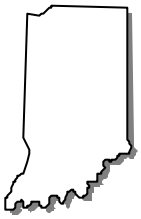
Indiana Health Coverage Programs



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

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To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Implementation of Pharmacy Cost Avoidance; Pro-DUR Alert Changes; Days Supply Limitation**

Note: The information in this bulletin regarding pharmacy claims and prior authorization may vary for providers rendering services to members enrolled in the risk-based managed care (RMBC) delivery system.

Overview

This bulletin addresses the following policy changes that will become effective July 1, 2002:

- Pharmacy Cost Avoidance
- Hard Prospective Drug Utilization Review (Pro-DUR) Alerts
- 34-day Supply Limit For Non-Maintenance Medications

Pharmacy Cost Avoidance

Effective July 1, 2002, the State will implement a cost avoidance policy for pharmacy claims. Currently, when members have pharmacy insurance coverage (such as TPL), Medicaid pays the pharmacy claim up front and then attempts to recover (chase) the money from the other insurance carrier after Medicaid has paid the claim. A cost avoidance policy for pharmacy claims shifts the collection task from the state to the provider and is consistent with policy currently in place for all other provider types. Cost avoiding pharmacy claims benefits providers and the State in the following ways:

- Some insurers may pay the claim in full. The State will not have to incur the cost of processing and paying the claim. Some providers will receive a higher rate of reimbursement from the insurance carriers.

- Frequently, paid claim dollars cannot be recovered on the back end due to timely filing issues with other carriers (for example, Medicaid submits the claim after the other carrier's filing deadline).
- Some pharmacy benefit managers (PBMs) will not accept or process claims from non-providers such as a Medicaid program. Therefore, Medicaid is unable to recover claims paid by those PBMs—this is an issue for all State Medicaid programs.

Cost Avoidance Procedures for Point of Service Users

Effective July 1, 2002, providers must begin asking all Medicaid patients if they have pharmacy insurance coverage in addition to the coverage provided by Medicaid. When pharmacy insurance coverage is identified (or previously known to the provider), the provider will be expected to bill the insurance carrier prior to submitting a claim to Medicaid.

Effective October 1, 2002, point of service (POS) will be modified to deny payment when a member has pharmacy insurance coverage on Indiana*AIM*, but no TPL payment has been indicated in the *TPL field* of the claim. To support this change the follow changes to POS will also be made:

- When a claim is denied because a member has pharmacy insurance coverage, POS will return the other insurance carrier's name, policy number, and coverage type. Prior to October 1, 2002, the only way a provider knows if a member has insurance is to ask the member or by using one of several eligibility verification processes currently available to providers (see *Chapter 3* of the *IHCP Provider Manual*).
- Override codes will be available for providers to use that will allow providers to override the TPL claim denial in certain situations. These override codes will allow the provider to communicate, via POS, the reason why the provider could not collect from a third party insurer.

TPL override codes will be available when submitting POS claims for both the NCPDP 5.1 and 3.2C formats. When an override code is used, it will override the TPL edit and allow payment of the claim.

The NCPDP 3.2C version allows override codes in the Other Coverage Code field. Valid codes are as follows:

- *2 = Other coverage exists – payment collected* – Use of this code is optional since a valid payment amount entered in *TPL field* will automatically override the TPL edit and allow payment of a claim.
- *3 = Other coverage exists – this claim not covered* – This code should be used to communicate non-coverage for a variety of reasons. The member's coverage may have been terminated, the service billed could be outside of the member's scope of coverage, or the member may have exceeded their annual benefit limitation.

- *4 = Other coverage exists – payment not collected* – This code may be used to communicate any other valid reason for non- payment (such as managed care related denials).

The NCPDP 5.1 override codes are as follows:

- *2 = Other coverage exists – payment collected*- This code is optional for the same reason as noted in 2 above.
- *3 = Other coverage exists – this claim not covered*- Similar to 3 above, this code should be used to communicate non-coverage when the service billed is outside of the member's scope of coverage, or the member exceeded their annual benefit limitation.
- *5 = Managed care plan denial*- This code should be used to communicate any denial that is associated with a managed care TPL plan.
- *6 = Other coverage denied – not a participating provider*- This code should used if the claim is denied by the insurer because the provider dispensing the drug or the provider prescribing the drug is not part of the insurer's network.
- *7 = Other coverage exists – not in effect at this time of service*- Providers should use this code when an insurer denies a claim because the policy is no longer in effect on the date of service.

> *Note: While override code 8 (claim billing is for co-pay) is available on NCPDP 5.1, providers must not use this code. Providers must continue to use the NDC code 99999-9999-11 when billing for member co-payments.*

Cost Avoidance Procedures for Batch Claims Submission Users

Effective July 1, 2002, prior to submitting a claim to Medicaid, the provider must determine whether the member has TPL pharmacy coverage. The provider can use one of several eligibility verification options available to make this determination. Similar to the instructions for POS billers, when TPL is identified, the provider must bill the pharmacy insurance carrier before submitting the claim to Medicaid. However, unlike POS, the batch billing electronic format does not allow the use of override codes. Because of this, claims will not auto-deny if the provider fails to show a TPL collection amount on the claim. This does not relieve the provider's responsibility to bill the pharmacy insurance carrier when appropriate.

Providers must maintain documentation to demonstrate that a claim was filed with the pharmacy insurance carrier and the final disposition of the claim (for example paid, denied, or no response). The State will monitor pharmacy cost avoidance compliance. If it appears that providers who use the batch claim submission process are routinely disregarding the cost avoidance requirement, the State will be forced to deny all claims that fail to include a dollar amount in the *TPL field* when a member is

known to have TPL pharmacy coverage. Providers would then be required to submit paper claims along with copies of the denial notice from the insurance carriers.

Cost Avoidance Procedures for Paper Billers

Like POS and Batch Claim Submission users, providers who submit claims on paper will also be required to bill the pharmacy insurance carrier prior to submitting the claim to Medicaid.

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 EOB from the other carrier denying the claim. If a provider submits a paper claim with nothing in the *TPL field*, no EOB attachment, and the member has pharmacy TPL, the claim will deny and the EOB message will be *Recipient covered by private insurance*.

Additional Information

- Claims will bypass the TPL edit if the pharmacist bills up to a four-day supply with an emergency indicator.
- Over-the-counter (OTC) prescriptions are excluded from cost avoidance because most other insurance carriers do not cover OTC drugs.
- Supplies and durable medical equipment are excluded from cost avoidance because most commercial plans do not cover these items under a pharmacy benefit package.
- Pharmacy claims with a pregnancy indicator will bypass TPL edits per Federal requirements.
- Questions concerning the accuracy of TPL information on Indiana*AIM*, should be directed to the Medicaid TPL Unit at (317) 488-5046 locally, or 1-800-457-4510.

Prospective Drug Utilization Review Alerts

The IHCP's online Pro-DUR process includes several point-of-sale alerts that prompt pharmacy providers to scrutinize aspects of a prescription being dispensed. When an alert is activated, the pharmacy provider is required to respond before the transaction can proceed. Indiana*AIM* currently allows a provider to override the alert and continue with the transaction. Observation of alert overrides indicates that the ease with which a provider is able to override an alert may contribute to decreased scrutiny of prescription claims and the medical conditions for which they are prescribed. This situation could potentially lead to adverse health outcomes for patients, inappropriate billing activities, unnecessary expenditures, or other undesirable results.

The IHCP's online Pro-DUR system alerts will be modified as follows:

Early Refill

An early refill is defined as a request for refill on a medication at a time when the patient is expected to still possess at least 25 percent of a previously dispensed supply of the same medication. The Early Refill alert currently applies to Calcium Channel Blockers, Oral Hypoglycemics, Narcotic Analgesics, and Xanthines.

Effective immediately, the Early Refill alert will be applied to all drugs. Effective July 1, 2002, claims that post the Early Refill alert at the POS will be denied. Pharmacists will not be permitted to override the alert unless prior authorization (PA) is obtained. PA will not be granted unless an extenuating circumstance exists to substantiate the need for an early refill of the drug. Pharmacists will be allowed to request PA for override of an Early Refill alert.

The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Indiana Medicaid Drug Utilization Review Board, will review the override rate of the Early Refill alert, as well as the types of drugs that post the alert to determine the need to except specific drugs from point-of-sale claim denial and allow a pharmacist to override the alert. Providers will be notified separately of any exceptions to the Early Refill override policy.

High Dose

A high dose is defined as a dosage that exceeds the recommended dosage, based on criteria published by First DataBank. The High Dose alert currently applies to Calcium Channel Blockers, NSAIDS, Oral Hypoglycemics, and Anti-Anxiety Agents.

Effective immediately, the High Dose alert will be applied to all drugs. Effective July 1, 2002, claims that post the High Dose alert at the POS will be denied. Pharmacists will not be permitted to override the alert unless PA is obtained. PA will not be granted unless an extenuating circumstance exists to substantiate the need for a high dosage of the drug.

The OMPP, in conjunction with the Indiana Medicaid Drug Utilization Review Board, will review the override rate of the High Dose alert, as well as the types of drugs that post the alert to determine the need to except specific drugs from POS claim denial and allow a pharmacist to override the alert. Providers will be notified separately of any exceptions to the High Dose override policy.

Therapeutic Duplication

Therapeutic duplication is defined as the use or prescribing of two or more drug products of the same therapeutic class, based on criteria published by First DataBank. The Therapeutic Duplication alert currently applies to Phenothiazines, ACE Inhibitors, NSAIDS, Calcium Channel Blockers, Narcotic Analgesics, H2-Antagonists, and Antidepressants.

Effective July 1, 2002, the Therapeutic Duplication alert will also (i.e., in addition to those drugs listed above) be applied to Cardiovascular Agents, Diuretics, Alpha and Beta Blockers, Anti-Lipidemics, Anti-Infectives, and Non-Narcotic Analgesics. In

addition, claims that post the Therapeutic Duplication alert at the POS will be denied. Pharmacists will not be permitted to override the alert unless PA is obtained. PA will not be granted unless an extenuating circumstance exists to substantiate the need for multiple products of the same therapeutic class, or where one of the drugs has actually been discontinued.

Drug-Drug Interaction

A drug-drug interaction occurs when a patient has been prescribed two or more products that are contraindicated for simultaneous use and may result in serious harm or death for the patient. Currently, the Drug-Drug Interaction alert applies to Severity Level 1 interactions.

Effective July 1, 2002, claims that post the Drug-Drug Interaction alert at the POS will be denied. Pharmacists will not be permitted to override the alert unless PA is obtained. PA will not be granted unless an extenuating circumstance exists to substantiate the need to dispense products that are contraindicated for simultaneous use, or where one of the drugs has actually been discontinued.

In instances where PA cannot be immediately obtained, *42 U.S.C. § 1396r-8* provides for the dispensing of a 72-hour supply of a covered prescription drug in an emergency situation. Pharmacists that dispense a 72-hour supply of a covered prescription drug will be reimbursed by IHCP if, subsequent to dispensing in an emergent situation, indication is made on the claim that the supply was for an emergency need.

34-Day Supply Limit for Non-Maintenance Medications

Effective July 1, 2002, IHCP will prohibit dispensing certain drugs, not typically prescribed for on-going maintenance, in quantities greater than 34-days supply. Specifically, dispensing of covered drugs listed in Table 1.1, below, will be limited to a 34-day supply per dispensing.

A transaction exceeding a 34-day supply of a medication listed in Table 1.1 will be denied unless PA is obtained. PA will not be granted unless an extenuating circumstance exists to substantiate the need dispense greater than 34-days supply of the product. Pharmacists will be allowed to request PA for quantities that exceed a 34-day supply.

In instances where PA cannot be immediately obtained, a pharmacist may dispense a 72-hour supply of a covered prescription drug and will be reimbursed by IHCP if, subsequent to dispensing in an emergent situation, indication is made on the claim that the supply is for an emergency need. A pharmacist is also permitted to reduce the quantity that is dispensed to comply with the 34-day supply limitation.

While the primary goal of the IHCP is to ensure adequate and efficient supplies of prescription drugs to treat a patient's medical condition, the new policy is intended to reduce the volume of wasteful and/or unnecessary pharmacy services, fostering increased efficiency, and ensuring appropriate attention to overuse of medications.

Table 1.1

Drugs in the following therapeutic classes may not be dispensed in quantities greater than 34 days
Acidifying Agents
Adrenocortical Insufficiency
Alkalinizing Agents
Amebicides
Aminoglycosides
Ammonia Detoxicants
Amyloidosis
Androgens
Antacids and Adsorbents
Anthelmintics
Antibiotics
Antibiotics
Anticholinergic Agents
Antidiarrhea Agents
Antiemetics
Antiflatulents
Antifungal Antibiotics
Antifungals
Antifungals
Antiheparin Agents
Anti-Inflammatory Agents
Anti-Inflammatory Agents
Antimuscarinics/Antispasmodics
Antineoplastic Agents
Antipruritics and Local Anesthetics
Antithyroid Agents
Antitreponemal Agents
Antitrichomonal Agents
Antitussives
Antivirals
Antivirals

(Continued)

Table 1.1

Drugs in the following therapeutic classes may not be dispensed in quantities greater than 34 days
Astringents
Autonomic Drugs
Barbiturates
Basic Lotions and Liniments
Basic Oils and Other Solvents
Basic Ointments and Protectants
Basic Powders and Demulcents
Benzodiazepines
Blood Derivatives
Blood Volume
Brucellosis
Calcium-Removing Resins
Caloric Agents
Carbonic Anhydrase Inhibitors
Cardiac Function
Cathartics and Laxatives
Cell Stimulants and Proliferants
Cephalosporins
Chloramphenicol
Cholelitholytic Agents
Circulation Time
Coagulants
Dental Agents
Depigmenting Agents
Detergents
Digestants
Diphtheria
Drug Hypersensitivity
Emetics
Enzymes
Expectorants
Fungi

(Continued)

Table 1.1

Drugs in the following therapeutic classes may not be dispensed in quantities greater than 34 days
Gallbladder Function
Gastric Function
Gastrointestinal Smooth Muscle Relaxants
General Anesthetics
Genitourinary Smooth Muscle Relaxants
Gold Compounds
Gonadotropins
Heavy Metals Antagonists
Hematopoietic Agents
Hemorrheologic Agents
Hemostatics
Intestinal Absorption
Irrigating Solutions
Keratolytic Agents
Keratoplastic Agents
Kidney Function
Lipotropic Agents
Liver Function
Local Anesthetics
Local Anesthetics
Lymphogranuloma Venereum
Macrolides
Miotics
Misc. Anxiolytics, Sedatives and Hypnotics
Misc. Skin and Mucous Membrane Agents
Miscellaneous Analgesics and Antipyretics
Miscellaneous Antibiotics
Miscellaneous Anti-Infectives
Miscellaneous Anti-Infectives
Miscellaneous Autonomic Drugs
Miscellaneous B-Lactam Antibiotics
Miscellaneous EENT Drugs

(Continued)

Table 1.1

Drugs in the following therapeutic classes may not be dispensed in quantities greater than 34 days
Miscellaneous GI Drugs
Miscellaneous Local Anti-Infectives
Miscellaneous Psychotherapeutic Agents
Mouthwashes and Gargles
Mucolytic Agents
Mumps
Myashtenia Gravis
Mydriatics
Opiate Agonists
Opiate Antagonists
Opiate Partial Agonists
Other Corpus Luteum Hormones
Oxytocics
Pancreatic Function
Parasympathomimetic (Cholinergic Agents)
Parathyroid
Penicillins
Pharmaceutical Aids
Phenylketonuria
Pheochromocytoma
Pigmenting Agents
Pituitary Function
Pituitary Function
Potassium-Removing Resins
Quinolones
Radioactive Agents
Respiratory and Cerebral Stimulants
Roentgenography
Scabicides and Pediculicides
Scarlet Fever
Sclerosing Agents
Serums

(Continued)

Table 1.1

Drugs in the following therapeutic classes may not be dispensed in quantities greater than 34 days
Skeletal Muscle Relaxants
Sodium-Removing Resins
Sulfonamides
Sulfonamides
Sulfones
Sunscreen Agents
Sweating
Sympatholytic Adrenergic Blocking Agents
Tetracyclines
Thrombolytic Agents
Thyroid Function
Toxoids
Tranquilizers
Trichinosis
Tuberculosis
Uricosuric Agents
Urinary Anti-Infectives
Vaccines
Vasoconstrictors
Vitamin A
Vitamin B Complex
Vitamin C
Vitamin D
Vitamin E
Vitamin K Activity