Chapter 9: IHCP Pharmacy Services Benefit

Chapter 9: Revision History

Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
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Version 10.0	August 3, 2010 Policies and procedures as of June 1, 2010	Semiannual Update • Updated *Overview* section • Changed Prudent Rx references to HMS • Updated *Drug Copayment* section • Updated *Billing Procedures for Drug-Related Medical Supplies and Medical Devices* section • Updated *Billing Procedures for Procedure-Coded Drugs* section] • Added *Pharmacy Claims Greater Than or Equal to $5,000* section • Added *Pharmacy Claims Greater Than or Equal to $10,000* section • Added *Pharmacies Servicing Long-Term Care and Home Health Care Patients* section • Updated links to IHCP Web site	HP Provider Relations and Publications Units

Chapter 9: Table of Contents

Chapter 9: Revision History 9-2

Chapter 9: Table of Contents 9-4

Section 1: Introduction 9-6
Overview 9-6

Section 2: Medicare Prescription Drug Coverage 9-10
Overview 9-10
IHCP Prescription Drug Changes 9-10
IHCP Claims Processing 9-10
Medicare Part D and the IHCP Over-The-Counter Drug Formulary and Preferred Drug List 9-11

Section 3: Pharmacy Coverage and Reimbursement 9-12
General Information 9-12
Legend Drug Coverage 9-12
Legend Drug Reimbursement 9-13
Blood Factor Reimbursement 9-13
Federal Rebate Program 9-14
Federal Drug Efficacy Study and Implementation Program 9-15
Mandatory Generic Substitution/Brand Medically Necessary 9-16
Pharmacy Pricing File – First DataBank 9-16
Medical Supplies Durable Medical Equipment and Home Medical Equipment 9-16
Tamper-Resistant Prescription Pads (TRPPs) 9-16
Maximum Allowable Cost Programs 9-18
Dispensing Fee 9-18
Usual and Customary Charge 9-18
Drug Copayment 9-19
Nonlegend (Over-the-Counter, or “OTC”) Drug Coverage and Reimbursement; OTC Drug Formulary 9-20
Claim Reimbursement Adjustments 9-21

Section 4: Pharmacy Billing Policy and Procedures 9-22
Overview 9-22
POS Claim Format 9-22
Paper Claims 9-22
Batch Claim Submission 9-22
Claims for Returned-to-Stock Prescriptions 9-23
General Billing Information 9-23
Billing Only Usual and Customary Charge 9-23
Service Product Identifiers 9-23
Service Provider Identification Number – NPI 9-24
Prescriber Identifier – NPI 9-24
Third-Party Liability 9-24
Billing Procedures for Home Infusion and Enteral Therapy Services 9-26
Billing Procedures for Drug-Related Medical Supplies and Medical Devices9-26
Billing Procedures for Procedure-Coded Drugs 9-27

Section 5: Medicaid-Certified Long-Term Care (LTC) Facilities 9-28
Overview 9-28
Medical and Nonmedical Supplies and Equipment 9-28

Unit Dose Packaging ... 9-28
Returned Medications ... 9-28
Prior Authorization Requests - LTC Facility Residents ... 9-29
Retroactive Eligibility and PA Requests ... 9-29
Level of Care Information and the LTC Pharmacy ... 9-29

Section 6: Pharmacy Claim Review Processes ... 9-30
Drug Utilization Review ... 9-30
Prospective Drug Utilization Review ... 9-30
Patient Counseling Standards ... 9-31
Maintenance of Patient Records ... 9-31
Therapeutic Screening ... 9-32
Alert Process ... 9-32
Response Process ... 9-32
Retrospective Drug Utilization Review ... 9-34
Suspended Compound Claims ... 9-35
Pharmacy Claims Greater Than or Equal to $5,000 ... 9-35
Pharmacy Claims Greater Than or Equal to $10,000 ... 9-36
Pharmacy Audit ... 9-37
Required Information for Appeals ... 9-38
Corrected Claims (Paper Submissions) ... 9-38

Section 7: Preferred Drug List, Prior Authorization Requirements ... 9-40
Overview ... 9-40
Preferred Drug List ... 9-40
Criteria-Based Prior Authorization Requirements ... 9-40
Automated Pharmacy Prior Authorization (PA) ... 9-40
DUR Edits Requiring PA ... 9-41
Brand Medically Necessary ... 9-41
Emergency Supply ... 9-42
100-Day Supply – Maintenance Medications ... 9-42
Pharmacies Servicing Long-Term Care and Home Health Care Patients ... 9-43
HEA 1325 ... 9-43
Mental Health Quality Advisory Committee ... 9-43
Utilization Edits ... 9-43
Mental Health Medical Necessity Quality Edits ... 9-43
Claim Appeal Process ... 9-44
Prior Authorization Denial Appeal Process ... 9-44

Index ... 9-45

Section 1: Introduction

Overview

This chapter gives Indiana Health Coverage Programs (IHCP)-enrolled pharmacies access to relevant information about the IHCP pharmacy benefit. The information in this chapter applies only to fee-for-service (FFS) claims.

Note: For more information on these IHCP programs, see Chapter 2.

For outpatient pharmacy claims with dates of service prior to December 31, 2009, for IHCP members enrolled in the risk-based managed care (RBMC) or Healthy Indiana Plan (HIP) delivery system, providers need to contact the member's managed care entity (MCE) for coverage and billing information. For outpatient pharmacy claims with dates of service on or December 31, 2009, for all IHCP members, please refer to this chapter for relevant information about the IHCP pharmacy benefit.

The IHCP pharmacy benefit is a dynamic program and, as such, this manual does not contain all applicable information. A significant amount of program information is available and maintained in an up-to-date format on the IHCP Web site. Refer to Table 9.1 for a list of pharmacy-related contacts. Refer to Table 9.2 for a list of Web sites of interest to pharmacy providers. Providers can direct questions about the information in this manual or on the IHCP Web site to the HP Pharmacy Services Help Desk at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278 between the hours of 8 a.m. and 6 p.m. Eastern Time, Monday through Friday except for State holidays. Pharmacy providers with drug claim questions should select option 2. *Chapter 1* provides a list of contact names, addresses, and telephone numbers useful to pharmacy providers.

Updates to this manual are issued periodically. In the interim, providers should read and retain the bulletins, banner pages, and monthly newsletters published by the IHCP. Current and archived copies of these publications are available on the IHCP Web site at http://provider.indianamedicaid.com. These publications advise providers of program changes prior to the publication of an updated manual.

Table 9.1 is a current, comprehensive list of pharmacy-related contact information.

Table 9.1 – Pharmacy Contact Information

Pharmacy Contact Information		
HP Pharmacy Services Help Desk for POS claims processing (317) 655-3240 option 2 1-800-577-1278 option 2 INXIXPharmacy@hp.com	**PA For ProDUR and Preferred Drug List – ACS Clinical Call Center** 1-866-879-0106 option 2 or Fax: 1-866-780-2198	**EDI Solutions Help Desk for Electronic Batch Claims** (317) 488-5160 local or 1-877-877-5182 or INXIXElectronicSolution@hp.com

<table>
<tr><th colspan="3">Pharmacy Contact Information</th></tr>
<tr><th colspan="3">Right Choices Program Contact Information</th></tr>
<tr><td>ADVANTAGE Health Solutions Traditional Medicaid and Care Select
1-800-784-3981</td><td rowspan="2">MDwise
Care Select
1-866-440-2449
Hoosier Healthwise
1-800-356-1204
Healthy Indiana Plan
1-877-822-7196</td><td rowspan="2">Anthem
Hoosier Healthwise
1-866-902-1690 – Option 3
Healthy Indiana Plan
1-866-902-1690 – Option 3</td></tr>
<tr><td>Managed Health Services
Hoosier Health Wise
1-877-647-4848</td></tr>
<tr><th colspan="3">Prior Authorization for Drugs and Drug-related Supplies Billed on CMS-1500 or 837P</th></tr>
<tr><td>ADVANTAGE Health Solutions[SM] Prior Authorization – FFS
P.O. Box 40789
Indianapolis, IN 46240
1-800-269-5720
Fax: 1-800-689-2759</td><td>ADVANTAGE Health Solutions[SM]
Care Select
1-800-784-3981
Fax: 1-800-689-2759
P.O. Box 80068
Indianapolis, IN 46280</td><td>MDwise
Care Select
1-866-440-2449
Fax: 1-877-822-7186
P.O. Box 44214
Indianapolis, IN 46244-0214</td></tr>
<tr><th colspan="3">Pharmacy Claims and Adjustments Contact Information</th></tr>
<tr><td>HP Pharmacy Claims Adjustments
P.O. Box 7265
Indianapolis, IN 46207-7265</td><td>HP Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268</td><td>To make refunds to IHCP for pharmacy claims, send check to:
HP Pharmacy Refunds
P.O. Box 2303 Dept 130
Indianapolis, IN 46206-2303</td></tr>
<tr><td>HP CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269</td><td>HMS Inc. – Pharmacy Audit
100 Corporate Pointe, Suite 395
Culver City, CA 90230
Telephone: (310) 642-1700
or
1-866-642-0622
Fax: (310) 642-1701</td><td>Indiana Administrative Review/Pharmacy Claims
HP Pharmacy Claims Administrative Review
P.O. Box 7263
Indianapolis, IN 46207-7263</td></tr>
<tr><td colspan="2">Myers and Stauffer – State MAC program
9265 Counselors Row, Suite 200
Indianapolis, IN 46240
Help desk: 1-800-591-1183
Fax: (317) 571-8481</td><td>ACS Drug Rebate
ACS State Healthcare
ACS – Indiana Drug Rebate
P. O. Box 2011332
Dallas, TX 75320-1332</td></tr>
</table>

Table 9.2 – Pharmacy-Related Web Sites

Name	Description	Address
IHCP Web Site	This is the official Medicaid Web site that includes forms, publications, Web interChange, Drug Utilization Review (DUR) Board information, and information about Trading Partners and Electronic Communications Guides.	www.indianamedicaid.com
ACS Indiana Medicaid Web Site	This site provides access to the Preferred Drug List (PDL), Drug rebate labelers, Over-the-Counter (OTC) Drug Formulary, and Prior Authorization (PA) request forms, as well as information about the Therapeutics Committee.	www.indianapbm.com For questions concerning the PDL, contact PDL@fssa.in.gov.
Indiana Administrative Code (IAC)	This site provides information about Indiana Medicaid.	http://www.in.gov/legislative/iac/
NPPES National Provider Identifier (NPI) Lookup Tool	This site provides users a no-charge way to look up NPI numbers.	https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
Myers and Stauffer (M&S)	This site provides a link to the OTC Drug Formulary.	http://in.mslc.com/StateMacServices.aspx
NPI Number Lookup Tool	This site provides users a no-charge way to look up NPI numbers.	http://www.npinumberlookup.org/
Centers for Medicare & Medicaid Services (CMS)	This is the official Web site for CMS.	http://www.cms.hhs.gov/
HMS	Pharmacy audit information can be found on the Prudent Rx Web site.	http://www.prudentrx.com/
Medicare	This is the official U.S. government Web site for people with Medicare.	http://www.medicare.gov/

Table 9.3 – Roles of Contractors for FFS Medicaid

Contractor	Responsibilities
ACS State Healthcare, LLC	Pharmacy Benefit Manager (PBM) for the IHCP pharmacy benefit. Primary responsibilities include: • Prior authorization and related clinical call center operations • PDL development and maintenance • DUR Board and Therapeutics Committee support functions • Federal and state supplemental rebate program administration • Federal-, State-, and Office of Medicaid Policy and Planning (OMPP)-required reporting • Stakeholder communications • Retrospective Drug Utilization Review (Retro-DUR) • Review of suspended compound prescription claims • OTC Drug Formulary maintenance – does not include development of OTC Maximum Allowable Cost (MAC) rates
HP Enterprise Services	Claims processor/fiscal agent for the IHCP pharmacy benefit and HIP. Primary responsibilities include: • Adjudication of and payment for pharmacy claims • Provider enrollment functions • Provider and member assistance functions • Systems support
Myers & Stauffer, LLC	Provides support services for the IHCP pharmacy benefit and HIP. Primary responsibilities include: • Administration and maintenance of the State Maximum Allowable Cost (SMAC) program, including development of SMAC rates • Development and maintenance of OTC Drug Formulary MAC rates, including drafting of provider communications regarding same • Performance of state statute-required "dispensing fee survey" • Pharmacy-related analyses, as required by the OMPP • Hemophilia State MAC program
HMS	Through contract with HMS, provides a full range of pharmacy audit services for the IHCP pharmacy benefit HIP. This includes Concurrent Audit, Central Script Review (CSR), and On-site Review (OSR).

Section 2: Medicare Prescription Drug Coverage

Overview

Effective January 1, 2006, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare prescription drug coverage program, also known as **Medicare Part D**. With the implementation of this coverage, the Indiana Health Coverage Programs (IHCP) no longer reimburses for Medicare-covered prescription drugs for members who receive Medicare benefits. IHCP will reimburse for only those 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 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 www.medicare.gov.

IHCP Prescription Drug Changes

The IHCP reimburses for other IHCP-covered health services for people with Medicare and IHCP benefits. Medicaid provides coverage for Medicare Part D-excluded drugs that are a covered IHCP benefit for people with Medicare and IHCP benefits. This includes, but is not limited to, barbiturates, benzodiazepines, and over-the-counter (OTC) drugs that are on the *State of Indiana Over-the-Counter Drug Formulary.* Medicare prescription drug plans (PDPs) may choose to cover Medicare Part D-excluded drugs; therefore, pharmacy providers should attempt to bill Medicare prior to submitting claims to the IHCP. For a comprehensive list of drugs covered by IHCP for dual eligible members, visit the IHCP Web site at http://provider.indianamedicaid.com/media/27754/medicare_part_d_excluded_drug.pdf.

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)*, the emergency supply provisions apply only to 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.

IHCP Claims Processing

Pharmacy claims for dual-eligible members are adjudicated based on the 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*. Indiana*AIM* 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 claims processing information is as follows:

- Pharmacy claims for Medicare Part D-covered drugs for dual-eligible members are cost avoided for Medicare coverage. The pharmacy must bill Medicare prior to 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:
  - Denial Explanation of Benefit Message – EOB 2510 – *Member eligible for Medicare B/D*.
  - This message explains that the claim was denied because the drug is not a Medicare D excluded drug and therefore could be covered by Medicare Part D and, as such, is not covered by the IHCP.

Medicare Part D and the IHCP Over-The-Counter Drug Formulary and Preferred Drug List

The IHCP reimburses for a Medicare Part D-excluded drug only if the drug is an IHCP-covered drug. For an OTC drug to be covered by the IHCP, the drug must be included on the *State of Indiana OTC Drug Formulary*. The OTC Drug Formulary can be viewed at http://in.mslc.com/StateMacServices.aspx and the PDL can be viewed at www.indianapbm.com. For Medicare Part D-excluded prescription drugs that are in classes subject to the Preferred Drug List (PDL), all existing PDL limits and requirements are applicable. Pharmacies and prescribing practitioners should contact ACS with any questions related to the PDL by calling 1-866-879-0106.

Section 3: Pharmacy Coverage and Reimbursement

General Information

The following are some basic parameters under which the IHCP pharmacy benefit and Healthy Indiana Plan (HIP) pharmacy program operates. Providers must be aware of and abide by these provisions:

1. Scope of coverage and reimbursement methodologies are as set out in the Indiana Health Coverage Programs (IHCP) rule at *405 IAC 5-24*.
2. All covered drugs require a prescriber's order or prescription, as defined in Indiana Board of Pharmacy law.
3. 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 funds, and as such there are both federal and state requirements that must be met.
4. 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 drugs in accordance with the IHCP rule *405 IAC 5-24-3,* which, at the time of publication of this manual, 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)*[1] 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.

[1] Currently known as Centers for Medicare & Medicaid Services (CMS).

Legend Drug Reimbursement

A pharmacy provider is entitled to reimbursement for covered legend drugs in accordance with Indiana Medicaid rule at *405 IAC 5-24-4*, which, at the time of publication of this manual, is as follows:

405 IAC 5-24-4 Reimbursement for 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. 4. (a) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following:

(1) The estimated acquisition cost (EAC) of the drug as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(2) The state maximum allowable cost (State MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(b) For purposes of this section, the Indiana Medicaid EAC is:

(1) For brand name legend drugs, 84 percent (84%) of the Average Wholesale Price (AWP) for the National Drug Code (NDC) according to the Medicaid contractor's drug database file.

(2) For generic drugs, eighty percent (80%); of the AWP for each NDC according to the Medicaid contractor's drug database file.

(c) The State MAC is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The purpose of the multiplier is 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.

(d) OMPP will review State MAC rates on an ongoing basis and adjust the rates as necessary to reflect prevailing market conditions and ensure reasonable access by providers to drugs at or below the applicable state MAC rate.

(e) Pharmacies and providers that are enrolled in the IHCP are required, as a condition of participation, to make available and submit to the OMPP or its designee acquisition cost information, product availability information, or other information deemed necessary by the OMPP for the efficient operation of the pharmacy benefit within the IHCP in the format requested by the OMPP or its designee. Providers will not be reimbursed for this information and will submit information to the OMPP or its designee within thirty (30) days following a request for such information unless the OMPP or its designee grants an extension upon written request of the pharmacy or provider.

Effective January 30, 2008, the OMPP changed the reimbursement policy for legend drugs to exclude federal upper limit (FUL) pricing considerations.

Blood Factor Reimbursement

Effective October 12, 2008, Indiana Medicaid reimburses claims for blood factor products administered during inpatient hospital stays at the lowest of the following:

- Estimated Acquisition Cost (84 percent of the Average Wholesale Price)
- Inpatient blood factor – State maximum allowable cost (MAC)
- Submitted charge

Blood factor that is used during inpatient hospital stays must be billed separately from the inpatient hospital diagnosis related group or Level of Care claim. If a patient was admitted prior to October 12, 2008, and blood factor was administered prior to October 12, 2008, the charges should remain on the inpatient claim.

Hospitals must submit claims for blood factor administered during inpatient hospital stays on the *CMS-1500* claim form, and should include on the claim both the NDC and the NDC quantity of the blood factor. Hospitals must use the National Provider Identifiers (NPIs) for their facility on their *CMS-1500* claim forms.

Claims with quantities greater than 9,999.99 units require special handling by HP, because the NDC will be the same for each detail and therefore the claim will deny as a result of duplicate claim systems logic. These claims must be sent to the following address for special handling:

HP Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

The Place of Service (POS) entered in Block 24B must be 21 – Inpatient hospital for blood factor administered during an inpatient hospital stay.

Instructions for completing the CMS-1500 are located in *Chapter 8* of the *IHCP Provider Manual*. Questions regarding product availability, rates, or other related matters should be directed to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 or 1-800-591-1183. Office hours for the Myers and Stauffer Pharmacy Unit are 8 a.m. to 5 p.m. weekdays. Blood factor State MAC rate information can be accessed at http://in.mslc.com/StateMacServices.aspx.

For members enrolled in risk-based managed care (RBMC), providers must contact the managed care organization (MCO) to obtain billing instructions for blood factor administered during an inpatient hospital stay.

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 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 their 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 number (the first five digits of the NDC), that have entered into a rebate agreement with the federal government is available at http://provider.indianamedicaid.com/provider-specific-information/pharmacy-services/related-information.aspx under the Drug Rebate Labeler link. It is essential that pharmacies check this list for the status of a drug manufacturer before dispensing. 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.

Pharmaceutical Ingredients (APIs)

The CMS, through the pharmacy technical advisory group, notified states that it has removed nondrug products (Active Pharmaceutical Ingredients) used in compounded prescriptions from the CMS covered

outpatient drug file. These nondrug products will remain reimbursable under Indiana Medicaid, even though they do not require a drug rebate agreement for coverage. Nondrug products that are considered APIs have historically been covered by Indiana Medicaid and, as of July 1, 2009, do not require a drug rebate agreement in order to be covered by the program. An example of an API is 17 alpha-hydroxyprogesterone caproate. This product is reimbursable even when it is from a non-rebating manufacturer, and may be billed on the National Council for Prescription Drug Programs (NCPDP) claim or *CMS-1500*/837P format. When billed using either format, the product is reimbursable only if included in a compound. The required National Drug Code (NDC) information must be provided when billed on the *CMS-1500*/837P format.

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. Indiana*AIM* has systematic claim processing logic edits that are 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 three billing units, and they are as follows:

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

Common Rebate-Related Disputes

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 exceed what would be expected as being within the normal range for the product; for example, the billed units appear inconsistent with what would be a normally dispensed quantity
- The submitted charge on the claim suggests a generic might have been dispensed when a brand name NDC was submitted on the claim

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 it 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. A comprehensive listing of these drugs can be found at http://provider.indianamedicaid.com/provider-specific-information/pharmacy-services/related-information.aspx under DESI Drug List. They are listed on the Web site by NDC, dosage form, name, and manufacturer. These drugs are not covered by the IHCP and providers are not entitled to reimbursement for them.

Mandatory Generic Substitution/Brand Medically Necessary

Generic substitution under the program is mandatory (refer to Preferred Drug List for exceptions), as set out by statute at *Indiana Code (IC) 16-42-22-10*. Pharmacy providers must be aware of these provisions 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 of any excess reimbursement that occurred as a result. In particular, pharmacy providers must be fully aware of and dispense in accordance with the *brand medically necessary* provisions of the Medicaid rule at *405 IAC 5-24-8* and view the *IC 16-42-22 Drugs: Generic Drugs*.

Pharmacy Pricing File – First DataBank

The IHCP uses First DataBank (FDB) for pharmacy pricing data to process drug claims. FDB is a source of electronic drug information. FDB provides to the Medicaid fiscal contractor weekly updates of the National Drug Data File (NDDF), which is the most comprehensive database of drug products approved by the Food and Drug Administration (FDA).

Medical Supplies Durable Medical Equipment and Home Medical Equipment

Information about medical supplies (includes diabetic supplies), durable medical equipment (DME), and home medical equipment (HME) policy and billing is available in *Chapter 8* of this manual and *405 IAC 5-19*.

Tamper-Resistant Prescription Pads (TRPPs)

The federal supplemental appropriations bill for fiscal year 2007 (P.L. 110-28) included a provision that mandates use of "tamper-resistant prescription pads" for all Medicaid nonelectronic prescriptions as of October 1, 2007. H.R. 3668, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007," was signed by President Bush September 29, 2007. In part, it established a six-month delay for the tamper-resistant prescription pads provisions for Medicaid prescription drugs. Those provisions were set to become effective October 1, 2007. Given the passage of H.R. 3668, the revised effective date for the tamper-resistant prescription pads requirements was April 1, 2008.

As of October 1, 2008, all handwritten and/or computer-generated prescriptions processed by the IHCP pharmacy benefit, must be fully compliant with federal and/or state guidance for prescription tamper resistance. These prescriptions contain *at least one* industry recognized feature *from each of the three* categories of tamper resistance:

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

The Office of Medicaid Policy and Planning (OMPP) suggests that prescribers consider utilizing Indiana Board of Pharmacy security prescriptions to facilitate compliance with the new 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 9.4 for the three categories and their descriptions.

In an emergency situation, prescriptions written on nontamper-resistant pads will be 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.

As of December 31, 2009, outpatient pharmacy claims that were previously paid by Hoosier Healthwise or the HIP health plans are reimbursed by the IHCP pharmacy delivery system and are subject to the tamper-resistant prescription pad requirements.

Prescriptions for IHCP or HIP members that are telephoned, faxed, or ePrescribed are exempt from TRPP requirements.

Table 9.4 – 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) Micro print 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/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	Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. *Note: This 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 Background that consists of a solid color or consistent pattern that has been printed onto the paper; this will inhibit a forger from physically erasing written or printed information on a prescription form	In addition to the written quantity on the prescription, quantities are indicated in ranges. Quantities and refill # are surrounded by special characters, such as an 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 determine compliance. Printing vendor is registered with the State Board of Pharmacy.

For questions about tamper-resistance prescription pads, please contact the HP Pharmacy Services Help Desk at (317) 655-3240 or 1-800-577-1278.

Maximum Allowable Cost Programs

To ensure the greatest possible utilization of therapeutically equivalent, less expensive generic drugs, the program uses State-developed maximum allowable cost (State MAC) limits. The State MAC program also encompasses blood factor products. Myers and Stauffer, an IHCP contractor, maintains the State MAC rates. Providers can access their Web site at http://in.mslc.com/ for more information. In addition, users may access the Myers and Stauffer Web site through the State MAC Program link located in the Pharmacy Links under the Pharmacy Services tab at http://provider.indianamedicaid.com.

Dispensing Fee

A provider is entitled to dispensing fees in accordance with the IHCP rule at *405 IAC 5-24-6* which, at the time of publication of this manual, is as follows:

405 IAC 5-24-6 Dispensing fee

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

Sec. 6. (a) For purposes of this rule, the Indiana Medicaid dispensing fee maximum is four dollars and ninety cents ($4.90) per legend drug.

(b) A maximum of one (1) dispensing fee per month is allowable per recipient per drug order for legend drugs provided to Medicaid recipients residing in Medicaid certified long-term care facilities.

(c) The practice of split billing of legend drugs, defined as the dispensing of less than the prescribed amount of drug 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.

> *Note: A maximum of one dispensing fee is allowable per recipient per drug order per 28 days for legend drugs provided to Medicaid recipients residing in Medicaid certified long-term care facilities. Providers are not entitled to any dispensing fee reimbursement that is not in accordance with this requirement of law.*

Usual and Customary Charge

Providers may bill the program for covered services with **only** the provider's usual and customary charge to the general public for the covered service. The provider's usual and customary charge includes any

dispensing fee that the provider may charge to the general public as part of the provider's usual and customary charge to the general public. Usual and customary charges are verified by the pharmacy auditing contractor, HMS, during on-site audits.

Drug Copayment

The IHCP drug copayment is set out in Indiana Medicaid rule at *405 IAC 5-24-7* which, at the time of publication of this manual, 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 *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 $10 copayment for each covered name brand drug dispensed.

** As of December 31, 2009, HMO pharmacy services is no longer valid due to the pharmacy benefit consolidation.

> *Note: 42 CFR 447.15 mandates that a provider may not refuse to provide services to a recipient 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 done in the same manner that notification is made to private pay customers.*

Nonlegend (Over-the-Counter, or "OTC") Drug Coverage and Reimbursement; OTC Drug Formulary

Coverage and reimbursement of over-the-counter (OTC) drugs is in accordance with the Indiana Medicaid rule at *405 IAC 5-24-5,* which, at the time of publication of this manual is as follows:

405 IAC 5-24-5 Reimbursement for nonlegend drugs

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

Sec. 5. (a) The office shall reimburse pharmacy providers for the cost and dispensation of nonlegend (over-the-counter) drugs included on the Medicaid nonlegend drug formulary as provided for in this section.

(b) The office shall reimburse for nonlegend drugs, except insulin, at the lowest of the following rates:

(1) One hundred fifty percent (150%) of the state maximum allowable cost (MAC), as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, for the drug in the quantity dispensed, as of the date dispensed.

(2) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

The OTC Drug Formulary can be accessed at http://in.mslc.com/ under the Pharmacy tab.

> *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. Injectable OTC insulins* ***are*** *covered by the program if from a rebating manufacturer. The formulary is drug-, strength-, and dosage form-specific 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 was developed and recommended to the IHCP by the Indiana Drug Utilization Review (DUR) Board. The Board and its subcommittee, the Therapeutics Committee, review the OTC Drug Formulary on a periodic basis to ensure that products listed thereon are reasonable, appropriate, and medically necessary, as well as to ensure that sufficient products are included on the Formulary. Providers with suggestions for inclusion of OTC drug products on the OTC Drug Formulary should forward the suggestions to PDL@fssa.in.gov.

Claim Reimbursement Adjustments

Chapter 10 specifies procedures for claim payment adjustments and refund requests. Paid claims must be submitted for adjustment within the one-year filing limit. Pharmacy providers must fill out a *Pharmacy Paid Claim Adjustment Request* form, which can be located in the Forms section on the IHCP Web site at http://provider.indianamedicaid.com. This form must be filled out in its entirety to be processed. The forms and any necessary attachments can be sent to the following address:

HP Pharmacy Claims Adjustments
P.O. Box 7265
Indianapolis, IN 46207-7265

Section 4: Pharmacy Billing Policy and Procedures

Overview

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

- Point-of-sale (POS)
- Paper claims
- Electronic batch claims

Please see *Chapter 6: Prior Authorization* and *Chapter 10: Claim Processing Procedures* of the *IHCP Provider Manual* for important information that can affect how claims are adjudicated and edited.

POS Claim Format

In a POS transaction, the pharmacy enters the recipient identification number (RID) and the prescription information into the pharmacy computer and transmits the claim using the approved telecommunication or switching vendor and any POS software that supports National Council for Prescription Drug Programs (NCPDP) version 5.1. From that information, online and real-time edits and Prospective Drug Utilization Review (ProDUR) alerts occur within a few seconds. The response(s) to the provider are based on the submitted information and historical paid claims information. For immediate response and payment information, POS is the preferred mode of claims submission. For claim formatting information, providers should review the Payer Sheet by clicking on the Pharmacy Services tab on http://provider.indianamedicaid.com.

Paper Claims

Although all pharmacy claim types may be billed electronically, providers choosing to bill pharmacy claims on paper claim forms must use the appropriate claim forms. These forms, as well as detailed billing instructions, can be found on the IHCP Web site at http://provider.indianamedicaid.com. Providers must submit all paper claims to HP at only the following address:

HP Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

Since the mandatory use of the National Provider Identifier (NPI) for IHCP claims, the Compound Prescription Claim Form and the 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.

Batch Claim Submission

Batch pharmacy claims is a method of submitting multiple claims in a single file or transmission. This method of claims submission is ideal for those providers that bill the IHCP on a monthly basis. The IHCP accepts the NCPDP 1.1 Batch Claim Format. Providers can submit these batch claim files using HP's File Exchange secure file transfer protocol (FTP) Web Connection.

In accordance with Health Insurance Portability and Accountability Act (HIPAA) requirements, providers that submit electronic batch pharmacy claims to HP must first become established as a *trading partner* with the IHCP. Trading partners receive a secure ID and password. Providers can find instructions and more information about becoming a *trading partner* and obtaining IDs by visiting the IHCP Web site at http://provider.indianamedicaid.com/general-provider-services/electronic-data-interchange-(edi)-solutions.aspx.

Providers submit batch claim files using HP's file exchange secure FTP Web connection. Additional information on file exchange can be found in the *Batch Submission* section of the *Electronic Data Interchange Communications Companion Guide* found at http://provider.indianamedicaid.com/media/22679/comm.pdf.

Claims for Returned-to-Stock Prescriptions

Claims that have been billed to and paid by the program for prescriptions that have been filled but not received by the member or the member's representative must be reversed within 15 calendar days of the date of service. The date of service is considered as "Day 1." This policy became effective September 11, 2009.

General Billing Information

Billing Only Usual and Customary Charge

When billing the program for any covered service, the provider submits **only** the provider's usual and customary charge to the general public for the covered service. This includes any special pricing that is offered to the general public, such as for $4 generic programs. The usual and customary charge includes the provider's dispensing fee, if any.

Service Product Identifiers

Each medication listed under Section 510 of the U.S. Federal Food, Drug, and Cosmetic Act is assigned a unique 11-digit, three-segment number. This number is known as the NDC, and it identifies the labeler or vendor, product, and package size.

The National Drug Code (NDC) of a dispensed drug must be used on the claim submitted to HP for the drug. NDCs must be configured as follows, to match to the First DataBank (FDB) 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 characters in length. The NDC must be in the 5-4-2 configuration. For example: 12345-1234-12 is a correctly configured NDC. Because a zero can be a valid digit in the NDC, this can lead to confusion when trying to reconstitute the NDC to its 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 National Drug Code (NDC) that does not match the corresponding code listed on the drug pricing file will result in denial of the billed service because the improperly configured code will not be recognizable to the claims processing system. Providers with

questions about the correct configuration of codes they are attempting to bill should contact the HP Pharmacy Services Help Desk by calling (317) 655-3240 in the Indianapolis local area or toll-free 1-800-577-1278.

Service Provider Identification Number – NPI

IHCP pharmacy providers must submit their 10-digit pharmacy NPI number in the service provider identification field on each pharmacy claim. The NPI number is required on all claims; POS billing, reversals, adjustments, and batch claims. For more information on this topic, providers should refer to the IHCP payer sheet located at: http://provider.indianamedicaid.com/media/22805/payersheet.pdf.

Prescriber Identifier – NPI

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, links to online resources are available at http://provider.indianamedicaid.com/become-a-provider/national-provider-identifier-(npi).aspx, https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do, and http://www.npinumberlookup.org/ to assist pharmacy providers and prescribers.

> *Note: Use of inaccurate NPIs, such as using one prescriber's NPI on a claim from a different prescriber is strictly forbidden and will subject the pharmacy provider to recoupment of payment and possible sanctions. Provider compliance will be monitored via postpayment review and referrals by the OMPP and the OMPP contractors will be made to the Indiana Medicaid Fraud Control Unit (IMFCU) for those noncompliant providers.*

Third-Party Liability

The IHCP edits pharmacy claims for third-party liability (TPL) cost avoidance. This means that if a member is identified in the Indiana*AIM* eligibility system to have TPL information on file, the pharmacy provider must file the claim with the other payer before billing to the IHCP. The IHCP is the payer of last resort.

When submitting paper claims, if another insurance carrier is billed but pays nothing or denies the claim, the pharmacy must submit the paper claim to Medicaid with an explanation of benefits (EOB) from the other carrier denying the claim. If a provider submits a paper claim with the TPL field blank, no EOB attachment, and the member has pharmacy TPL, the claim denies and the EOB message is *Recipient Covered by Private Insurance*.

If a provider submits claims for members who have pharmacy TPL coverage on file and who have no evidence of TPL for collection on the claim, the claim will be denied with an NCPDP reject code of *41 - Submit Bill to Other Processor*.

The program recognizes there will be 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 9.5.

Table 9.5 – Other Insurance Indicator (Field 308)

Code	Description	Additional Explanation
Code 2	Other coverage exists – payment collected	This code should be used when other insurance exists and payment is collected. The other payer amount collected (NCPDP field 431-DV) and other payer date (NCPDP field 443-E8) fields must be populated.
Code 3	Other coverage exists – this claim not covered	This code should be used when the primary insurance does not cover any portion of the claim. Examples of this include over-the-counter (OTC) items and any other items that are covered by the IHCP and not covered by the primary insurance.
Code 4	Other coverage exists – payment not collected	This code should be used only in cases in which a patient has active TPL coverage, but the claim is not paid. Deductibles and exhausted benefits are examples of such situations. This code should not be used to indicate that a patient's TPL is no longer valid.
Code 5	Managed Care Plan denial	This code should not be used for risk-based managed care (RBMC) IHCP denials; rather, it is to be used when the primary insurance is a managed care organization (MCO) that denies the claim.
Code 6	Other coverage denied – not a participating provider	This code should be used when the dispensing pharmacy or prescribing physician is not a participating provider in the primary insurance company's network.
Code 7	Other coverage exists – not in effect at this time of service	The dispensing pharmacy should use this code only if a denial has been received from the primary insurance company stating the coverage for the participant has been terminated or if it has been otherwise verified that there is no other existing primary coverage.
Code 8	Billing for another payer's copayment	This code is used in situations where the pharmacy is billing the IHCP for a copayment required by another insurer. To bill claims for TPL copay only, the pharmacy must include TPL override code **8** in the *Claim Segment* field (NCPDP field *308-C8*). In addition, the pharmacy must include a value of **1** in the *Other Amount Submitted Count* field (*478-H7*), a value of **99** (other) in the *Other Amount Claims Submitted* field (*479-H9*), and include the copay amount due in both the *Other Amount Claim Submitted* field (*480-H9*) and *Gross Amount Due* field (*430-DU*). The amount listed in both fields 4*80-H9* and *430-DU* must match exactly. The provider should submit the actual number of units dispensed in the quantity dispensed field (NCPDP field 442-E7). The provider will be reimbursed for the actual copayment amount as indicated in field *480-H9* and *430-DU* or the allowed amount plus dispensing fee of as much as $4.90, if the IHCP was the sole payer, *whichever is less.*

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 – NDC 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 and instances of inappropriate use, which results in payment recoupment and possible imposition of sanctions against the provider.

Billing Procedures for Home Infusion and Enteral Therapy Services

See *Chapter 8* for billing procedures for home infusion and enteral therapy services.

Billing Procedures for Drug-Related Medical Supplies and Medical Devices

As a result of drugs being reimbursed on an FFS basis, some drug-related medical supplies and medical devices will also be reimbursed on an FFS basis. Table 9.6 lists drug-related medical supplies and medical devices that will be paid for by the FFS medical benefit for all Hoosier Healthwise and Healthy Indiana Plan (HIP) health plan members for claims with dates of service on or after December 31, 2009. Services must be provided by an IHCP-enrolled pharmacy or durable medical equipment (DME) provider. This list is subject to change. Providers will be notified via an IHCP provider bulletin or other formal communication at least 45 calendar days prior to the change. Only the drug-related medical supplies and medical devices listed below are reimbursable by the FFS medical benefit. Claims submitted to the FFS, Hoosier Healthwise, or HIP health plan pharmacy benefits with dates of service on or after December 31, 2009, will be denied.

For more detailed billing instructions, see *Chapter 8*.

Refer to *EDI Solutions Trading Partner Registration Procedure* and *Chapter 3: Electronic Solutions* for instructions about how to enroll as a trading partner with the IHCP and submit these medical claims.

Note: Claims for supplies and devices not found in Table 9.6 must be submitted to the Hoosier Healthwise and HIP health plans. Refer to the Pharmacy Contact Information for the appropriate entity if you have billing questions.

Table 9.6 – Drug-Related Medical Supplies and Medical Devices

Procedure Code	Description
A4210	Needle-free injection device
A4211	Supplies for self-administered injection
A4245	Alcohol wipes, per box
A4206	Syringe with needle; sterile, 1cc or less, each
A4207	Sterile 2cc, each
A4208	Sterile 3cc, each
A4209	Sterile 5cc or greater, each
A4213	Syringe, sterile, 20cc or greater, each
A4215	Needle, sterile, any size, each
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4244	Alcohol or peroxide, per pint

Procedure Code	Description
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	Normal, low, and high calibrator solutions/chips
A4258	Lancet device
A4259	Lancets, per box of 100
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4267*	Contraceptive supply, condom, male, each
A4268*	Contraceptive supply, condom, female, each
A4269*	Contraceptive supply, spermicide (e.g., foam, gel), each
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler
A7018	Water, distilled, used with large volume nebulizer, 1000 ml
E0607	Home blood glucose monitor
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/blood sample
S8101	Holding Chamber or spacer for use with an
S8100	Holding chamber or spacer for use with an inhaler or nebulizer without mask

** Not covered by Healthy Indiana Plan.*

Billing Procedures for Procedure-Coded Drugs

The *Federal Deficit Reduction Act of 2005* mandates that the IHCP require submission of National Drug Codes (NDCs) on claims submitted with certain procedure-coded drugs. The requirement for the NDC submission was implemented August 1, 2007, for professional claims.

As stated above, Hoosier Healthwise and HIP health plans remain responsible for procedure-coded drugs billed to the Hoosier Healthwise and HIP health plans by entities other than IHCP-enrolled pharmacy providers. An updated list of the procedure codes that require an NDC is available from the *Provider Services* tab on the IHCP Web site. Click **Procedures That Require an NDC** from the drop-down menu to access the list.

See Chapter 8 for more information on billing procedure-coded drugs.

Section 5: Medicaid-Certified Long-Term Care (LTC) Facilities

Overview

This section contains information that applies only to services rendered to those 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 *405 IAC 5-24-10,* which at the time of publication of this manual, is 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.

These codes are located under Provider Code Sets on the Indiana Health Coverage Programs (IHCP) Web site at http://provider.indianamedicaid.com.

Please refer to *405 IAC 5-19* for additional information about Medicaid coverage and reimbursement for medical supplies and equipment.

> *Note: Pharmacy providers are not entitled to separate reimbursement for any IHCP-covered service that is solely per diem reimbursed.*

Unit Dose Packaging

The program reimburses for covered, manufacturer-packaged, unit dose medication. Such items are reimbursable only when provided to residents of IHCP-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).*

Returned Medications

State laws *IC 25-26-13-25(h)* and *(i); 856 IAC 1-21-1* 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 put 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. *Chapter 11: Paid Claim Adjustment Procedures* contains specific procedures for crediting the program for returned medications.

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 prescription number, name of medication, date the medication was returned and credited or destroyed, quantity returned and credited or quantity destroyed and, and if the medication was destroyed, who it was returned to for destruction. The pharmacy auditing contractor, HMS, will verify compliance with these requirements. LTC pharmacies and LTC facilities found to be noncompliant will, as deemed appropriate, be referred to Indiana Medicaid Fraud Control Unit (IMFCU).

Prior Authorization Requests - LTC Facility Residents

The program recognizes that there are circumstances under which, despite the best efforts of the dispensing pharmacist, it is not possible for prior authorization (PA) to be obtained for dispensing to a resident of a nursing facility. For this reason, a grace period of up to 30 days may be granted when requesting PA for Drug Utilization Review (DUR) edits. Forms for LTC PA requests are available at http://provider.indianamedicaid.com.

Retroactive Eligibility and PA Requests

Retroactive eligibility may be granted to members. Under such circumstances, claims may result for prescriptions that were paid for by the member before the person became IHCP eligible. If these claims include medications that are covered by the IHCP but have Preferred Drug List (PDL) status of *nonpreferred*, the pharmacy provider can request PA for past dates of service. Questions related to retroactive eligibility-related claims should be directed to the ACS Clinical Call Center at 1-866-879-0106.

Level of Care Information and the LTC Pharmacy

Due to the frequency of admissions and discharges from LTCs, it is not always possible for the IHCP to have the most current level-of-care information on file. For this reason, the program allows a pharmacy servicing LTC facility residents to indicate on a point of sale (POS) or paper claim the member's LTC status. Entering **03** or **04** in field number 307-C7 indicates to the claims processing system that the member resides in an IHCP-certified LTC facility.

> *Note: Appropriate use of this indicator is monitored via postpayment auditing of claims.*

Questions about POS claims submission should be directed to the HP Pharmacy Services Help Desk by calling (317) 655-3240 in the Indianapolis local area or toll-free 1-800-577-1278 from 8 a.m. to 6 p.m. Eastern Time, Monday through Friday excluding State holidays.

Section 6: Pharmacy Claim Review Processes

Drug Utilization Review

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 retrospective drug use is 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 criteria are reviewed and approved by the Indiana Medicaid DUR Board. For more information about the Indiana Medicaid DUR board, its members, and duties, visit http://provider.indianamedicaid.com and refer to the information listed under the Pharmacy Services tab.

Prospective Drug Utilization Review

The purpose of the Prospective Drug Utilization Review (ProDUR) 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 automated review of drug regimens alerts the pharmacist to potential drug therapy problems before medication is dispensed to the member. The ProDUR only screens prescriptions submitted via point of sale (POS). This systematic review of selected claims, before adjudication, provides pharmacists with valuable information that can affect decisions about dispensing medications.

While IHCP agencies implement and administer the programs mandated by *OBRA '90*, pharmacy providers are responsible for performing many of the required activities, as follows:

- ProDUR
- Patient counseling
- Proper patient records maintenance

For more information on applicable Indiana pharmacy law, visit http://www.in.gov/pla/pharmacy.htm.

OBRA '90 ProDUR language requires IHCP pharmacists to review the IHCP member's entire drug profile **before** filling prescriptions. *OBRA '90* requires evaluation of the following drug therapy problems:

- 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

To comply with *OBRA '90* ProDUR requirements, IHCP agencies must adopt criteria and standards to detect these conditions 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 or adverse effects or interactions
- Therapeutic intervention that may be encountered, including avoidance, and the action required if contraindications do occur
- Techniques for self-monitoring drug therapy
- Proper storage
- Refill information
- Appropriate action in case of a missed dose

Providers should consult the Indiana Board of Pharmacy for further requirements and for information about the status of currently applicable practice law.

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 explicit written criteria or the Pharmacy Claims Adjudication (PCA) system to conduct ProDUR 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

If the PCA system detects a ProDUR alert condition, the pharmacist receives a claim-rejected response that includes the ProDUR alert information. The alert information includes the following information:

- 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 interactions, therapeutic duplication alerts, and early refill alerts, the free text area contains the name of the drug in history and the dispense dates that the current claim hits.

Response Process

The claim is held in suspense until the provider sends a response claim that includes the corresponding reason for service code, professional service code, and result of service code. The response claim format is the same as the original claim format; however, it must include the reason for service, professional service, and result of service codes. The reason for service code on the response claim must match at least one of the alert codes on the denied claim. Response claims received with a reason for service code that does not match the alert code on the denied claim or an invalid reason for or result of service code are denied with an appropriate explanation of benefits (EOB). When submitting a response for a claim that sets more than one DUR alert, the pharmacist must choose the reason for service code to send with the response. 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 pharmacist may receive a false positive early refill rejection due to varying factors. Pharmacists should follow the instructions in Table 9.7 to attempt to clear the alert prior to calling ACS for a prior authorization.

Table 9.7 – How to Respond to a False Positive Early Refill

If	Then
Claim denies for Early Refill (ER) against a claim that was submitted with wrong days supply	Step 1: Pharmacy must respond to the current claim with DUR Response of: ER = Early Refill R0 = Pharmacist Consulted 2B = Filled with different Directions This will result in a denied claim that has an EOB code of 7507 = 2A/2B RQST ACCEPTED DUR ALERTS CANCELED Step 2: Pharmacy must reverse (B2) or rebill (B3) the old claim with the correct day supply Step 3: Pharmacy must resubmit the reversed claim with the correct day supply and NO DUR response Step 4: Pharmacy must resubmit the current claim with NO DUR response
Claim is denying for ER and the old claim has been reversed	Step 1: Pharmacy must respond to the reversed claim with DUR Response of: ER = Early Refill R0 = Pharmacist Consulted 2B = Filled with different Directions This will result in a denied claim that has an EOB code of 7507 = 2A/2B RQST ACCEPTED DUR ALERTS CANCELED Step 2: Pharmacy must resubmit the reversed claim with the correct day supply and NO DUR response Step 3: Pharmacy must resubmit the current claim with NO DUR response

If	Then
Claim denies for ER against a claim that was within the 75 percent used realm	Step 1: Pharmacy must wait until the claim has passed the 75 percent realm and then resubmit the claim on the proper day using the following instructions if it is within three days of current claim submission: Step 2: Pharmacy must respond to the claim with DUR Response of: ER = Early Refill R0 = Pharmacist Consulted 2B = Filled with Different Directions This will result in a denied claim that has an EOB code of 7507 = 2A/2B RQST ACCEPTED DUR ALERTS CANCELED Step 3: Pharmacy must resubmit the current claim with NO DUR response
Claim is denying for ER and there has been a change in directions	Step 1: Pharmacy calls ACS at 1-866-879-0106 for PA override.
Claim is denying for ER and the member needs additional meds due to lost or stolen	
Claim is denying for ER and the member needs additional supply due to vacation	
Claim is denying for ER against a previous claim with an invalid days supply and the pharmacy can NOT reverse the claim to correct the error.	

For additional information or assistance, contact the HP Pharmacy Services Help Desk at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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 Board’s outreach programs, are educational and not punitive in nature, and are conducted primarily by means of letters to selected prescribing practitioners. The intent of Retro-DUR interventions is to bring to the attention of practitioners patient-specific information, based on paid pharmacy claims, which may assist the practitioner in better managing the care of his or her patients. Retro-DUR activities are administered by the pharmacy benefits manager (PBM) services vendor, which is currently ACS.

Suspended Compound Claims

All compound claims for which the submitted charge is $275 or greater are suspended for review by an ACS pharmacist prior to being released for adjudication. The dispensing pharmacy receives an edit message that the claim has been suspended for manual review. No further action by the pharmacy is required. These claims are reviewed to ensure that the compound is logical and medically necessary. The claims are released for adjudication within 21 days of suspending.

Pharmacy Claims Greater Than or Equal to $5,000

Pharmacy claims with billed amounts greater than or equal to $5,000 will be denied (excluding the drug classes listed in table 9.8). If the claim is denied and the billed amount and quantity dispensed on the claim are not correct, the pharmacy provider can correct the information and resubmit the claim. If the claim is denied and the billed amount and quantity dispensed on the claim are correct, the pharmacy provider must contact Affiliated Computer Systems (ACS) for prior authorization by calling 1-866-879-0106.

Table 9.8 – Exclusions to Verification Edits

Drug Class Description	Full Exclusion/Partial Exclusion from Limit	Notes
Pulmonary anti-HTN, endothelin receptor antagonist	Full	
Pulmonary antihypertensives, prostacyclin-type	Full	
Pulm. 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	

Drug Class Description	Full Exclusion/Partial Exclusion from Limit	Notes
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	
Factor IX preparations	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 Greater Than or Equal to $10,000

Pharmacy claims with billed amounts greater than or equal to $10,000 will be denied for the drug classes listed in table 9.9. If the claim is denied and the billed amount and quantity dispensed on the claim are not correct, the pharmacy provider can correct the information and resubmit the claim. If the claim is denied and the billed amount and quantity dispensed on the claim are correct, the pharmacy provider must contact Affiliated Computer Systems (ACS) for prior authorization by calling 1-866-879-0106.

Table 9.9 – Drug Classes with Billed Amount 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 Dz of Colon	Cimzia only
Antimetabolites	Xeloda only
Skeletal Muscle Relaxants	Lioresal IT only

Pharmacy Audit

Federal regulations require IHCP to be able to identify and refer cases of fraud or abuse for investigation and, if deemed appropriate, prosecution. HMS is contracted to provide pharmacy audit services for IHCP, and those services include what is referred to as *concurrent audit*, *central script review* (CSR), and *on-site review* (OSR).These functions review claims for compliance with program requirements. After December 30, 2009, outpatient pharmacy claims that were previously paid by Hoosier Healthwise or the Healthy Indiana Plan (HIP) are paid by the fee-for-service (FFS) pharmacy delivery system and those claims are subject to the HMS pharmacy audit processes.

Concurrent audit is a function that resembles a "real-time" audit environment. HMS contacts the billing provider via fax or mail within one business day of identification of a potentially aberrant pharmacy claim, presenting the pharmacy with an opportunity to review, correct, and resubmit the claim in question. If the provider does not modify the claim, and it continues to appear aberrant, the claim will be included in the CSR process described immediately below.

HMS performs CSR activities on a quarterly basis. The CSR process uses multiple algorithms in the review of paid claims. If a prescription is selected for review during this process, the dispensing provider receives a letter requesting documentation related to the claim. Such documentation can include, for example, a copy of the prescription at issue and reason(s) for early refill of a given prescription.

On-site reviews are performed quarterly. HMS generates ranking reports to identify providers that will receive on-site visits from a HMS auditor. Focus areas of on-site reviews may include a review of signature logs, purchasing records, on-hand inventory, usual and customary pricing, and pharmacy operating procedures. Providers are typically notified in advance of an on-site audit.

> *Note: Signature logs for outpatient pharmacies and signed records of delivery to long-term care facilities are required to be maintained by the billing provider as proof of the service being provided.*

Information regarding Medicaid fraud and abuse is located in *Chapter 13*.

Providers are ***strongly*** encouraged to report any information related to potential IHCP fraud or abuse to the appropriate authorities. The following are the primary agencies to which fraud- and abuse-related matters may be reported:

Surveillance and Utilization Review Department or Provider and Member Concern Line (Fraud and Abuse)
P.O. Box 531700
Indianapolis, IN 46253-1700

Provider and Member Concern Line (Fraud and Abuse)
(317) 234-7598 in the Indianapolis local area or
1-800-457-4515 outside of the Indianapolis local area

Medicaid Fraud Control Unit
8005 Castleway Drive
Indianapolis, IN 46250
(317) 915-5300

HMS Audit Department
100 Corporate Pointe, Suite 395
Culver City, CA 90230
1-866- 642-0622(inside Indiana)
(310) 642-1700 (phone)
(310) 642-1701 (fax)
http://www.prudentrx.com

Required Information for Appeals

Providers are required to submit certain types of information when submitting an appeal of overpayment findings. HMS has published a document on its Web site to assist providers in submitting additional information that may be used for reconsideration of an overpayment. The document is available at http://www.prudentrx.com/provider/index.html.

Corrected Claims (Paper Submissions)

Postpayment auditing of pharmacy claims identifies instances in which providers billed in a manner that resulted in payments to which the provider is not entitled. In some instances, these cases can be corrected by adjustment of the claim. In other instances, HMS cannot adjust the claim fields that would require modification in order to be correct. HMS cannot adjust the following fields:

- Patient ID
- National Drug Code (NDC)
- Dispense as Written (DAW) codes
- Override codes

For example, a provider submitted a claim for 75 cubic centimeters (cc) of albuterol solution, 5 milligrams (mg)/cc using the NDC for the 20cc bottle. The prescription, however, was written and dispensed for one box of 25 vials of the 3cc premixed vials. These are different products and the submitted NDC is incorrect; therefore, HMS cannot adjust the claim.

If the claim is **one year old or less**, it must be reversed via the audit process and the pharmacy must resubmit the replacement claim via POS to accurately reflect the product dispensed.

For those claims with dates of service **more than one year old**, the following procedure has been established to allow providers to submit a replacement claim for payment. The pharmacy provider must:

1. Prepare the paper claim for the rendered service with the correct billing information.
2. Complete the Overpayment Option Form, return it, and indicate acceptance of the recovery of the inappropriately billed claim.
3. Send the new replacement claim and the Overpayment Option Form to HMS as instructed in the audit letter.
4. Clearly indicate on all new replacement claims the internal control number (ICN) of the audited claim that is being replaced.

HMS forwards the audited claim(s) to HP to be reversed. After the overpayment has been collected and the audited claim has been reversed, HMS forwards the replacement claim to HP to be paid. Copies of documents pertaining to replacement claims will be retained by HMS for recordkeeping purposes.

Providers should remember the following important information:

- This process must be followed in this order to prevent the replacement claims from being denied as duplicates.
- Replacement claims are not processed unless the provider has agreed to recovery of the overpayment.
- Providers must correct the error identified on the audited claim. Submitting the replacement claim exactly as it was originally billed results in the claim being re-audited.

- HMS **accepts only** replacement paper claims that are:
  - More than one year old
  - Subject to the audit and recovery process
- HMS does not accept claims for services that are more than one year old but were not subject to the audit process; HMS returns such claims to the provider.

Section 7: Preferred Drug List, Prior Authorization Requirements

Overview

The Indiana Health Coverage Programs (IHCP) initiated the Indiana Rational Drug Program (IRDP) and from that initiative evolved the Preferred Drug List (PDL). Prior authorization, a key part of the PDL, is a utilization management tool that ensures 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.

PA request forms are located at http://provider.indianamedicaid.com/general-provider-services/forms.aspx.

Preferred Drug List

Not all drug classes covered by the IHCP pharmacy benefit are subject to the PDL. Drugs that are within classes that are subject to the PDL have either a *preferred* or *nonpreferred* status. In general, *preferred* drugs do not require PDL prior authorization (PA), whereas *nonpreferred* drugs do require such PA. Usually, it is the prescriber who must initiate 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 reviews the PDL in its entirety twice annually. Please visit www.indianapbm.com for information about the PDL, the Therapeutics Committee, and the DUR Board. A complete and up-to-date copy of the PDL is available at that site. Providers should direct all questions about the PDL to the ACS Clinical Call Center at 1-866-879-0106.

Criteria-Based Prior Authorization Requirements

The PDL and criteria-based PA 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.

For information on the criteria pertaining to or authorization requirements for these drugs, please access www.indianapbm.com, or call the ACS Clinical Call Center at 1-866-879-0106.

ACS provides services for pharmacy-related PA. PA request forms are available at http://provider.indianamedicaid.com. Providers should direct all questions about and requests for pharmacy-related PA to ACS at 1-866-879-0106.

Automated Pharmacy Prior Authorization (PA)

On November 1, 2009, the IHCP pharmacy program implemented an automated PA tool known as SmartPA™. SmartPA is integrated into the ACS Indianapolis Clinical Call Center and the HP pharmacy claims adjudication (PCA) systems. It executes real-time prior authorization decisions by utilizing highly sophisticated clinical PA edits supported by the member's medical and pharmacy claims data. SmartPA results in quicker PA determinations for pharmacy claims processed by the FFS pharmacy benefit, with

less intervention on the part of pharmacy and prescribing providers. In addition, SmartPA has the capability to allow certain prescriber specialties to bypass designated PA requirements.

SmartPA ensures that the prescribed therapy meets Indiana-specific evidence-based criteria for appropriate use. If applicable edit criteria are met, the claim will continue through the pharmacy claims processing system. If the criteria are not met, the claim will be denied and the provider will receive notification to contact the Affiliated Computer Services (ACS) Indianapolis Clinical Call Center. The Office of Medicaid Policy and Planning, 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), reviews and approves the clinical edits and criteria used within SmartPA.

Subsequent to the approval process noted above, clinical edits are added to the SmartPA system. Providers are provided advance notification of implementation of SmartPA edits, via HP provider bulletins and/or banner pages.

Please access http://www.indianapbm.com/automatedrxpa.htm for additional information regarding SmartPA edits.

DUR Edits Requiring PA

- Drug–Drug severity level 1 interactions
- Overutilization (early refill)
- 34-Day Supply on nonmaintenance medications

For an override of a drug-drug interaction that involves a discontinued medication (for example, a “false positive”), the *pharmacist* may call the ACS Clinical Call Center at 1-866-879-0106. 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 *pharmacist* may call the ACS Clinical Call Center at 1-866-879-0106.

Brand Medically Necessary

A prescriber’s specification of *brand medically necessary* requires PA. Currently exempted from the PA requirement otherwise associated with *brand medically necessary* are the following medications:

- Dilantin
- Coumadin
- Lanoxin
- Premarin
- Tegretol
- Provera
- Synthroid
- Mental health medications as defined by State statute

Emergency Supply

Policy and procedures regarding provision of *emergency supply* of covered drugs are clearly set forth on the *Emergency Supply* of the IHCP Web site, http://www.indianapbm.com/emergencySupply.htm. The following text is from that site:

> In instances in which prior authorization (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 4 days

The purpose of the "emergency supply" policy is to comply with federal emergency supply provisions and ensure that patients do not go without covered outpatient drugs in emergency situations. Emergency situations include instances in which 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. **The IHCP does not reimburse for "emergency supply" claims for Medicare Part D covered drugs for dual eligibles**.

Compliance with IHCP "emergency supply" provisions is a primary focus of review by HMS. Providers found to be violating the "emergency supply" billing policies may incur recoupment of funds associated with the incorrect billings, as well as other applicable sanctions.

100-Day Supply – Maintenance Medications

Effective January 1, 2008, 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. This policy has been approved by the Indiana Medicaid DUR Board. It is intended to align Medicaid policy with that of other payers, minimize the possibility of wasted medication, and encourage communication among pharmacists, physicians, and patients.

Nonmaintenance medications are limited in quantity to no more than a 34-day supply per dispensation.

Pharmacies Servicing Long-Term Care and Home Health Care Patients

The IHCP recognizes there are circumstances under which, despite the best efforts of the pharmacy provider, it may not be possible for prior authorization (PA) for drug utilization review (DUR) edits to be obtained for dispensing to an Indiana Medicaid member receiving long-term care or home health care services. For this reason, a grace period of up to 30 days may be granted when requesting such prior authorization. Forms for long-term care PA requests are available at http://provider.indianamedicaid.com.

HEA 1325

Mental Health Quality Advisory Committee

State legislation HEA 1325 created the Mental Health Quality Advisory Committee (MHQAC) to provide advice as to implementation of the law. Pursuant to the statute, the MHQAC comprises the director of Health Policy and Medicaid (who chairs the committee); the medical director of the Division of Mental Health and Addiction (DMHA), Family and Social Services Administration (FSSA); a representative of a statewide mental health advocacy organization; a representative of a statewide mental health provider organization; a representative from an MCO that participates in the state's Medicaid program; a member with expertise in psychiatric research representing an academic institution; a pharmacist licensed under Indiana law; and the Commissioner of the Department of Corrections or the Commissioner's designee.

The purpose of the committee is to develop guidelines and programs to allow open and appropriate access to mental health medications, provide educational materials to prescribers, and promote appropriate use of mental health 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.

Utilization Edits

Utilization edits are defined as pharmacy claims 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. Utilization edits include, but are not limited to, those designed to detect or focus on drug interactions, frequency of refills, dose optimization, age, days supply, and quantities dispensed. Claims for compounds are also included in the editing. The intent of the edits is to promote patient adherence to medication regimens and ensure safe, appropriate use of medications in the Indiana Medicaid population. Utilization edits do not constitute formulary restrictions. Utilization edits are reviewed quarterly. The definition of utilization edits is consistent with the rules and regulations published in *Indiana Code (IC) 12-15-35.5-7*. Providers should refer to bulletins and banner pages for the most current information regarding utilization edits or, for an up-to-date list of the utilization edits, refer to http://provider.indianamedicaid.com/media/42991/utilization%20edit%20document%20v9%2020100719.pdf.

Mental Health Medical Necessity Quality Edits

On January 1, 2007, six mental health medical necessity quality edits were implemented for all IHCP members. The edits were approved by both the DUR Board and MHQAC. The edits require a medical necessity review via existing PA processes.

Additional Mental Health Medical Necessity Quality Edits have been implemented. Refer to http://www.indianapbm.com/automatedrxpa.htm for additional information.

Claim Appeal Process

The procedures that providers must follow if they are dissatisfied with the adjudication of a claim are specified in *Chapter 10, Section 6*, of the *IHCP Provider Manual*. Pharmacy providers must direct any requests for administrative review to the following address:

HP Pharmacy Claims Administrative Review
P.O. Box 7263
Indianapolis, IN 46207-7263

If a provider disagrees with the IHCP determination of payment, the provider's right of recourse is to file an administrative review and appeal as provided in *405 IAC 1-1-3*.

Prior Authorization Denial Appeal Process

A provider 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. (Rejection is *not* modification or denial.)

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

1. 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
2. Documentation including medical records, equipment, consultations, case histories, and/or therapy evaluations. Include any documentation supporting the provider/appellant case.

   Send the above information to this address:

   ACS Government Healthcare Solutions
   4550 Victory Lane
   Indianapolis, IN 46203

Please note the following important information:

1. Failure by a provider to timely request an administrative review will result in the loss of the right to request an administrative hearing – *405 IAC 1.1*.
2. The review decision of the contractor will be rendered within **seven** working days of receipt of the request for administrative review.
3. The review will assess medical information pertinent to the case in question.
4. The Medicaid medical director, or that individual’s designee, will perform the review.
5. The requesting provider and the member will receive written notification of the decision containing:
   a. The determination reached by the Medicaid contractor and the rationale for the decision
   b. Provider/member appeal rights through the Family and Social Services Administration

Index

1

100-day supply – maintenance medications9-42

A

automated pharmacy prior authorization...9-40

B

batch pharmacy claim submission.............9-22
billed amount limit 9-36
billing usual and customary charge 9-23
brand medically necessary.........................9-41

C

claim reimbursement adjustments 9-21
claims for returned-to-stock prescriptions.9-23

D

DESI 9-15
dispensing fees 9-18
drug age precaution 9-32
drug claims
  submission 9-22
drug classes
  billed amount limit................................9-36
drug copayment 9-19
drug disease alerts 9-32
drug pregnancy alert..................................9-32
Drug Utilization Review 9-30
drug-drug interaction.................................9-32
drugs
  identical, related, or similar 9-15
  less than effective 9-15
DUR 9-30
DUR edits requiring PA 9-41

E

emergency supply......................................9-42

F

federal DESI Program 9-15
federal rebate program...............................9-14
FFS Medicaid contractor roles 9-9
First DataBank...9-16

H

high and low dose alerts 9-32

I

identical, related, or similar 9-15
Indiana Medicaid DUR Board...................9-30
introduction 9-6
IRS..9-15

L

legend drug coverage.................................9-12
legend drug reimbursement 9-13
less than effective 9-15
level-of-care information and the LTC pharmacy
 9-29
LTE...9-15

M

maintenance medications...........................9-42
mandatory substitution 9-16
medical and nonmedical supplies and equipment
 9-28
medical supplies and DME........................9-16
medications returned to the dispensing pharmacy
 9-28

N

National Drug Code (NDC).......................9-14
nonmaintenance medications.....................9-42

O

OTC Drug Formulary 9-20
other insurance indicator 9-25
over and under-use precaution...................9-32
over-the-counter 9-20
overview 9-6

P

paper drug claims 9-22
patient counseling......................................9-31
patient information 9-31
pharmacies servicing long-term care and home
  health care patients 9-43
pharmacy
  billing usual and customary charge 9-23
  labeler number 9-14
  mandatory substitution..........................9-16
  manufacturers 9-14
  return of medications 9-28
  therapeutic screenings...........................9-32
pharmacy audit 9-37
pharmacy contact information 9-6
pharmacy coverage and reimbursement 9-12
pharmacy program......................................9-6
pharmacy-related Web sites.........................9-8
point of sale
  alert process 9-32

response process 9-32
POS claim format 9-22
Preferred Drug List....................................9-40
prescriber identifier 9-24
prior authorization denial appeal process ..9-44
prior authorization requests
long term care 9-29
ProDUR...9-30
Prospective Drug Utilization Review........9-30

R

retroactive eligibility and prior authorization
requests 9-29
Retrospective Drug Utilization Review.....9-34
return of medications................................9-28
roles of contractors for FFS Medicaid.........9-9

S

SmartPA 9-40
suspended compound claims 9-35

T

tamper-resistant prescription pads 9-16
therapeutic duplication 9-32
therapeutic screenings 9-32
third-party liability.....................................9-24
TRPP 9-16

U

unit dose 9-28
usual and customary 9-18