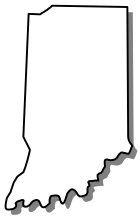
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Pharmacy Providers

Subject: Pharmacy Provider Reviews

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

Overview

Myers and Stauffer LC, on behalf of the Office of Medicaid Policy and Planning (OMPP), conducted a review of services rendered by pharmacy providers. The purpose of this review was, in part, to gauge provider compliance with applicable statutes, regulations, policies, and procedures. The review included on-site audits of pharmacies, as well as a review of paid pharmacy claims. Based on the results of the review, several issues were identified that have resulted, or will result, in recoupment of Indiana Health Coverage Programs (IHCP) funds.

Note: Claims for IHCP reimbursed services, when such services are subsequently found to have been rendered out of compliance with applicable law and/or policy, are subject to recoupment by the IHCP, and referral of the practice violation to the Indiana Board of Pharmacy, Health Professions Bureau, for follow-up action as deemed necessary and appropriate by that professional regulatory body.

This bulletin reminds providers of policies and procedures that apply to the primary issues identified as a result of the review. It is expected that by bringing these matters to providers' attention, providers will ensure full compliance with applicable law and program parameters. The IHCP expects all pharmacy providers to render all services to IHCP members in full compliance with state and federal practice laws, and with strict observance of, and adherence to, IHCP service documentation requirements. Significant issues revealed as a result of the Myers and Stauffer review are addressed in this bulletin. All pharmacy providers are encouraged to carefully review this information. The IHCP will monitor compliance through future reviews and audits.

Maintenance of Prescription Records

The IHCP requires providers to maintain records for a period of three years from the date of service, and to fully document the services provided to IHCP members according to Indiana Administrative Code (IAC) *405 IAC 1-5-1*. The examination of records maintained by some pharmacies revealed instances where the prescription necessary to support the paid claim was not found. Providers must maintain documentation to support the billing of a claim to the IHCP. All claims billed for prescriptions and subsequent refills for which the provider has not maintained the required documentation are subject to recoupment by the IHCP.

Prescriber License Numbers on Controlled Substance Prescription Forms

Indiana Board of Pharmacy regulation *856 IAC 1-34-2(a)(9)* requires that "all controlled substance prescriptions written by licensed Indiana practitioners, as defined by Indiana code (IC) *IC 16-42-19-5*, must contain the practitioner name and state issued professional license number." The state issued professional license number "must be preprinted, stamped, or manually printed on the prescription." Additionally, the IHCP requires the eight-digit prescriber license number on all pharmacy claims. Out-of-state providers should see the section below titled *State-Issued Professional License Number.*

The review showed numerous instances where controlled substance prescriptions and drug claim forms did not contain the required prescriber license number. In some instances, the drug claim form contained an incorrect prescriber license number.

Prescriber Signature on Controlled Substance Prescription Forms

Regulation *856 IAC 2-6-4* requires that "all prescriptions for controlled substances shall be dated as of, and signed on, the day when issued…. A practitioner may sign a prescription in the same manner as he would sign a check or legal document. The prescriptions may be prepared by a secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by these regulations."

Records maintained by some pharmacies show prescriptions for controlled substances (not received by telephone) that did not contain a prescriber signature. Filling prescriptions that do not contain the prescriber signature is in violation of pharmacy law and can result in recoupment of IHCP funds and referral to the Indiana Board of Pharmacy.

Collection of Copayments

Regulation *405 IAC 5-24-7* requires that "the copayment shall be paid by the recipient and collected by the provider at the time the service is rendered…. The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid." However, the member cannot be denied the prescription if unable to meet the copayment requirement. Certain exceptions to this rule apply such as emergency services; services to individuals younger than 18 years old; services to pregnant women; inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or other institution; family planning services; and health maintenance organization (HMO) pharmacy services.

Circumstances were found where pharmacies did not charge applicable copayments to members. Additionally, instances were noted where pharmacy records indicated copayments were collected from nursing facility residents, a practice that is contrary to the IHCP rule. Applicable copayments must be charged to members, and copayments cannot be charged to members who qualify for the exceptions explained previously.

Dispensing of Brand Name Drugs/Mandatory Substitution

Regulation *IC 16-42-22-10* states, all pharmacies are to "substitute a generically equivalent drug product and inform the customer of the substitution if the substitution would result in a lower price unless: (1) the words 'Brand Medically Necessary' are written in the practitioner's own writing on the form; or (2) the practitioner has indicated that the pharmacist may not substitute a generically equivalent drug product by orally stating that a substitution is not permitted. If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the Brand Medically Necessary

instruction appropriately indicated in the physician's own handwriting." When the words *brand medically necessary* are stated on the prescription, a generic drug cannot be dispensed.

Records maintained by some pharmacies show instances in which prescriptions were dispensed with brand name drugs rather than a generic equivalent when the prescription did not contain the words *brand medically necessary* written in the prescriber's own handwriting and a generic version was available. The review also noted prescriptions filled with generic equivalents when the prescription contained the words *brand medically necessary* in the prescriber's handwriting.

Multiple Dispensing Fees

Regulation *405 IAC 5-24-6(b)* requires that "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."

The review revealed some pharmacies received multiple dispensing fees within a month (defined as a 28-day period) for the same legend drug order for a member in an IHCP-certified long term care facility. Enhancements were made to the claims processing system to better enforce this policy; nonetheless, it is a pharmacy provider's responsibility to ensure these overpayments are promptly refunded to the IHCP. Providers must submit all refunds for overpayments to ACS at the following address:

Indiana Pharmacy Claims
c/o ACS
P. O. Box 502327
Atlanta, GA 31150

Brand Medically Necessary *Overrides on Claims for* Generic *Drugs*

Regulation *405 IAC 5-24-4* specifies that reimbursement for legend drugs is based on "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 maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration, under *42 CFR 447.332* as of the date of dispensing, plus any applicable Medicaid dispensing fee; (3) The state maximum allowable cost (MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid dispensing fee; or (4) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing."

The review revealed some pharmacy providers received additional reimbursement due to specifying an *06 – Brand medically necessary override* on the drug claim when billing for *generic* drug products and when the prescriber did not specify *brand medically necessary*. Specifying *brand medically necessary* on a claim for a generic drug is an error. This prompted Indiana*AIM* to suspend pricing at the otherwise applicable MAC rate for the presumably dispensed generic drug. This resulted in payment to the provider at a higher rate than what would have occurred had the MAC pricing not been inappropriately suspended because the pharmacy provider specified *brand medically necessary* on a claim for a generic drug.

> *Note: Providers are advised that purposefully receiving higher reimbursement than what is entitled by indicating* brand medically necessary *when dispensing a generic drug product is considered fraud, and could subject the provider to removal from the IHCP, and prosecution by the appropriate state and federal agencies.*

Medicare Skilled Nursing Facility Per Diem

According to *42 CFR 409.25*, pharmacy services for Medicare beneficiaries during their post-hospitalization skilled nursing facility (SNF) inpatient stay are covered under the Medicare nursing facility per diem. The Medicare nursing facility per diem includes the cost of all drugs used by a resident during the Medicare stay, excluding certain chemotherapy drugs. Drugs obtained from an outside source are the financial responsibility of the SNF. Pharmacies that supply drugs for residents during a Medicare SNF stay should look to the SNF, not the Medicare intermediary or the IHCP, for payment. Specifically, providers should not bill the IHCP for pharmacy services provided to these residents under the care of an SNF. For more information about the Medicare SNF reimbursement of drugs and biologicals, consult the *Centers for Medicare and Medicaid Services (CMS) SNF Prospective Payment System and Consolidated Billing Manual*, *Chapter 3*. This manual is available online at the CMS Web site, http://cms.hhs.gov/.

Examination of records maintained by some pharmacies indicated that pharmacy providers billed and received payment from the IHCP for prescriptions for dually-eligible Medicare and IHCP members during a covered Medicare SNF stay. It is the joint responsibility of the nursing facility and the pharmacy provider to communicate necessary information so that pharmacy providers do not bill the IHCP separately under these circumstances.

Prescription Refills Documentation

Regulation *IC 25-26-13-25(d)* requires that refill records must include "(1) the date of the refill; (2) the quantity dispensed if other than the original quantity; and (3) the dispenser's identity on: (A) the original prescription form; or (B) another board approved, uniformly maintained, readily retrievable record."

The review showed several instances in which prescriptions did not contain necessary information such as date of refill, quantity of refill, or identity of dispenser. Additionally, many prescriptions did not specify that refills had been properly authorized. Such instances are grounds for recoupment of IHCP funds.

Split Billing

Regulation *405 IAC 5-24-6 (c)* states that 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."

The review indicated instances of split billing with no required and appropriate documentation. Again, these situations are subject to recoupment of inappropriately reimbursed IHCP funds.

State-Issued Professional License Number

Chapter 9 of the *IHCP Provider Manual* states that all pharmacy claims for prescriptions written by a prescriber located in Indiana must contain the prescriber's Indiana-issued medical license number. For prescriptions written by out-of-state prescribers, and **only** for such prescriptions, pharmacies are to use the appropriate out-of-state dummy number, applicable to the area where the prescriber is located, on the claim. Pharmacies must not use out-of-state dummy license numbers on claims for prescriptions written by an Indiana-licensed prescriber located in Indiana. Failure by pharmacy providers to strictly

observe this policy has significant patient care implications, as the validity of retrospective drug utilization review (DUR) is greatly compromised by the inability to accurately identify the prescriber.

The review revealed significant departure from the above-referenced policy, primarily in situations where the pharmacy provider inappropriately used an out-of-state dummy number when filing a claim for a prescription written by an in-state, Indiana-licensed prescriber. Future reviews will focus on this area to ensure pharmacy provider compliance.

Returns and Credits

Chapter 9 of the *IHCP Provider Manual* states that "…medications returned to the dispensing pharmacy that are redispensed must be credited to the program. 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." This crediting must occur within 30 days of return of the medication to the pharmacy. Pharmacies can alternatively complete a claim reversal on the point of sale system. If the medication is not returned to inventory for redistribution, the medication must be destroyed.

Note: Unless disposed of or destroyed, returned IHCP medications not credited to the IHCP are considered overpayments and must be credited to the IHCP immediately. Pharmacies and extended care facilities must keep the appropriate documentation to support returned or destroyed medications.

Information obtained during the review indicated that some providers were not complying with this policy. Documented instances of this violation are subject to recoupment and future reviews will focus on this area to ensure pharmacy provider compliance. Providers must submit all credit requests for returned medications to ACS at the following address:

Indiana Pharmacy Claims
c/o ACS
P. O. Box 502327
Atlanta, GA 31150

Summary

The information in this bulletin is intended to highlight areas of IHCP compliance found to be out of compliance based on review and audit. It is also intended to remind providers to review internal processes to ensure that business practices are fully compliant with all applicable law, policy, and service documentation requirements. The OMPP hopes the information contained in this bulletin assists providers in the review and confirmation process.

Additional Information

Direct questions about this bulletin to Myers and Stauffer LC, at (317) 846-9521, extension 345.