are not entitled to any professional dispensing fee reimbursement that is not in accordance with this requirement of law.

The practice of split-billing, defined as the dispensing of less than the prescribed amount solely for the purpose of collecting more dispensing fees than would otherwise be allowed, is prohibited. In cases in which the pharmacist's professional judgment dictates that a quantity less than the amount prescribed be dispensed, the pharmacist should contact the prescribing practitioner for authorization to dispense a lesser quantity. The pharmacist must document the result of the contact and the pharmacist's rationale for dispensing less than the amount prescribed on the prescription or in the pharmacist's records.

Adult Vaccination Administration Fee

The IHCP reimburses pharmacy providers for pharmacist-administered vaccines to eligible IHCP members 19 years of age and older. Pharmacy claims for this service must be submitted through the standard point-of-sale (POS) system or via paper pharmacy claims. Vaccinations for IHCP members who are dually eligible for Medicaid and Medicare must be billed to Medicare. The maximum allowable reimbursement for the administration component of the service is consistent with reimbursement for vaccines administered by medical providers, currently $17.61 (includes intranasal and oral vaccines, as well as percutaneous, intradermal, subcutaneous, and intramuscular injections).

The administration of vaccines is reimbursable with a protocol approved by an IHCP-enrolled physician who meets the requirements of *IC 25-26-13-31.2* for the following vaccines only:

- Influenza
- Herpes zoster (shingles) for members 50 years of age and older
- Tetanus, diphtheria, and a cellular pertussis (Tdap)
- Human papilloma virus (HPV); for males and females
- Pneumococcal for members 65 years of age or older
- Meningococcal

Blood Factor Reimbursement

The IHCP reimburses claims for blood factor products administered in an outpatient setting at the lowest of the following:

- Estimated Acquisition Cost (84% of the Average Wholesale Price)
- Blood factor – State MAC
- Submitted charge

Questions regarding product availability, rates, or other related matters should be directed to the OptumRx Clinical and Technical Help Desk; call toll-free at 1-855-577-6317 or fax toll-free at 1-877-293-1845. The blood factor State MAC rate can be accessed under the Pharmacy Services quick link at indianamedicaid.com.

Usual and Customary Charge

Providers must bill the program for covered services with only the provider's usual and customary charge to the general public, including any special pricing (for example, $4 generic programs), for the covered service. The provider's usual and customary charge includes any dispensing fee that the provider may charge to the general public. Usual and customary charges are subject to verification by OptumRx audits.

OTC Drug Formulary and Pharmacy Supplements Formulary

The OTC Drug Formulary and Pharmacy Supplements Formulary can be accessed under the Pharmacy Services quick link at indianamedicaid.com.

Note:	*Only **drugs** are eligible for inclusion on the OTC Drug Formulary. Nondrug items cannot be considered for inclusion. Only those drugs that are listed on the OTC Drug Formulary and are from rebating manufacturers are reimbursable by the program. The formulary is specific to drug, strength, and dosage form to the extent noted on the formulary. For example, if a drug is listed on the formulary only as a 10 milligram (mg) tablet, and other strengths exist, only the 10 mg tablet is reimbursable. All drugs included on the OTC Drug Formulary have applicable MAC rates.*

The OTC Drug Formulary and Pharmacy Supplements Formulary were developed and recommended to the IHCP by the Indiana Drug Utilization Review (DUR) Board. The Board reviews the OTC Drug Formulary and Pharmacy Supplements Formulary on a periodic basis to ensure that products listed on the formularies are reasonable, appropriate, and medically necessary, as well as to ensure that sufficient products are included on the formularies. Providers with suggestions for inclusion of OTC drug products or pharmacy supplements on the OTC Drug Formulary or Pharmacy Supplements Formulary should forward the suggestions to PDL@fssa.in.gov.

Active Pharmaceutical Ingredients

According to the CMS, an active pharmaceutical ingredient (API) is a bulk drug substance. Bulk drug substance is defined by the Food and Drug Administration (FDA) as any substance or mixture of substances intended to be used in the manufacture of a drug product and that, when used in production of a drug, becomes an active ingredient in the drug product. APIs may be included in extemporaneously compounded prescriptions and may serve as the active drug component in a compounded formulation. APIs

are not considered to be covered outpatient drugs and thus are not subject to the provisions of the federal rebate program. Therefore, APIs do not have to be from rebating manufacturers to be covered by the IHCP.

APIs are reimbursable only when included in a compounded prescription. APIs may be billed on the *IHCP Compounded Prescription Claim Form*, a National Council for Prescription Drug Programs (NCPDP) transaction, or as a professional claim (*CMS-1500* claim form, 837P electronic transaction, or Portal professional claim). APIs must be billed with their corresponding NDCs.

Medical Supplies (Including Preferred Diabetic Supplies) and Durable and Home Medical Equipment

Information about medical supplies (including diabetic supplies), durable medical equipment (DME), and home medical equipment (HME) policy and billing is available in the *Durable and Home Medical Equipment and Supplies* module. For information about implantable DME, see the *Surgical Services* module.

Abbott Diabetes Care, Roche Diagnostics, and Trividia Health are preferred vendors to supply blood glucose monitors and diabetic test strips for all IHCP members, including HIP, Hoosier Care Connect, and Hoosier Healthwise members. The following Preferred Diabetic Supply List (PDSL) is for professional claims (*CMS-1500* claim forms and electronic equivalents). This requirement affects all Portal, batch, and professional Medicare crossover claims. For product information, contact Abbott Diabetes Care at 1-888-522-5226, Roche Diagnostics at 1-888-803-8934, or Trividia Health at 1-800-803-6049.

Table 8 – Preferred Diabetic Supply List

Blood Glucose Monitor	Corresponding Test Strip
FreeStyle InsuLinx Meter	FreeStyle InsuLinx Test Strips
FreeStyle Lite Meter	FreeStyle Lite Test Strips
FreeStyle Freedom Lite Meter	FreeStyle Lite Test Strips
Accu-Chek Aviva	Accu-Chek Aviva Plus Test Strips
Accu-Chek Nano SmartView	Accu-Chek SmartView Test Strips
True Metrix Self-Monitoring Blood Glucose System (with or without Bluetooth)	True Metrix Test Strips

NDC Required on All Procedure-Coded Drug Claims

Providers must submit the product NDC, the NDC unit of measure (UOM), and NDC quantity of units, along with the procedure code, when submitting claims to the IHCP for all procedure-coded drugs. For more information, see the *Injections, Vaccines, and Other Physician-Administered Drugs* module. For general medical (professional or institutional) claim billing instructions, see the *Claim Submission and Processing* module.

Pharmacy Copayment

The IHCP pharmacy copayment is set out in Indiana Medicaid rule at *405 IAC 5-24-7 Copayment for legend and nonlegend drug,* which, at the time of publication of this document, is as follows:

***405 IAC 5-24-7* Copayment for legend and nonlegend drugs**

Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2*
Affected: *IC 12-13-7-3; IC 12-15-6*

Sec. 7. (a) Under *IC 12-15-6*, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:

(1) The copayment shall be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.

(2) In accordance with *Code of Federal Regulations 42 CFR 447.15*, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under *42 CFR 447.15*, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.*

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions.

(5) Family planning services and supplies furnished to individuals of child bearing age.

(6) Health maintenance organization (HMO) pharmacy services.

* *Children's Health Insurance Program (CHIP) Package C members have a $3 copayment for each covered generic drug dispensed and a $10 copayment for each covered name brand drug dispensed.*

> *Note: 42 CFR 447.15 mandates that a provider may not refuse to provide services to a member who cannot afford the copayment. IHCP policy is that the member remains liable to the provider for the copayment, and the provider may take action to collect it. The provider may bill the member for that amount and take action to collect the delinquent amount in the same manner that the provider collects delinquent amounts from private pay customers. Providers may set office policies for delinquent payment of incurred expenses including copayments. The policy must apply to private pay patients as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past due bills for "X" months, has unpaid bills exceeding "Y" dollars, and has refused to arrange for, or not complied with, a plan to reimburse the expenses. Notification of the policy must be made in the same manner that notification is made to private pay customers.*

Emergency Services Only: Package E

Prescription coverage for Package E members is limited to prescriptions written during the course of a covered emergency medical service. Coverage is limited to a maximum of a four-day supply of the prescribed drug. Prospective drug utilization evaluation will be performed for the drug listed on the claim form.

> *Note: Emergency Services Only (Package E) should not be confused with "emergency supply."*

Pharmacy Services Provided Prior to Indiana Medicaid Eligibility Determination

PA requests for pharmacy services provided prior to member eligibility determination will be considered on a case-by-case basis and only if the request form is completed and submitted by the prescribing provider within 12 months of issuance of the member's Medicaid acceptance. The request form can be accessed from the Pharmacy Services quick link at indianamedicaid.com, by selecting PA Criteria and Administrative Forms. If it is determined that PA criteria is applicable on the date of service, the pharmacy provider may submit a claim for service. See *IAC 405 5-3-5*, *IAC 405 5-3-9*, and *IAC 405 5-3-10*.

Coverage of Drug Products for Treating Tobacco Dependence

The IHCP reimburses pharmacy providers for tobacco dependence drug products, including over-the-counter products, only when a licensed practitioner prescribes them for a member within the scope of the practitioner's license under Indiana law. For the IHCP to reimburse the pharmacy for over-the-counter tobacco dependence drug products, a licensed practitioner must prescribe them.

> *Note: Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence drug products. The prescribing practitioner may want to have the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug products. See the Mental Health and Addiction Services module for more information about tobacco dependence counseling.*

The practitioner may prescribe tobacco dependence drug products for up to 180 days per member per calendar year. Treatment beyond 180 days within a calendar year will require the prescriber to document the medical necessity of continued treatment.

The list of tobacco dependence drug products covered by the IHCP includes, but is not limited to, the following:

- Sustained-release bupropion products
- Varenicline tablets
- Nicotine replacement drug products, such as a patch or gum

Pharmacy Reimbursement of Methadone

Indiana Code IC 12-15-35.5-7.5 (required in *Senate Enrolled Act 464*) allows Medicaid reimbursement for methadone on a pharmacy claim if the drug is prescribed for the treatment plan of pain or pain management. Accordingly, the IHCP reimburses pharmacy claims for methadone only under the following conditions:

- The drug must be prescribed for the treatment of pain or pain management.
- The daily dosage cannot exceed 60 milligrams without PA.
- A daily dosage greater than 60 milligrams requires PA based on proof of medical necessity.

This reimbursement applies to FFS and managed care IHCP programs, subject to limitations established for certain benefit packages.

Pharmacy Claims for Hepatitis C Drugs

All pharmacy claims for covered hepatitis C drugs, including those dispensed to members enrolled in a managed care program, are processed and reimbursed through the FFS PBM, OptumRx. The hepatitis C pharmacy benefit is carved out from all IHCP managed care programs, including HIP, Hoosier Care Connect, and Hoosier Healthwise.

Reimbursement for all other pharmacy and capitated services, including procedure-coded drugs billed by providers other than IHCP-enrolled pharmacy providers, most medical supplies and medical devices, durable medical equipment (DME), and enteral or oral nutritional supplements, remain the responsibility of the HIP, Hoosier Care Connect, and Hoosier Healthwise health plans. Providers should refer to the Preferred Drug List (PDL) for information regarding preferred status and prior authorization (PA) requirements for hepatitis C agents. The FFS PDL and PA criteria can be accessed under the Pharmacy Services quick link at indianamedicaid.com.

Compounded Pharmacy Claims Equal to or Greater Than $500

All compounded pharmacy claims with submitted charges equal to or greater than $500 will require PA.

The purpose of the PA requirement is to confirm the accuracy of the claim and determine the medical necessity of the prescribed compound. Compounded pharmacy claims with charges equal to or greater than $500 that are submitted via point of sale (POS) without PA will reject with a message stating, "Compounded claims >/= $500 require prior authorization." Prescribers requesting PA should complete a *Compound Claim Prior Authorization Form* and fax it to the OptumRx Clinical and Technical Help Desk at 1-855-577-6384. An OptumRx clinical pharmacist will review the request and approve or deny it within 24 hours.

Pharmacy PA criteria and PA forms are available under the Pharmacy Services quick link at indianamedicaid.com.

Pharmacy Claims Equal to or Greater Than $5,000

Pharmacy claims with submitted charges equal to or greater than $5,000 are denied (excluding the drug classes listed in Table 9). If the submitted charge and quantity dispensed on the claim are not correct, the pharmacy provider can correct the information and resubmit the claim. If the submitted charge and quantity dispensed on the claim are correct, the pharmacy provider must contact OptumRx for PA by calling toll-free at 1-855-577-6317.

Table 9 – Exclusions to $5,000 Limit

Drug Class Description	Full Exclusion/ Partial Exclusion from Limit	Notes
Pulmonary anti-HTN, endothelin receptor antagonist	Full	
Pulmonary antihypertensives, prostacyclin-type	Full	
Pulmonary anti-HTN, sel. C-GMP phosphodiesterase T5 inhibitor	Full	
Metallic poison, agents to treat	Full	
Drugs to treat hereditary tyrosinemia	Full	
Agents to treat multiple sclerosis	Full	
Movement disorders (drug therapy)	Full	
Heparin and related preparations	Full	
Hematinics, other	Full	
Leukocyte (WBC) stimulants	Full	
CXCR4 chemokine receptor antagonist	Full	
Growth hormones	Full	
Adrenocorticotrophic hormones	Full	
LHRH (GNRH) agonist analog pituitary suppressants	Full	
Anti-inflammatory tumor necrosis factor inhibitor	Full	
Alkylating agents	Full	
Antineoplastics antibody/antibody-drug complexes	Full	
Antineoplastic immunomodulator agents	Full	
Antineoplastic systemic enzyme inhibitors	Full	
Antineoplastic, histone deacetylase inhibitors, HDIS	Full	
Antineoplastic – mTOR kinase inhibitors	Full	
Antiviral monoclonal antibodies	Full	
Antivirals, HIV-specific, fusion inhibitors	Full	
Antisera	Full	
Metabolic DX enzyme replace, mucopolysaccharidosis	Full	
Systemic enzyme inhibitors	Full	
Antihemophilic factors	Full	
Gastric enzymes	Partial	Sucraid excluded
Antileprotics	Partial	Thalomid excluded
Immunomodulators	Full	
PKU Tx Agent	Full	
Hepatitis C Treatment Agents	Full	
Monoclonal Antibodies to IG	Full	

Pharmacy Claims Equal to or Greater Than $10,000

Pharmacy claims with submitted charges equal to or greater than $10,000 are denied for the drug classes listed in Table 10. If the submitted charge and quantity dispensed on the claim are not correct, the pharmacy provider can correct the information and resubmit the claim. If the submitted charge and quantity dispensed on the claim are correct, the pharmacy provider must contact OptumRx for PA by calling toll-free at 1-855-577-6317.

Table 10 – Drug Classes with $10,000 Limit

Drug Class Description	Full Inclusion/Partial Inclusion in the Limit
Hepatitis C Treatment Agents	Full
Monoclonal Antibodies to IG	Full
ARTV CMB Nucleoside	Atripla only
Anticonvulsants	Sabril packets and tablets only
Aminoglycosides	TOBI inhalation solution only
Drugs to Tx Chronic Inflammation Disease of Colon	Cimzia only
Antimetabolites	Xeloda only
Skeletal Muscle Relaxants	Lioresal IT only

Section 3: Pharmacy Billing Policy and Procedures

Overview

A pharmacy provider can submit Indiana Health Coverage Programs (IHCP) drug claims by the following three methods:

- Point-of-sale (POS) transaction
- Paper pharmacy claim forms
- Professional billing (*CMS-1500* claim form or electronic equivalent)

POS Transaction

In a POS transaction, the pharmacy enters the Member ID (also known as RID) and the prescription information into the pharmacy computer and transmits the claim using the approved telecommunication or switching vendor and any National Council for Prescription Drug Programs (NCPDP) version D.0. From that information, online, real-time claim editing, including the posting of Prospective Drug Utilization Review (pro-DUR) alerts, occurs within seconds. Responses to the provider are based on the submitted information and historical paid claims information. For claim-formatting information, providers should review the IHCP payer sheet under the Pharmacy Services quick link at indianamedicaid.com.

Note:	*Pharmacy claims for Package E members cannot be submitted via POS transaction. Package E pharmacy claims must be submitted using the appropriate paper claim form (IHCP Drug Claim Form or the IHCP Compounded Prescription Claim Form). See the Billing Procedures for Emergency Services Only: Package E section for complete billing instructions.*

Paper Pharmacy Claim Forms

Paper pharmacy claim forms, as well as detailed billing instructions, can be accessed from the Pharmacy Services quick link at indianamedicaid.com. Providers must submit all paper pharmacy claims to OptumRx at the following address:

OptumRx Manual Claims
Department #620
P.O. Box 968022
Schaumburg, IL 60173-6801

Because of the mandatory use of the National Provider Identifier (NPI) for IHCP claims, the *IHCP Compounded Prescription Claim Form* and the *IHCP Drug Claim Form* must be submitted to the IHCP with NPI information in the billing provider and prescriber fields. If these forms are not submitted with the prescriber's NPI, the IHCP returns the unprocessed claim form to the provider.

Professional Billing – Paper and Electronic Claims

See the *Claim Submission and Processing* module for detailed instructions for billing professional claims using the *CMS-1500* claim form or 837P electronic transaction. For information about billing professional, fee-for-service claims online, see the *Provider Healthcare Portal* module.

Administrative Reconsideration and Appeal Process for Claims

If a provider disagrees with the IHCP determination of payment, the provider's right of recourse is to file an administrative reconsideration and appeal, as provided for in *405 IAC 1-1-3 Filing of claims; filing date; waiver of limit; claim auditing; payment liability; third party payments.*

Pharmacy providers must direct any requests for administrative reconsideration to the following address:

OptumRx
P.O. Box 44085
Indianapolis, IN 46244-0085

Claim Reimbursement Adjustments

Paid claims must be submitted for adjustment within the one-year filing limit (for example, one year from the date of service). Pharmacy providers must fill out a *Pharmacy Paid Claim Adjustment Request* form, which can be found under the Pharmacy Services quick link at indianamedicaid.com. This form must be filled out in its entirety to be processed.

The forms and any necessary attachments should be sent to the following address:

OptumRx Manual Claims
Department #620
P.O. Box 968022
Schaumburg, IL 60173-6801

Mandatory Reversal of Paid Claims for Unclaimed "Return-to-Stock" Prescriptions

Claims for prescriptions that are unclaimed (that is, filled but not obtained by the member or the member's representative or delivered) and have been submitted to and reimbursed by the program must be reversed within 15 calendar days from the claim's date of fill. Claims for prescriptions that are unclaimed but not reversed within 15 calendar days are subject to audit and recovery.

General Billing Information

Pharmacy Drug File – Medi-Span

The IHCP uses Medi-Span for pharmacy product data to process drug claims. Medi-Span provides OptumRx with daily updates of the Master Drug file, which is the most comprehensive database of drug product. In addition, the Medi-Span drug file provides Prospective Drug Utilization Review (pro-DUR) criteria.

Billing Units

Billing units for some drug products, such as tablets or capsules, are easy to determine; they are billed as *each*. Correct billing units for injectable products and other products are not as easy to determine. The claim-processing system is designed to identify potentially misbilled units. Even with these edits, some products result in a large number of manufacturer rebate disputes, due to provider misunderstanding of correct billing units.

The IHCP accepts only the following three billing units:

- Each (ea) – Billing unit for capsules, tablets, kits, and vials for reconstitution
- Milliliters (ml) – Billing unit for liquid dosage form having a uniform concentration
- Grams (gm) – Billing unit for products packaged by weight, such as ointments, creams, and powders that are reconstituted for injection

Common Billing Errors

Analysis consistently reveals the following factors as the most common causes for rebate disputes:

- Incorrect billing unit, such as billing for the number of milliliters in a vial instead of billing *each* to specify the entire contents of the vial
- Provider data entry errors, including those involving decimal or fractional quantities
- Units billed exceeding what would be expected as being within the normal range for the product
  - For example, the billed units appear inconsistent with a normally dispensed quantity.
- Submitted charge on the claim suggesting a generic might have been dispensed when a brand name National Drug Code (NDC) was submitted on the claim
- Products that the manufacturer distributes in a box or package, but the units are individually labeled with the drug name, expiration date, lot number, and NDC
  - These products should be dispensed as individual units to dispense the proper quantity prescribed and for the days supply billed.
- Quantities submitted for topical products that suggest a partial amount of the package was dispensed or multiple package sizes were used to dispense a certain quantity
  - Each claim, except for multi-ingredient compounds, should be dispensed for only the NDC submitted.
- Days supply for insulin products calculated based on units used per day
  - "Sliding scale" or "as directed" without a daily maximum is not sufficient.
- Drugs administered for a single dose but dose covers a greater days supply than "1"
  - These drugs should be billed with the days supply of total coverage. For example, Medroxyprogesterone Injection for contraception is administered once every 90 days; correct days supply is 90, not 1.

National Drug Codes – Configuration

Each medication is assigned a unique three-segment number. This number is known as the NDC, and it identifies the labeler or vendor, product, and package size.

The NDC of a dispensed drug must be used on the claim submitted to OptumRx for the drug and must match all 11 digits exactly, with no exceptions. NDCs must be configured as follows, to match to the Medi-Span drug file:

- Labeler code – First five digits
- Drug name, strength, dosage form – Next four digits
- Package size – Last two digits

Submitted codes must be 11 digits in length. The NDC must be in the 5-4-2 configuration. For example: 12345-1234-12 is a correctly configured NDC. A zero can be a valid digit in the NDC, which can lead to confusion when trying to reconstitute the NDC to its Food and Drug Administration (FDA) standard. Example: 12345-0678-09 (11 digits) could appear as 12345-678-09 or 12345-0678-9 on the label, depending on the labeler's configuration. To ensure proper payment of claims, the NDC must be zero-padded as appropriate.

An improperly configured or reconfigured NDC that does not match the corresponding code listed on the drug pricing file results in denial of the billed service because the improperly configured code is not recognizable to the claim-processing system. NDCs submitted that do not exactly match the NDC dispensed are subject to audit and full recovery. Providers with questions about the correct configuration of codes they are attempting to bill should contact OptumRx toll-free at 1-855-577-6317.

Patient Residence Code

It is the responsibility of the pharmacist or pharmacy dispensing the prescription or adjudicating the claim to ensure that the Patient Residence (NCPDP field 384-4X) is populated correctly. See Table 11 for the list of valid values for the Patient Residence field.

Table 11 – Patient Residence Codes

Code	Description
1	Home
2	Skilled nursing facility
3	Nursing facility
4	Assisted living facility
5	Custodial care facility
6	Group home
7	Inpatient psychiatric facility
9	Intermediate care facility for individuals with intellectual disability
11	Hospice
12	Psychiatric residential treatment facility
13	Comprehensive inpatient rehabilitation facility

The Patient Residence field is used by pharmacies to communicate to the IHCP whether a member is a resident of a long-term care (LTC) facility. Patient residence values drive the following:

- Number of allowable dispensing fees when a member is in an LTC facility
- Elimination of copays when a member is in an LTC facility
- Adjudication of claims for services that are reimbursed *per diem* in an LTC facility and not separately billable to the IHCP
- Appropriate retro-Drug Utilization Review (DUR) screening

The use of this field in claims adjudication is subject to pharmacy audit. Please direct questions about the patient residence code to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317.

Patient Gender Code and Pregnancy Indicator

The IHCP requires inclusion of a Patient Gender Code (NCPDP field 305-C5) on all fee-for-service (FFS) pharmacy claims. See Table 12 for a list of valid Patient Gender Code values.

Table 12 – Valid Patient Gender Code Values (Field 305-C5)

Code	Description
0	Not specified/Unknown
1	Male
2	Female

The IHCP will reimburse FFS pharmacy claims submitted with a Pregnancy Indicator (NCPDP field 335-2C) of "2 – Pregnant*"* only if the Patient Gender Code is "2 – Female.*"* All claims submitted with a Patient Gender Code other than "2 – Female" combined with a *Pregnancy Indicator* of "2 – Pregnant*"* will be rejected. The Pregnancy Indicator is used to notify the payer that the member is pregnant and, therefore, excluded from the copayment requirement. See Table 13 for a list of valid Pregnancy Indicator values.

Table 13 – Valid Pregnancy Indicator Values (NCPDP Field 335-2C)

Code	Description
Blank	Not specified/Unknown
1	Not Pregnant
2	Pregnant

The pharmacy provider is responsible for ensuring that the Patient Gender Code and Pregnancy Indicator fields are populated correctly. The use of these fields in claim adjudication is subject to pharmacy audit.

National Provider Identifier

Pharmacy Provider Identifier

Identification of the pharmacy provider is necessary for the IHCP to maintain compliance with federal requirements. All pharmacy claims require the pharmacy provider's 10-digit National Provider Identifier (NPI) in the Service Provider ID field.

Prescribing Provider Identifier

Identifying the prescriber is necessary for the State to maintain compliance with federal requirements for a Drug Utilization Review (DUR) program. Without this information, the effectiveness of DUR is significantly compromised. Pharmacy claims require the 10-digit NPI in the Prescriber ID field on all pharmacy claims. If the dispensing pharmacy does not know the NPI for the prescribing practitioner, the pharmacy can contact the prescriber directly to attain the NPI. Also, see the *National Provider Identifier* page at indianamedicaid.com, *NPPES NPI Registry* at cms.hhs.gov, and *NPI Number Lookup* at npinumberlookup.org for more assistance.

Use of inaccurate NPIs, such as using one prescriber's NPI on a claim for a prescription from a different prescriber, is strictly forbidden and subjects the pharmacy provider to possible recoupment of IHCP payment and sanction. The IHCP monitors provider adherence to NPI requirements.

Note:	*Pharmacy claims are monitored via postpayment review. Pharmacy claims must be submitted with the correct prescriber's NPI. Pharmacy claims submitted with inaccurate NPIs are subject to recoupment, with possible referral of the provider to the Indiana Medicaid Fraud Control Unit (IMFCU) and/or imposition of sanctions.*

Ordering, Prescribing, and Referring Practitioners

Ordering, prescribing, and referring (OPR) providers do not bill the IHCP for services rendered, but they may order, prescribe, or refer services and supplies for IHCP members. See the *Ordering, Prescribing, or Referring Providers (Type 50)* section of the *Provider Enrollment* module.

Key claim-processing points include the following:

- Claims deny with the NCPDP reject 71 – *Prescriber is not covered,* followed by a custom message: *Prescriber not enrolled in IHCP.*
- Reporting the OPR practitioner's NPI applies to third-party liability (TPL) and Medicaid-primary claims.
- For prescriptions written by a prescriber within a hospital or a federally qualified health center (FQHC), the pharmacy provider may use the NPI of the hospital or FQHC in the prescriber field.
- If the prescriber is not enrolled, a pharmacist may dispense and be reimbursed for up to a 72-hour supply of a covered outpatient drug as an "emergency supply."
- Using inaccurate NPIs, such as using one prescriber's NPI on a claim for a prescription from a different prescriber, is strictly forbidden and subjects the pharmacy provider to recoupment of IHCP payment and possible sanction. This rule applies to mid-level prescribers as well; billing the supervising prescriber is not permitted. The Family and Social Services Administration (FSSA) and its contractors monitor providers' compliance via postpayment review, and if necessary, refer noncompliant providers to the Indiana Medicaid Fraud Control Unit (IMFCU).
- See the *Ordering, Prescribing, or Referring Providers* page at indianamedicaid.com for more information on enrolling in the program. Use the OPR Provider Search to determine if a provider is enrolled in the IHCP.

Third-Party Liability, Coordination of Benefits, and Cost Avoidance

By law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This requirement is known as "third-party liability" or TPL. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and federal programs (unless specifically excluded by federal statute). Third-party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State Plan.

In general, if the State has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. This process is known as "cost avoidance." See the *Third Party Liability* module for more information.

If a provider submits electronic claims for members who have pharmacy TPL coverage on file and who have no evidence of TPL for collection on the claim, the claim is denied with an NCPDP reject code of 41 − *Submit Bill to Other Processor*. Members who state that they do not have primary pharmacy insurance must contact the DXC TPL Unit to have the coverage removed. Members can contact the TPL Unit by mail, telephone, or fax using the following contact information:

IHCP Third Party Liability (TPL) Unit
P.O. Box 7262
Indianapolis, IN 46207-7262

Toll-Free Telephone: 1-800-457-4584
Toll-Free Fax: 1-866-667-6579

The program recognizes there are times when, despite the provider's efforts, a TPL payment is not collected. To accommodate these situations, override codes are available. The TPL-related codes are shown in Table 14.

Table 14 – Other Insurance Indicator (NCPDP Field 308-C8)

Code	Description	Additional Explanation
1	No other coverage	Code used in coordination of benefits transactions to convey that no other coverage is available
2	Other coverage exists – Payment collected	Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received
3	Other coverage billed – Claim not covered	Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered
4	Other coverage exists – Payment not collected	Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received

Providers are required to maintain documentation that substantiates the circumstances under which any given TPL codes were used. For example, if the provider uses code 3 − *Other coverage billed − Claim not covered*, the provider must maintain documentation from the insurance carrier that the code billed is a noncovered service. Appropriate use of override codes is closely monitored via postpayment audits. Instances of inappropriate use may result in payment recoupment and possible imposition of sanctions against the provider.

Billing Procedures for Specific Services and Programs

Billing Procedures for Compounds and Drug Products Requiring Reconstitution

For the process for billing compounds or multiple NDCs for drug products requiring reconstitution, see the *NCPDP D.0 Payer Sheet,* which is located under the Pharmacy Services quick link at indianamedicaid.com. Compounds containing a Medicare Part D-covered drug product will not be covered for IHCP members who are also eligible for Medicare Part D coverage.

Billing Procedures for Enteral Nutrition Therapy

For billing procedures for enteral nutrition therapy, see the *Durable and Home Medical Equipment and Supplies* module and the *Home Health Services* module.

IHCP Policy Regarding the 340B Program

Section 340B of the *Public Health Service Act* limits the cost of covered outpatient drugs to entities such as certain federal grantees, FQHCs, FQHC look-alikes, and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources. IHCP policy regarding the 340B program follows:

- Federal law allows eligible entities to decide if they do or do not want to serve Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to serve or not serve Medicaid members with 340B stock, the entity is "locked into" that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.
- If the entity wishes to serve Medicaid members using 340B stock, it must only dispense 340B stock drugs and bill the program accordingly at its acquisition cost for the drug, plus the Medicaid dispensing fee. The IHCP requires that any entities enrolled in the 340B program (that intend to use 340B stock to Medicaid recipients) be listed in the *Health Resources and Services Administration (HRSA) Medicaid Exclusion File* at opanet.hrsa/gov/340B.
- If the entity wishes to serve Medicaid members using a separate, non-340B stock, it may not use 340B stock at any time. The entity is to bill the program at its usual and customary (U&C) charge.
- Upon an audit request, the provider must submit all documentation requested for **both** inventories.

Billing Procedures for HIP Employer Link

As a part of the Healthy Indiana Plan (HIP) program, the IHCP enrolls qualifying low-income Hoosiers in *HIP Employer Link* to help them afford their employer-sponsored insurance (ESI). *HIP Employer Link* helps pay a portion of the employee's ESI premium costs as well as other out-of-pocket cost-sharing obligations required by the ESI plan, such as deductibles and copayments.

All services rendered to *HIP Employer Link* members must be billed to the ESI plan as the primary payer. After the claim has been adjudicated by the primary payer, the provider may submit a claim to the IHCP to receive direct reimbursement for the member's out-of-pocket costs.

Pharmacy claims for *HIP Employer Link* members must be submitted to OptumRx, the IHCP pharmacy benefit manager (PBM). To adjudicate correctly, claims should be submitted using an Other Coverage Code (OCC) of 2, 3, or 4, depending on how the primary payer adjudicated the claim:

- OCC 2 – *Other coverage exists payment collected* – Used to convey that other coverage is available, the payer has been billed, and payment was made
- OCC 3 – *Other coverage billed* – Used to convey that other coverage is available, the payer has been billed, and the payer denied payment
- OCC 4 – *Other coverage billed* – Used to convey that other coverage is available, the payer has been billed, and the payer applied 100% of billed amount to patient responsibility

Providers can direct questions about filing *HIP Employer Link* pharmacy claims to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317.

Billing Procedures for Emergency Services Only: Package E

For a description of Emergency Services Only (Package E) benefits, see the *Member Eligibility and Benefit Coverage* module. Prescription coverage for Package E members is limited to prescriptions written during the course of a covered emergency medical service. Coverage is limited to a maximum of a four-day supply of the prescribed drug.

Pharmacy claims for members with Package E must be submitted using the *IHCP Drug Claim Form* or the *IHCP Compounded Prescription Claim Form*, as appropriate. These forms are available under the Pharmacy Services quick link at indianamedicaid.com (Pharmacy Services > PA Criteria and Administrative Forms). Claim forms for Package E must be completed as directed in Table 15.

Table 15 – Pharmacy Claim Form Instructions for Package E: Emergency Services Only Members

Claim Form	Location
IHCP Drug Claim Form	**Field Number 03:** EMERGENCY Enter YES for emergency services. **Field Number 11:** DAYS SUPPLY Days supply must be less than five for emergency services.
IHCP Compounded Prescription Claim Form	**Field Number 04:** EMERGENCY Enter YES for emergency services. **Field Number 13:** DAYS SUPPLY Days supply must be less than five for emergency services.

Electronic Funds Transfer Payments

The IHCP offers the benefit of electronic funds transfer (EFT) for pharmacy payments through its PBM, OptumRx.

To enroll for this service, providers must complete the *Electronic Funds Transfer (EFT) Request Form* found on the *Forms* page under the Pharmacy Services quick link at indianamedicaid.com and fax it to OptumRx at 1-866-244-8543. Please include a copy of a voided check or a letter from your financial institution with all the requested information.

OptumRx processes the form and transitions your payments to EFT status within approximately 10 days from receipt of a completed form. Questions regarding EFT enrollment should be directed to the OptumRx Provider Relations Department via email at provider.relations@Optum.com.

Additionally, paper Remittance Advices (RAs) are not generated with EFT payments. Instead, electronic forms (835 transactions) with remittance information are provided for each payment cycle.

Providers must register with OptumRx to receive the 835 transaction. Providers must complete the *835 Payment Advice Request Form* found on the *Forms* page under the Pharmacy Services quick link at indianamedicaid.com and fax it to OptumRx at 1-866-244-8543. Upon registration, providers receive an email indicating that a file is available to download along with login information. Questions regarding 835 registration should be directed to OptumRx via email at pharmacy.operations@Optum.com.

Section 4: Medicare Prescription Drug Coverage

Overview

The Indiana Health Coverage Programs (IHCP) does not reimburse for Medicare-covered prescription drugs for members who receive Medicaid benefits and are eligible for Medicare (dual eligibility). The IHCP reimburses only for drugs excluded from the Medicare program, and then only to the extent the drugs are covered under the IHCP pharmacy benefit. Members entitled to receive traditional Medicare and who receive full IHCP benefits are eligible for Medicare Part D. Medicare pays for the majority of prescription drugs for these members. Medicare Part D is a pharmacy benefit administered by the Centers for Medicare & Medicaid Services (CMS). For current Medicare Part D program information or for answers to questions pertaining to the benefit, providers should contact the CMS at 1-800-MEDICARE or medicare.gov.

IHCP Drug Coverage for Medicare and Medicaid Dual-Eligible Members

For dual-eligible members, Medicaid may provide coverage for Medicare Part D excluded drugs that are covered by the IHCP benefit. This benefit includes over-the-counter (OTC) drugs and pharmacy supplements that are on the *State of Indiana Over-the-Counter Drug Formulary and Pharmacy Supplements Formulary*. Medicare prescription drug plans (PDPs) may choose to cover Medicare Part D excluded drugs; therefore, pharmacy providers must attempt to bill Medicare before submitting claims to the IHCP. See the *Indiana Medicaid Pharmacy Benefit Coverage for Medicare Part D Excluded Products* document for a comprehensive list of drugs covered by the IHCP for dual-eligible members. Covered agents are still subject to PA criteria and preference status on the Preferred Drug List. This list can also be found at indianamedicaid.com by using the Pharmacy Services quick link and then the *Medicare Prescription Drug Coverage* quick link.

Pharmacies and prescribing practitioners should contact OptumRx with any questions related to the Preferred Drug List (PDL) by calling toll-free 1-855-577-6317.

The IHCP does not pay for emergency supplies of a Medicare Part D covered drug for members who decline Medicare prescription drug coverage. Per *42 USC 1396r-8(d)(5)*, emergency supply provisions apply only to Medicare Part D covered drugs. Members who receive Medicare benefits and also receive full IHCP benefits and who decline or disenroll from Medicare prescription drug coverage do not have prescription drug coverage through the IHCP.

Claim Processing for Medicare and Medicaid Dual-Eligible Members

Pharmacy claims for dual-eligible members are adjudicated based on covered benefits determined by the IHCP. Covered benefits represent drugs that are excluded by Medicare but are covered by the IHCP. Claims for members with Medicare Part D are subject to edits as described in this section. PDPs have a formulary of all Medicare-covered drugs. The IHCP does not track specific PDP formularies. The IHCP does not reimburse for a drug solely because it is excluded from a PDP formulary; it must be *excluded by Medicare Part D*. The claim-processing system maintains and edits against the primary Medicare Part D excluded and the IHCP covered services.

IHCP pharmacy claims process according to the member's IHCP benefits. Important claim-processing information follows:

- Pharmacy claims for Medicare Part D covered drugs for dual-eligible members are cost avoided for Medicare coverage. The pharmacy must bill Medicare before billing the IHCP.
- Pharmacy claims for Medicare Part D do not cross over. Copayments for drugs covered by Medicare Part D are not billable to the IHCP.
- Pharmacy claims for members who receive Medicare Part D benefits and who also receive full Medicaid benefits are subject to Part D editing, as follows:
  - National Council on Prescription Drug Programs (NCPDP) reject 70 − with a custom message stating *Member eligible for Medicare B/D*
    - This message explains that the claim was denied because the drug is not a Medicare D excluded drug. Therefore, the drug could be covered by Medicare Part D and, as such, is not reimbursed by the IHCP.

Section 5: Medicaid-Certified Long-Term Care Facilities

Overview

This section contains information that applies only to services rendered to members who reside within a Medicaid-certified long-term care (LTC) facility.

Medical and Nonmedical Supplies and Equipment

Medical and nonmedical supplies and equipment are subject to the provisions of Indiana Medicaid rule *Indiana Administrative Code 405 IAC 5-24-10 Medical and nonmedical supply items for long term care facility residents*, which, at the time of publication of this document, are as follows:

> ***405 IAC 5-24-10* Medical and nonmedical supply items for long term care facility residents**
>
> Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2*
> Affected: *IC 12-13-7-3; IC 12-15*
>
> Sec. 10. The cost of both medical and nonmedical supply items is included in the *per diem* rate for long term care facilities. Under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider.
>
> *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

For more information, see the *Long-Term Care* module. For durable medical equipment (DME) and supply billing codes, see the *Durable and Home Medical Equipment and Supply Codes* on the *Code Sets* page at indianamedicaid.com.

See *405 IAC 5-19 Medical Supplies and Equipment* for additional information about Medicaid coverage and reimbursement for medical supplies and equipment.

Note:	*Pharmacy providers are not entitled to separate reimbursement for any Indiana Health Coverage Programs (IHCP)-covered service that is reimbursed solely on a per diem basis.*

Unit Dose Packaging

The program reimburses for covered, manufacturer-packaged, unit-dose medication. Such items are reimbursable only when provided to residents of Medicaid-certified LTC facilities.

It is not the intent or the policy of the IHCP to reimburse a pharmacy for costs associated with a pharmacy's packaging of its own unit-dose medications. See *405 IAC 5-24-1 (b) Reimbursement Policy*.

Returned Medications

State laws *Indiana Code IC 25-26-12-25 (h) Prescriptions: numbering, filing, and inspection: refills; duration of validity; demise of practitioner or patient; resale or distribution of returned medication* and *IAC 1-21-1 Resale of returned substances under certain circumstances* allow for the return of medications from LTC facilities to the pharmacy that dispensed the medications, under certain circumstances.

Note:	*Medications returned to the dispensing pharmacy that are placed back in stock for redispensing **must** be credited to the program within 30 days of being returned to the pharmacy.*

To credit the program, providers submit a credit request for the amount of the returned medication, less any applicable dispensing fee. This amount is applied against future payments. The credited amount is posted to the provider Remittance Advice, and totals on the *Provider 1099 Summary Report* are adjusted.

The IHCP requires that the LTC pharmacy and the LTC facility to which it is providing services must document the medications being returned and credited to the program. Both providers are required to document any medications being destroyed. Providers must have documentation that clearly shows the following:

- Prescription number
- Name of medication
- Date the medication was returned and credited or destroyed
- Quantity returned and credited or quantity destroyed
- To whom it was returned for destruction, if the medication was destroyed
- Documentation of patients discharged from a facility, then readmitted and requiring an override of an "early refill" denial, including detailed records of any returned or destroyed medications

OptumRx verifies compliance with these requirements. LTC pharmacies and LTC facilities found to be noncompliant are referred, as deemed appropriate, to the Indiana Medicaid Fraud Control Unit (IMFCU).

Section 6: Drug Utilization Review Processes

Overview

The *Omnibus Budget Reconciliation Act of 1990* (OBRA-90) specifies Drug Utilization Review (DUR) requirements for the Indiana Health Coverage Programs (IHCP). Federal rules require that each Medicaid program include comprehensive DUR. These guidelines provide maximum flexibility, but the State must ensure that drugs are dispensed appropriately, and that drug use is retrospectively reviewed.

DUR is an administrative process of utilization review and quality assessment. The process includes criteria to describe appropriate drug use standards and to describe the allowable deviation from the criteria. The Indiana Medicaid DUR Board review and approve the criteria. For more information about the Indiana Medicaid DUR Board, its members, and duties, access the Pharmacy Services quick link at indianamedicaid.com.

Prospective Drug Utilization Review

The purpose of the Prospective Drug Utilization Review (pro-DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical reactions. This systematic review of selected claims, before adjudication, provides pharmacists with valuable information that can affect decisions about dispensing medications and alerts the pharmacist to potential drug therapy problems before medication is dispensed to the member. The pro-DUR edits are not intended to meet all the OBRA-90 responsibilities of the dispensing pharmacist. The pharmacist should contact the prescriber for any drug-related concerns, regardless of whether a pro-DUR alert is posted. All contact with the prescriber regarding any DUR intervention must be documented on the prescription drug order. Only those claims submitted via POS are subjected to pro-DUR. Per the OBRA-90, pharmacy providers are responsible for performing many of the required activities, as follows:

- Pro-DUR screening
- Patient counseling
- Proper patient records maintenance

For more information, access the *Statutes & Rules* page at in.gov.

OBRA-90 requires pharmacists to review the member's entire drug profile before filling prescriptions, including checking for the following:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions, including serious interactions with nonprescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Evidence of clinical abuse or misuse

Pro-DUR criteria and standards were adopted from the following sources:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia Dispensing Information
- American Medical Association (AMA) Drug Evaluations
- Other peer-reviewed medical literature

Patient Counseling Standards

OBRA-90 also requires states to establish standards governing patient counseling. In particular, dispensing pharmacists must offer to discuss the unique drug therapy regimen of each IHCP member when filling prescriptions.

Such discussions must involve matters that are significant, in the professional judgment of the pharmacist, and include, but are not limited to, the following information:

- Name and description of the medication
- Route of administration
- Dose
- Dosage form
- Duration of drug therapy

OBRA-90 also mandates that pharmacists discuss special directions and precautions for preparation of drugs and include the following details:

- Administration and use by the patient
- Common severe side effects that may be encountered, including avoidance, and the action required should they occur
- Techniques for self-monitoring drug therapy
- Proper storage
- Refill information
- Action taken in case of a missed dose

Providers should access the Indiana Board of Pharmacy website regarding questions pertaining to the *Statutes & Rules* page at in.gov.

Maintenance of Patient Records

Under OBRA-90, IHCP pharmacy providers must also make reasonable efforts to obtain, record, and maintain at least the following IHCP patient information:

- Name
- Address
- Telephone number
- Age
- Gender
- Individual history, where significant, including disease state or states, known allergies, and drug reactions
- Comprehensive list of medications and relevant devices
- Pharmacist comments about the individual's drug therapy

Therapeutic Screening

Dispensing pharmacists are responsible for conducting therapeutic screenings before filling prescriptions. Pharmacists can use their own explicit criteria or the information returned from the claim-processing system to conduct pro-DUR screening. Indiana's therapeutic screening detection system alerts pharmacists to the following potential conflicts:

- Drug-drug interaction
- Drug age precaution
- Drug disease alerts
- Drug pregnancy alert
- High- and low-dose alerts
- Over- and under-use precaution
- Therapeutic duplication

Alert Process

Claims that fail a pro-DUR alert post a claim rejected response that includes the pro-DUR alert information, as follows:

- Drug conflict code
- Clinical significance code or severity
- Other pharmacy indicator
- Previous date of fill
- Quantity of previous fill
- Database indicator
- Other prescriber indicator
- Free text

In the case of drug-drug interaction alerts, therapeutic duplication alerts, and early refill alerts, the free-text area contains the name of the drug in history and the dispense dates of the drugs causing the alert.

Response Process

Rejected claims requiring a DUR response will not process with a paid status until the provider submits an updated claim that includes:

- Corresponding reason-for-service code
- Professional service code
- Result-of-service code

The reason for service code on the updated claim must match at least one of the alert codes on the rejected claim. Updated claims received with a reason for service code that does not match the alert code on the rejected claim or an invalid reason for or result of service code are rejected with an appropriate explanation of benefits (EOB). When submitting a response for a rejected claim that triggers more than one DUR alert, the pharmacist must choose the reason for service code to send with each claim. Because the National Council on Prescription Drug Programs (NCPDP) standard format allows for only one reason for service code to be returned with a response, the pharmacist should choose the reason for service code that best reflects the actual situation. Occasionally, a pharmacy may receive a false positive early refill rejection due to varying factors. In this instance, the pharmacy should contact OptumRx toll-free at 1-855-577-6317 for a prior authorization.

Early Refill Policy and Criteria

Policy requires at least 85% of a prescription claim's days supply to elapse to allow subsequent prescription claims to pay or PA requests to be approved.

The following tables illustrate early refill scenarios for retail pharmacies and, separately, for long-term care (LTC) pharmacies.

Table 16 – Early Refill Scenarios for Retail Pharmacies

Retail Pharmacy Scenario	Authorized Provider	Additional Information *Note: Approvals are for one date of service only.*
Pharmacy has entered wrong days supply	Pharmacy	Approved only after call center agent has verified claim in claims history and pharmacy was unable to resubmit claim with correct days supply
Controlled substance medication has been lost, spilled, or damaged	Prescriber	Approved only after prescriber has confirmed medication has been lost, spilled, or damaged
Noncontrolled substance medication has been lost, spilled, or damaged	Pharmacy	Approved only after pharmacy has confirmed medication has been lost, spilled, or damaged
Controlled substance medication has been stolen	Prescriber	Approved only after law enforcement and/or insurance documentation has been received by call center
Noncontrolled substance medication has been stolen	Pharmacy	Approved only after law enforcement and/or insurance documentation has been received by call center
Controlled substance medication has been destroyed by fire	Prescriber	Approved only after law enforcement and/or insurance documentation has been received by call center
Noncontrolled substance medication has been destroyed by fire	Pharmacy	Approved only after law enforcement and/or insurance documentation has been received by call center
Controlled substance medication has been destroyed by a natural disaster (for example, tornado, flooding, and so forth)	Prescriber	Approved only after confirmation from prescriber
Noncontrolled substance medication has been destroyed by a natural disaster (for example, tornado, flooding, and so forth)	Pharmacy	Approved only after confirmation from pharmacy

Retail Pharmacy Scenario	Authorized Provider	Additional Information *Note: Approvals are for one date of service only.*
Vacation/absence from Indiana place of residence to place outside Indiana	Pharmacy	Approved only after confirmation from pharmacy; only one request per medication per member per 365 rolling calendar days is allowed
Change in dosage	Pharmacy	Approved only after confirmation from pharmacy
School or work supply for nontransportable items	Pharmacy	Approved only after confirmation from pharmacy
Released from hospital, LTC facility, or group home	Pharmacy	Approved only after confirmation from pharmacy

Table 17 – Early Refill Scenarios for Long-Term Care Pharmacies

LTC Pharmacy Scenario	Authorized Provider	Additional Information *Note: Approvals are for one date of service only.*
Pharmacy has entered wrong days supply	Pharmacy	Approved only after call center agent has verified claim in claims history and pharmacy was unable to resubmit claim with correct days supply
Change in dosage	Pharmacy	Approved only after confirmation from pharmacy
LTC facility has lost, spilled, or damaged medication or medications have been stolen	NA	Denied
Pharmacy is taking on new LTC facility and wants to do a one-time rollover for all patients	NA	Denied
New admit or re-admit	Pharmacy	Approved only after confirmation from pharmacy
Patient is going on leave of absence	Pharmacy	Approved only after confirmation from pharmacy
LTC facility returned medication by mistake	NA	Denied
Patient has a *pro re nata* (PRN) order and a routine order with different prescription numbers	Pharmacy	Approved only after confirmation from pharmacy

Retrospective Drug Utilization Review

Retrospective Drug Utilization Review (retro-DUR) is a function of the DUR Board and involves the retrospective review and analysis of paid pharmacy claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care associated with specific drugs or groups of drugs. Retro-DUR *interventions* are a component of the DUR Board's outreach programs, are educational and not punitive in nature, and are conducted primarily by means of faxed letters to selected prescribing practitioners. The intent of retro-DUR interventions is to call practitioners' attention to patient-specific information, based on paid pharmacy claims, which may assist the practitioners in better managing the care of their patients. Retro-DUR activities are administered by the pharmacy benefit manager (PBM), OptumRx.

Overview

Audits of pharmacy providers are necessary for the Indiana Health Coverage Programs (IHCP) to meet federal requirements regarding protections against fraud and abuse. Audits also serve as a means to assist providers in correcting billing practices that may not be in compliance with program requirements. Violations by pharmacy providers of applicable law (as enforced by the Indiana Board of Pharmacy or other entities) that are detected by auditors will be remanded to the appropriate oversight agency. Paid claims that are attributable to prescriptions that do not fully meet all applicable requirements of law or Medicaid policies and procedures are subject to recoupment.

The State's pharmacy benefit manager (PBM), OptumRx, provides the IHCP with pharmacy audit services. In general, there are five distinct types of pharmacy audits, as briefly described in the following sections.

Real-Time/Telephone Audits

Real-time/telephone audits are conducted via telephone. The goals of real-time/telephone audits are to:

- Reduce the burden on pharmacy providers as related to documentation requests.
- Reduce the number of claims subject to the appeals process.
- Minimize recurring incorrect billing practices.
- Correct the claim before it is dispensed.

All provider claims are subjected to real-time/telephone audits. If a claim is found to be aberrant, the provider is so notified by telephone call or secure email from OptumRx. The provider has the opportunity to correct and resubmit the claim. If the claim is not corrected and resubmitted, it will be included in a subsequent desk audit and may be referred to Family and Social Services Administration (FSSA) Program Integrity.

Self-Audits

Self-audits are audits that contain a list of claims that are emailed or faxed to the provider with a request to review the claims for accuracy. The provider may be requested to furnish the prescription label directions and is asked to indicate whether or not corrections were made.

Desk Audits

Desk audits are audits that are performed internally by OptumRx and do not require on-site audit activities. These audits are performed on a routine basis and involve the application of sophisticated algorithms to provider claims data. Desk audits are designed to ensure correct claim submissions by providers and to recover overpayments that are caused by billing errors made by providers. The desk audit program uses letters, faxes, and email to request information from providers. If a claim is selected for review during a desk audit, the dispensing provider receives a letter requesting documentation related to the claim associated with the prescription. Copies of prescriptions, signature or delivery logs, compound worksheets, and any other applicable documentation may be requested to confirm the accuracy and appropriateness of the claims at issue.

Invoice Reconciliation Audits

Invoice reconciliation audits are audits that are sent by OptumRx to providers by email or fax to request summary statements of purchases, by National Drug Code (NDC), from the pharmacy provider's distributors. Distributors are required to submit responses directly to OptumRx. Distributor information may include records from reverse distributors and purchases from other pharmacies. Upon request, copies of the following items must be provided:

- Drug pedigree documentation
- Front and back of cancelled checks to support purchases
- Comprehensive drug utilization report that includes all payers for NDCs requested (protected health information [PHI] redacted)

Any denial to invoice reconciliation audit requests is a denial of access.

On-Site Audits

On-site audits, like desk audits, are performed on a routine basis. Focus areas of on-site audits may include, but are not limited to, reviews of signature logs, purchasing records, on-hand inventory, usual and customary pricing, and pharmacy operating procedures. Providers are notified in advance of scheduled full-scope, on-site audits; however, all providers are subject to unannounced visits by auditors to assess compliance. At the conclusion of on-site audits, if deficiencies are noted, a Notice of Corrective Action may be issued. Providers will have 15 calendar days to correct deficiencies. Failure to correct deficiencies may result in a referral to the FSSA Program Integrity team and/or the Indiana Board of Pharmacy.

Requirements for Prescriptions and Drug Orders

Prescriptions, including faxed prescriptions, and drug orders should be in compliance with *Indiana Code IC 25-26-13-2* (pg. 769) and *Indiana Administrative Code 856 IAC 1-31-2*, which specify requirements for these items.

Tamper-Resistant Prescription Pads (TRPPs)

For all information regarding tamper-resistant prescriptions, see *Tamper-Resistant Prescriptions* in Section 2 of this document.

Required Pharmacy Documentation

Documentation retained by the provider must clearly demonstrate that all IHCP-reimbursed services rendered by the provider were provided in compliance with all applicable laws, policies, and program rules.

Documentation required by OptumRx specifically for desktop and on-site audits includes, but is not necessarily limited to, the following:

- For long-term care (LTC) pharmacies:
  - Prescriber's original written order or prescription
  - Telephoned prescription or drug order called in by the prescriber or the prescriber's representative
  - Faxed prescription or drug order
  - Discharge orders

  - Signed monthly physician's order summary dated within the previous 12 months of the fill date
  - Medication administration records
  - Faxed refill authorizations
  - Proof of delivery
- For retail pharmacies:
  - Original written prescription
  - Telephoned prescription
  - Computer or fax refill authorization containing all relevant information
  - Faxed prescription
  - E-prescription

Note:	*For reconsideration or appeal, OptumRx cannot accept telephone orders. The provider must obtain a copy of the prescription from prescriber via fax, mail, or electronic prescription.*

Questions regarding acceptable forms of documentation should be directed to the OptumRx Pharmacy Audit Department toll-free at 1-866-618-6853 or by email at RxAudit.INM@Optum.com.

Proof of Delivery

Signature logs for outpatient pharmacies must be dated and signed by the member. Providers must not predate signature logs. Stickers that show the fill dates do not fully satisfy the requirements for proof of delivery can be used. Signed records of delivery for LTC facilities must be maintained by the billing provider as proof of the pharmacy service being delivered and must include the prescription number, drug, quantity and date signed. All information on the delivery manifests should be provided. For mail delivery services, the delivery service's tracking number that can be traced back to a specific claim is required. For deliveries where a signature is not provided, OptumRx may request documentation that the patient authorized the prescription to be filled.

Corrected Claims

Auditing of pharmacy claims may identify instances in which a provider billed in a manner that resulted in payments to which the provider was not entitled. In some instances, these cases can be corrected by adjustment of the claim by OptumRx. In other instances, OptumRx cannot adjust the claim fields that would require modification to be correct. OptumRx **cannot** adjust the following fields:

- Cardholder ID
- National Drug Code (NDC)
- Dispense-as-written (DAW) codes
- Override codes

If the claim is **one year old or less**, it may be reversed and the pharmacy must resubmit the replacement claim via POS to accurately reflect the dispensing situation at issue.

Claims with dates of service **more than one year old** require the use of a replacement paper claim, which must be submitted in accordance with the following:

- Prepare the replacement paper claim for the service at issue with the correct billing information.
- Complete the *Overpayment Option Form* and indicate acceptance of the recovery of the inappropriately billed claim.
- Send the replacement paper claim and the *Overpayment Option Form* to OptumRx as instructed in the audit letter.

Be sure to clearly indicate on all replacement claims the internal control number (ICN)/Claim ID of the audited claim that is being replaced.

Please note the following regarding paper replacement claims:

- The process as described previously in this section must be followed to prevent the paper replacement claims from being denied as a duplicate.
- Paper replacement claims are not to be submitted and will not be processed unless the provider has agreed to recovery of the overpayment.
- Providers must correct the error identified on the audited claim. Submitting the paper replacement claim exactly as it was originally billed results in the claim being re-audited.
- OptumRx accepts **only** paper replacement paper claims that fulfill both of the following:
  - More than one year old
  - Subject to the audit and recovery process

Reporting of Suspected Fraud/Abuse

Providers are strongly encouraged to report any information related to potential fraud or abuse to the appropriate authorities.

Information regarding reporting of suspected Medicaid fraud or abuse is located in the *Provider and Member Utilization Review* module.

Section 8: Preferred Drug List and Prior Authorization Requirements

Overview

The Indiana Health Coverage Programs (IHCP) initiated the Indiana Rational Drug Program (IRDP), and the Preferred Drug List (PDL) evolved from that initiative. Prior authorization (PA), a key part of the PDL, is a utilization management tool that helps to ensure that only medically necessary services are authorized for payment. In this manner, the IHCP prescription benefit is based on both clinically appropriate and fiscally sound prescribing practices. See PA Criteria and Administrative Forms, located under Pharmacy Services quick link at indianamedicaid.com.

Preferred Drug List

Not all drug classes covered by the IHCP pharmacy benefit are subject to the PDL. Drugs in classes that are subject to the PDL have a *preferred* or *nonpreferred* status. In general, *preferred* drugs do not require PA, whereas *nonpreferred* drugs do require PA. It is the prescriber who must initiate and submit a PA request for a nonpreferred drug.

The Therapeutics Committee, a subcommittee of the Drug Utilization Review (DUR) Board, evaluates therapeutic classes based upon clinical (first) and fiscal (second) considerations. The Therapeutics Committee makes recommendations to the DUR Board regarding the content of the PDL. The DUR Board performs a review of the PDL in its entirety annually. Access the Pharmacy Services quick link at indianamedicaid.com for information about the PDL, the Therapeutics Committee, the DUR Board and the PDL Evaluation Report. Providers should direct all questions about the PDL to OptumRx toll-free at 1-855-577-6317.

Prior Authorization Requirements

Pharmacy PA requests must be initiated, completed, and submitted by the prescriber. Policies are dynamic in nature; therefore, providers should always refer to the PDL, bulletins, and banner pages for the most up-to-date program information. Pharmacy providers may intervene when receiving the "PA required" notifications shown in Table 18. These notifications are considered "false positives," not requiring PA, with nonclinical information provided by the pharmacist.

Table 18 – Prior Authorization Criteria

Criteria Name	Criteria
Atypical antipsychotic 15-day limit	Pharmacy has claims in history prior to Medicaid eligibility or is able to confirm the use of drug samples
Early refill/duplicate fill	See the *Early Refill Prior Authorization for Legend Drugs* section of this document
Severity level 1 drug/drug interaction	Pharmacy has received direction to discontinue one of the drugs involved in the interaction
Edits based upon $ limits/parameters	Pharmacy to confirm the quantity and price of the claim only

For information on the criteria pertaining to or authorization requirements for these drugs, access the Pharmacy Services quick link at indianamedicaid.com or call OptumRx toll-free at 1-855-577-6317.

Automated Pharmacy Prior Authorization ("SilentAuth")

OptumRx executes real-time prior authorization decisions by using clinical PA edits supported by the member's medical and pharmacy claims data. This process results in quicker PA determinations for pharmacy claims processed by the fee-for-service (FFS) pharmacy benefit, with less intervention on the part of pharmacy and prescribing providers.

Automated prior authorization ensures that the prescribed therapy meets Indiana-specific evidence-based criteria for appropriate use. Based on recommendations from the Indiana Medicaid Drug Utilization Review Board, the Therapeutics Committee, and the Mental Health Quality Advisory Committee (applicable only to mental health drugs), the Family and Social Services Administration (FSSA) reviews and approves the clinical edits and criteria used in processing claims. If applicable edit criteria are met, the claim continues through the pharmacy claim-processing system. If the criteria are not met, the claim is denied and the provider receives notification to contact OptumRx.

Subsequent to the approval process noted previously, clinical edits are added. Providers are given advance notification of implementation of new edits, via provider bulletins or banner pages.

Access the Pharmacy Services quick link at indianamedicaid.com for additional information regarding prior authorization edits.

Pro-DUR Edits Requiring Prior Authorization

The following Prospective Drug Utilization Review (pro-DUR) edits require prior authorization:

- Drug – Drug severity level 1 interactions
- Overutilization (early refill [ER]) – See the *Early Refill Prior Authorization for Legend Drugs* section
- >34-day supply for nonmaintenance medications and >100-day supply for maintenance medications (see the *Days Supply – Maintenance and Nonmaintenance Medications* section)

For an override of a drug-drug interaction that involves a discontinued medication (for example, a "false positive"), the dispensing pharmacist may call OptumRx toll-free at 1-855-577-6317. For consideration of an override of a drug-drug interaction in which both medications are being taken concurrently, the *prescriber* must call and provide medical necessity justification. For overrides of overutilization (ER) edits, the dispensing pharmacist may call OptumRx toll-free at 1-855-577-6317.

Early Refill Prior Authorization for Legend Drugs

The IHCP requires at least 85% of a prescription claim's days supply to elapse to allow subsequent prescription claims to pay or PA requests to be approved.

Early Refill Prior Authorization for Drugs on the OTC Drug Formulary Dependent on Allowed Amount

PA is not required for an ER request for drugs included on the Over-the-Counter (OTC) Drug Formulary when the Medicaid-allowed amount for the claim is less than or equal to $20. The pharmacy receives a rejection message of "DUR Reject Error," which allows the pharmacist to override the rejection with the appropriate DUR response codes. For early refill rejections received on federal legend drugs and the OTC Drug Formulary medications with allowed amounts greater than $20, the pharmacy receives rejections of "Pro-DUR Alert Requires PA." For overrides of overutilization (ER) edits, the pharmacist may call OptumRx toll-free at 1-855-577-6317.

Emergency Supply

Policy and procedures regarding provision of *emergency supply* of covered drugs are clearly outlined under the Pharmacy Services quick link at indianamedicaid.com.

The following text is from that site:

> In instances in which PA cannot be immediately obtained, a pharmacist may dispense and be reimbursed for up to a 72-hour supply of a covered outpatient drug as an "emergency supply."
>
> In addition, to allow for holidays, weekends, and times when PA offices are closed, operational policy regarding "emergency supply" is that pharmacies can be paid for claims representing a maximum of a four-day supply of a covered outpatient drug, without PA. For packaging that inherently cannot be broken down to a four-day or less supply (example: metered dose inhalers), the pharmacy should dispense the smallest quantity possible that is adequate for the "emergency supply." The provider should internally document that the quantity dispensed was, due to manufacturer packaging constraints, the least that could be dispensed while meeting the patient needs for the "emergency supply."
>
> All "emergency supply" claims – both paper and electronic/point of sale (POS) – should be submitted with the Level of Service = 03 ("Emergency" Indicator) and the actual "days supply" being dispensed, up to but not exceeding "4."
>
> **Emergency Indicator** = 03 Level of Service
> **Days Supply** = less than or equal to four days

The purpose of the "emergency supply" policy is to comply with federal law pertaining to Medicaid prior authorization programs. As noted previously, emergency supplies can be provided in instances in which PA cannot be immediately obtained, including when providers cannot obtain PA due to offices being closed.

The IHCP does not intend for "emergency supply" provisions to allow pharmacy providers to circumvent otherwise applicable program parameters, such as PDL status, *brand medically necessary* requirements, PDL step-therapy edits, or early refill edits. If the prior authorization has not been approved after an emergency supply is dispensed, the pharmacy provider will contact the OptumRx call center to confirm whether a prior authorization request was submitted and whether the use of an additional emergency supply is appropriate. Provision of emergency supplies must be documented on the hardcopy of the prescription. **The IHCP does not reimburse for "emergency supply" claims for Medicare Part D covered drugs for dual eligibles**. For questions about "emergency supply" provisions, the pharmacist may call OptumRx toll-free at 1-855-577-6317.Compliance with IHCP "emergency supply" provisions is monitored via provider audits. Applicable sanctions may be imposed for violations of policy.

Note:	*"Emergency supply" should not be confused with Emergency Services Only (Package E).*

Days Supply – Maintenance and Nonmaintenance Medications

Fee-for-service claims for maintenance medications are limited in quantity to no more than a 100-day supply per dispensation. A *maintenance medication* is a drug that is prescribed for chronic, long-term conditions and is taken on a regular, recurring basis. Nonmaintenance medications are limited in quantity to no more than a 34-day supply per dispensation.

Mental Health Medications and Mental Health Quality Advisory Committee

State legislation House Enrolled Act (HEA) 1325 created the Mental Health Quality Advisory Committee (MHQAC) as an advisory body to the Office of Medicaid Policy and Planning (OMPP). Pursuant to statute (*IC 12-15-35-51*), the MHQAC members include:

- Director of Health Policy and Medicaid (who chairs the committee)
- Medical director of the Division of Mental Health and Addiction (DMHA)
- FSSA representative
- Statewide mental health advocacy organization representative
- Statewide mental health provider organization representative
- Representative from a managed care entity (MCE) that participates in the state's Medicaid program
- Member with expertise in psychiatric research representing an academic institution
- Pharmacist licensed under Indiana law
- Commissioner of the Department of Corrections or the Commissioner's designee

The purpose of the committee is to advise the OMPP and make recommendations concerning the clinical use of mental health and addition medications. All recommendations made by the MHQAC must be reviewed and approved by the Indiana Medicaid DUR Board prior to implementation in the IHCP pharmacy benefit.

Mental Health Drug Utilization Edits

Mental health drug utilization edits are defined as pharmacy claim-processing edits, some of which require a medical necessity review through the PA process, addressing prescribing situations that are inconsistent with established pharmacokinetic principles and clinical practice guidelines. Mental health drug utilization edits include, but are not limited to:

- Drug interactions
- Frequency of refills
- Dose optimization
- Age
- Days supply
- Compounded drug claims

- Quantities dispensed
- Quality (for example, therapeutic indication, therapeutic duplications, and so on)

The intent of the mental health drug utilization edits is to promote patient adherence to medication regimens and ensure safe, appropriate use of medications in the IHCP population. Mental health drug utilization and medical necessity quality edits do not constitute formulary restrictions. Mental health drug utilization edits are reviewed quarterly by the MHQAC and DUR Board. The mental health drug utilization edits are consistent with the rules and regulations published in *Indiana Code IC 12-15-35.5-7 Drug Utilization Review*. Providers should refer to bulletins and banner pages for the most current information regarding utilization edits. For an up-to-date list of the mental health drug utilization edits, see the Mental Health Quality Advisory Committee selection in the Boards and Committees drop-down menu under the Pharmacy Services quick link at indianamedicaid.com.

Administrative Review and Appeal Process for Prior Authorization Denial

A prescriber desiring a review of a modification or denial decision of a prior authorization request must submit a written request for administrative review within seven working days of the receipt of notification of the modification or denial.

Prescribers need to include the following information with their written request for administrative review:

- Written *Medicaid Prior Review and Authorization Request* form (copy of original)
  -or-
  Summary letter with requested services described in detail; include the prior authorization number, member name, and Medicaid number
- Documentation, including medical records, equipment, consultations, case histories, and/or therapy evaluations; include any documentation supporting the provider/appellant case

Send the information to this address:

OptumRx
P.O. Box 44085
Indianapolis, IN 46244-0085

Please note the following important information:

- Failure by a prescriber to request an administrative review in a timely fashion will result in the loss of the right to request an administrative hearing – *405 IAC 1.1 General Provisions*.
- The review decision of the contractor will be rendered within **seven** business days of receipt of the request for administrative review.
- The review will assess medical information pertinent to the case in question.
- The Medicaid medical director, or that individual's designee, will perform the review.
- The requesting prescriber and the member will receive written notification of the decision containing:
  - The determination reached by the Medicaid contractor and the rationale for the decision
  - Prescriber/member appeal rights through the FSSA