27

27 Pharmacy

The Alabama Medicaid Agency pays for certain legend and non-legend drugs that meet both of the following criteria:

- Prescribed by medical doctors and other practitioners including, but not limited to, nurse practitioners, dentists, and optometrists who are legally authorized to prescribe these drugs
- Dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws

The policy provisions for Pharmacy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

27.1 Enrollment

HP enrolls Pharmacy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a pharmacy provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for pharmacy related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Pharmacy providers are assigned a provider type of 24 (Pharmacy). Valid specialties for Pharmacy providers include the following:

- Government Pharmacy 241
- Institutional Pharmacy 242
- Retail Pharmacy 240

Enrollment Policy for Pharmacy Providers

To participate in the Alabama Medicaid Program, Pharmacy providers must meet the following requirements:

- Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered.
- Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information.
- Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files, recipient signature logs, and invoices must be available for examination.
- Agree that Medicaid or its designated representative may conduct audits of required records as necessary. Invoice records must be maintained and readily available for inspection.

Out-of-State Pharmacies

Under State and Federal regulations, a pharmacy must sign an agreement with Alabama Medicaid Agency. However, when a recipient is in another state and requires service, the following procedure has been adopted.

Pharmacies Bordering Alabama

- Pharmacies bordering Alabama may participate in the Alabama Medicaid Program by completing an application for out-of-state pharmacies, and upon certification of the State Board of Pharmacy in that state that the pharmacy is registered and has been issued a permit.
- The pharmacy must then sign a Pharmacy Vendor Agreement with Alabama Medicaid Agency and agree to abide by the State pharmacy provider tax law.
- Pharmacies bordering Alabama are defined as those pharmacies located not more than 30 miles from the border of Alabama.

Pharmacies Not Bordering Alabama

- Drugs dispensed must be in concurrence with the limitations in place for in-state providers.
- Reimbursement will be made only for hemophilia products and specialty drugs which are not readily available in-state, and drugs dispensed to Medicaid recipients who may be traveling outside the state of Alabama.
- Providers of specialty drugs shall list the names of the drugs for which they intend to request reimbursement as well as the GCN or NDC numbers for each drug in the letter requesting enrollment with the Alabama Medicaid Agency.
- Pharmacies not bordering Alabama will be enrolled by the Medicaid fiscal agent on a temporary basis.
- Pharmacies not bordering Alabama are defined as those pharmacies located more than 30 miles from the border of Alabama.

27.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid pays for approved drug items when they are properly prescribed for eligible Medicaid recipients and dispensed in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

The number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to four brand name drugs per month per recipient. In no case can total brand name prescriptions exceed ten per month per recipient. There is no limit on generic and covered over-the-counter prescriptions. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

Brand name anti-psychotic and anti-retroviral agents may be paid up to ten prescriptions per month but in no case can total brand name prescriptions exceed ten per month per recipient.

Coverage of up to ten brand name prescriptions per month may be allowed through overrides for drugs classified by American Hospital Formulary Services (AHFS) or First Data Bank (FDB) Therapeutic Class as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Miscellaneous Vasodilating Agents, Miscellaneous Cardiac Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, -Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents, Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Amylinomimetics, Biguanides, Dipeptidyl Peptidase-4 Inhibitors, Incretin Mimetics, Insulins, Meglitinides, Sulfonylureas, Thiazolidinediones and Miscellaneous Diabetic Agents. Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the above named classes to a brand name product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid.

Medicaid will not compensate pharmacy providers for:

- DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act
- Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency
- Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency
- Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency

- Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency
- Agents when used to promote smoking cessation, unless authorized for pregnant females.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency
- Nonprescription drugs except for those specified by the Alabama Medicaid Agency
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Barbiturates and Benzodiazepines except for those specified by the Alabama Medicaid Agency
- Agents when used for the treatment of sexual or erectile dysfunction unless prior approved through medical necessity.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 16 for drugs not covered by Alabama Medicaid.

Unit Dosing in Nursing Facilities

Covered drug items may be dispensed to recipients, using an approved unit dose system for solid oral forms of the prescribed drug. Only one claim per drug per recipient may be submitted each month by any pharmacy using an approved unit dose system. Only the amount of the prescribed drug actually consumed by the patient may be billed.

Each dose of a drug dispensed using an approved unit dose system must be individually packaged in a sealed, tamper proof container and carry full disclosure labeling, including, but not limited to, product name and strength, manufacturer's or distributor's name, lot number and expiration date.

Prescriptions for controlled drugs must be filled or dispensed from a signed original or direct copy of the physician's prescription order.

27.2.1 Prescription Requirements

Medicaid reimburses for prescriptions documented and dated appropriately for legend and over-the-counter drugs covered by Medicaid.

Schedule II drug prescriptions require the manual signature of the prescribing physician before dispensing. Stamped or typewritten signatures are not acceptable. In accordance with the Code of Federal Regulations, § 1306.05, all prescriptions for schedule II substances shall be dated and signed by the prescribing physician the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name and address and registration number of the practioner.

Prescriptions dispensed by telephone for drugs other than Schedule II drugs are acceptable without subsequent signature of the practitioner.

Pharmacy providers should document any changes to the original prescription, such as physician approved changes in dosage, on the original prescription.

The pharmacy may refuse to accept Medicaid reimbursement for a Medicaid-covered item and bill the recipient as a regular paying patron if the provider informs the recipient prior to dispensing the prescription. The recipient has the right to have the prescription filled by any other authorized Medicaid pharmacy.

Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term “written prescription” does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

- If a written prescription is received which is not on a tamper-resistant prescription blank, the pharmacy must contact the prescribing provider and either have the prescription re-submitted in compliant written form or convert the prescription, where otherwise allowable, into verbal, faxed or electronic form.

- In an emergency situation where the pharmacy is unable to contact the prescribing provider, the pharmacy may choose to fill the prescription from the non-compliant form and subsequently obtain a prescription in compliant form. If a compliant prescription cannot be obtained within 72 hours, the pharmacy must withdraw the claim.

- To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

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

- To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

Effective May 1, 2008, an override will be required for a brand name drug with an exact generic equivalent submitted with a Dispense as Written code of 1. In this case, the provider must provide documentation of the medical necessity for the brand name, rather than the available generic equivalent and receive an override. This override applies to those instances where the prescriber has written a prescription for a brand name drug when a pharmaceutically and therapeutically equivalent drug product is available generically. Exclusions to this process include carbamazepine, levothyroxine, phenytoin, and warfarin. Overrides may be completed and faxed or mailed to the Pharmacy Administrative Services contractor, currently Health Information Designs.

27.2.2 Appropriate Utilization of Dispense As Written (DAW) Codes

Dispense As Written (DAW) product selection codes are an integral part of accurate billing to the Alabama Medicaid Agency and provide the agency with the reason why a specific brand or generic is dispensed based on the prescriber's instructions. Failure to accurately use DAW codes results in misinformation to the Pharmacy program and its decision making process. Misinformation on claims may also result in retrospective pharmacy review and/or recoupment. Inaccurate usage of DAW codes is among one of the discrepancies found during an audit and is one of the Primary Pharmacy Audit Components listed in the Provider Billing Manual Section 27.2.5. The following codes are the various DAW codes available to the Alabama Medicaid Pharmacy program with explanations that have been taken from the National Council on Prescription Drug Programs (NCPDP) version 5.1 data dictionary for field 408-D8 Product Selection Codes. Providers should utilize the correct codes based upon the information submitted on the prescription and the prescriber's signature:

- **0=No Product Selection Indicated-**This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

- **1=Substitution Not Allowed by Prescriber**-This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

- **2=Substitution Allowed-Patient Requested Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. *(Not permitted by Alabama Medicaid)*

- **3=Substitution Allowed-Pharmacist Selected Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

- **4=Substitution Allowed-Generic Drug Not in Stock**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

- **5=Substitution Allowed-Brand Drug Dispensed as a Generic**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.

- **6=Override** *(Not permitted by Alabama Medicaid)*

- **7=Substitution Not Allowed-Brand Drug Mandated by Law**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

- **8=Substitution Allowed-Generic Drug Not Available in Marketplace**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. *(In the event of an audit, provider shall make available documentation to validate product unavailability).*

- **9=Other** *(Not permitted by Alabama Medicaid)*

To indicate instructions to the dispensing pharmacy, a physician simply signs the prescription in a manner specified by prevailing law to indicate to a providing pharmacy whether or not generic substitution is allowed. Effective May 1, 2008 an override form and Medwatch 3500 form is required in order to medically justify a provider's reason for requesting a branded product when an exact generic equivalent is available. DAW overrides and the Medwatch 3500 form should be submitted to the Pharmacy Prior Authorization contractor.

27.2.3 Quantity Limitations

Claims must be submitted in the units specified on the prescription by the prescribing physician up to a 34 day supply. Medications supplied in a dosage form that would prevent the dispensing of an exact 30-34day supply for chronic medications, such as insulin, may require quantities that exceed the 34 day maximum and would not be subject to recoupment as long as the pharmacist can provide appropriate documentation.

Pharmacies may not split a 34 day supply into small units and submit them as separate claims.

A pharmacist should not change quantities (units) of drugs prescribed by a physician except by authorization of the physician. The pharmacist must contact the prescribing physician for authorization to reduce the quantity of any Medicaid prescription and note physician authorization on the prescription form.

If the prescription to be paid by Medicaid exceeds the limit, the pharmacist must request an override for the prescribed quantity. If the override is not approved, then the excess number above the limit is noncovered and the pharmacist can charge the recipient for that amount in excess of the Medicaid limit.

NOTE:
A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

If the full quantity prescribed is not available at the time of dispensing, the pharmacist may dispense the quantity available. In this case the pharmacist must note on the prescription the number of units dispensed and retain the claim until the balance of medication is dispensed. Only one claim with one dispensing fee may be billed.

27.2.4 Prescription Refill

Prescriptions cannot exceed eleven refills for non controlled prescriptions and five refills for Control III-V prescriptions. Medicaid will deny claims for prescription refills exceeding eleven for non controlled prescriptions and five for Control III-V prescriptions. Prescriptions may be refilled only with the prescribing provider’s authorization. Failure of the prescribing provider to designate refills on a prescription will be interpreted as no refills authorized. If a prescription is refilled, the date the prescription is refilled must appear on the prescription.

Pharmacy providers should refill all prescriptions only in quantities corresponding to dosage schedule and refill instructions.

The use of automatic refills by pharmacies is not allowed by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient’s authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within sixty days.

Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

Early Refills

Pharmacies should not dispense refill medication to recipients until the recipient has used at least 75% of the original supply. Pharmacists must document on the original prescription that the prescribing physician was consulted and the physician approved dispensing early refills.

NOTE:

Medicaid may recoup payments for early refills.

Health Information Designs (HID) is contracted with the Alabama Medicaid Agency to assist pharmacists receiving hard denials, such as early refills, therapeutic duplication and excessive quantity. Pharmacies must receive an override from HID before payment will be made. **Contact HID at 1 (800) 748-0130**. Only HID can issue the necessary override.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the patient will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

27.2.5 Reimbursement for Covered Drugs and Services

This section describes reimbursement for multiple source drugs, over-the-counter medications and other drugs, dispensing fees, vaccine administration and pricing.

Multiple Source Drugs

Medicaid reimbursement for covered multiple source drugs will not exceed the lowest of the:

- Federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS, plus a reasonable dispensing fee
- Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee
- Provider's Usual and Customary Charge to the general public for the drug

- Alabama State Maximum Allowable Cost (MAC) defined as the Average Acquisition Cost of a drug multiplied by 1.0 plus a reasonable dispensing fee that will apply to all multisource drugs within a particular drug grouping.

NOTE:

AEAC is defined the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%.

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases, the provider must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

Prescription Compounding

Alabama Medicaid pays for prescription drugs through the billing of NDCs. Pharmacists may dispense compounded medications when prescribed and can bill for each ingredient with a valid NDC on a single claim.

Pharmacists may also bill for the time spent compounding the medication if approved by Medicaid or its Contractor prior to dispensing. One or more of the legend ingredients within the compounded medication must be a covered ingredient with a valid NDC in order for the pharmacist to bill Medicaid for the time spent compounding the medication. The finished compound must not be available as a legend or over-the-counter product in an equivalent dosage form/route of administration. Compounded products are subject to review, must meet medical criteria and may require peer-reviewed medical literature before being covered. Compounding time approval requests should be referred to HID at 1(800) 748-0130. Reimbursement will be calculated by the minute and will not exceed a maximum monthly amount. Pharmacists must bill utilizing NDC 99999-9999-99, 99999-9998-88 or 99999-9997-77 for the minutes expended compounding.

In addition, if one or more NDC's on a compound transaction are noncovered, the entire claim will reject. Pharmacists submitting a compound claim will need to include an 8 as the submission clarification code. Instead of rejecting the entire transaction, this code value of 8 should be specified to pay the remaining NDC's that are covered by Alabama Medicaid. Pharmacists will receive one dispensing fee for the transaction. Please ensure that any compounding performed is consistent with Public Law 105-115.

Other Drugs

Reimbursement for covered drugs other than multiple source drugs will not exceed the lower of the Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee, OR the provider's Usual and Customary Charge to the general public for the drug. For blood clotting factor products, Medicare Part B Drug pricing plus a reasonable dispensing fee is utilized.

Dispensing Fees

A reasonable dispensing fee is set by the Agency. The fee is reviewed periodically for reasonableness and, when deemed appropriate by

Medicaid, may be adjusted. The dispensing fee paid by the agency effective September 22, 2010 is $10.64.

Only one dispensing fee is allowed for a 34 day supply of the same drug per month unless the recipient qualifies for an “early refill”. To qualify for an “early refill”, the recipient must have used 75% of the original supply or there is a documented consultation with the prescribing physician authorizing the refill.

Over-the-Counter Medications (OTCs)

Medicaid pays for certain OTCs through the Medicaid pharmacy program. OTCs dispensed to an eligible Medicaid recipient may be submitted for payment by utilizing the appropriate NDC number.

Over-the-counter medications require a prescription from a physician or other practitioner legally licensed by the State of Alabama to prescribe the drugs authorized under the program. Telephone prescriptions are acceptable for OTCs.

Long term care facilities may bill OTC insulins covered by the Medicaid pharmacy program by submitting for payment the NDC number utilized. All other OTCs should be billed by the nursing facility using the facility cost report.

If a prescribing physician writes a prescription that requires a pharmacist to break a bottle of medication, the pharmacist should bill Medicaid for the package size closest to the amount actually dispensed. For example, a bottle of ibuprofen is packaged with 100 tablets at a cost of $4.50. A recipient has a prescription for 90 tablets. The pharmacist should break the bottle, dispense 90 tablets, and bill $4.50.

Do not dispense more medication than indicated on the prescription unless authorized by the prescribing physician to do so.

Medicaid will reimburse for covered OTCs as stated under Multiple Source Drugs.

Non-Drug Items

Alabama Medicaid Agency reimburses for certain non-drug items, including but not limited to spacers, syringes, and tablet splitters, through the pharmacy program with a valid prescription and NDC number. Other supplies such as blood glucose testing strips and lancets may be billed through Durable Medical Equipment. Please refer to chapter 14.2 for complete information.

Vaccine Administration

Alabama Medicaid will reimburse Medicaid-enrolled pharmacy providers for the administration of the influenza, Tdap and pneumococcal vaccines for eligible recipients age 19 and older. Pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration: NDC 99999-9999-10 for seasonal influenza vaccine administration, NDC 99999-9992-11 for pneumococcal vaccine administration, and NDC 99999-9993-11 for Tdap vaccine administration.

Reimbursement will be $5 per administration with no dispensing fee or co-pay applied. Claims should be submitted with a dispense quantity of 1 for

vaccine administration. There is a maximum quantity for each administration of 1 injection per recipient within a timeframe in accordance with the CDC dosing regimen.

A prescription from a recipient's Primary Medical Provider (PMP) is required for each Tdap and pneumococcal vaccine administration. To facilitate coordination of care, Pharmacy providers are required to inform (via phone, fax, email, mail) each recipient's PMP upon administration of any vaccines for which an administration claim is submitted. Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) at 1-800-727-7848 to obtain the PMP information. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website.

Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.

Total Parenteral Nutrition

Alabama Medicaid Agency may reimburse for total parenteral nutrition (TPN) through the pharmacy program if the order/prescription and recipient meets certain requirements. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN) and intraperitoneal nutrition (IPN). Please refer to chapters 35.2 and 28.2 for complete information.

340 B Pricing

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage. Eligible entities are as follows:

- Federally qualified health centers
- Health centers for residents of public housing funded under section 340A of the Public Health Services Act, (42 U.S.C. 256a.)
- Family planning projects received grants or contracts under section 1001 of the Public Health Services Act, (42 U.S.C. 300.)
- An entity receiving a grant for outpatient early intervention services for HIV disease under subpart II of part C of title XXVI of the Public Health Services Act, (42 U.S.C. 300ff -51 et seq.)
- A State-operated AIDS drug purchasing assistance program receiving financial assistance.
- A black lung clinic receiving funds.
- A comprehensive hemophilia diagnostic treatment center receiving a grant.
- A native Hawaiian Health Center receiving funds.
- An urban Indian organization receiving funds.
- Any entity, certified by the Secretary, receiving assistance under title XXVI of the Public Health Services Act,

(42 U.S.C. 300ff et seq.)
- Any entity, certified by the Secretary, receiving funds relating in the treatment of sexually transmitted disease.
- A "disproportionate share" hospital as defined in section 1886 (d)(1)(B) of the Social Security Act.

When an eligible entity submits a bill to the Medicaid Agency for a drug purchase by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency. Covered entities are identified to Medicaid by the Department of Health and Human Service. These entities will be notified by Medicaid of their designation as a Veteran's Health Care Act provider. These providers are required to bill at actual invoice cost plus dispensing fee. As manufacturer price changes occur, providers must ensure that their billings are updated accordingly.

Audits of the eligible entities' claims submissions and invoices will be conducted by the Medicaid Agency. Providers must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency.

27.2.6 Primary Pharmacy Audit Components

The following information serves as a general guide to the components of a Medicaid Pharmacy Audit. Although the list provided may not be all-inclusive, it covers approximately 95% of discrepancies found through on-site and desk review audits. Questions regarding this information may be directed to Medicaid at (334) 242-5734.

- **DAW Audits** - Use of the Dispense As Written (DAW) codes will be audited on a regular basis to ensure correct billing.
- **Usual & Customary (U&C)** - For specified products, submitted charge will be compared to cash price to general public. Adjustments may be initiated.
- **Inaccurate Billing** - The NDC number of the product actually dispensed should be billed. The NDC number is package size and manufacturer specific. Days supply should be clinically appropriate according to prescription or physician’s instructions.
- **Multiple Dispensing Fees** - Providers must have documentation to include call-in and hard copy prescriptions to support the multiple dispensing of the same product, same strength to the same patient within a 30 day period.
- **Drug Name, Form Strength & Quantity Differs From Prescription –** On CII prescriptions, the prescribing physician must authorize all changes from the original prescription before dispensing. Any change must be documented on the prescription.

- **Requirements for Signatures and Prescriptions** - Schedule II products require original prescription and signature. Other drugs may be called in without the subsequent signature of the physician as allowed by State law.
- **Tamper Resistant Prescriptions** - Prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. Non-compliant prescriptions will result in recoupments.
- **Changing Claim Information to Force Payment** - The system recognizes and denies exact duplicates. Providers may not alter NDC number, date of service, prescription number, or any other claim requirement to force payment through duplicate edits.
- **Timely Prescription Reversal-** If a patient or a patient's authorized representative has not picked up his/her prescription within sixty (60) days, the pharmacy is required to reverse the claim and credit Medicaid the amount originally billed.
- **Total Parenteral Nutrition (TPN)-** TPN prescriptions/orders include those used for hyperalimentation intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). A certification statement of medical necessity must be written or stamped on the prescription/order, or accompany all TPN prescriptions/orders.

Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Alabama Attorney General's Office for investigation of fraud.

27.2.7 Drug Utilization Review (DUR)

The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.

This section contains information about the components of the DUR Program:

- General Information
- Prospective Drug Utilization Review (Pro DUR)
- Online Drug Utilization Review (Online DUR)
- National Council for Prescription Drug Programs (NCPDP) Standards
- Retrospective Drug Utilization Review (Retro DUR)

General Information

The DUR Program uses educational tools directed to physicians and pharmacists in order to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care by addressing:

- Potential and actual drug reactions
- Therapeutic appropriateness
- Over-utilization
- Under-utilization

- Appropriate use of generic products
- Therapeutic duplication
- Drug/disease contraindications
- Drug interactions
- Incorrect drug dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

The DUR Program reviews, analyzes and interprets patterns of drug usage against standards consistent with the American Medical Association Drug Evaluations, United States Pharmacopoeia Drug Index, American Hospital Formulary Service Drug Index, and peer reviewed medical literature.

DUR will be conducted for drugs dispensed to residents of nursing facilities.

NOTE:

Pharmacists should refer cases of possible fraud or abuse to the Medicaid Program Integrity Division. Information may be provided through the Medicaid Agency's Fraud hotline by calling 1(866) 452-4930. Calls may be made anonymously.

Prospective DUR

Prospective DUR (Pro-DUR) is required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include screening, patient counseling, and use of patient profiles.

Pro-DUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement for participation in the program.

Online DUR

Medicaid provides an online system to assist the dispensing pharmacist. Incoming drug claims are compared to the patient's medical and pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for significant problems discovered by this review.

Potential problems identified include:

- Therapeutic duplication – Examples of therapeutic duplication, involving overlapping periods of time where such therapy is not medically indicated, include:
  - Two or more doses of the same drug
  - At least two drugs from the same therapeutic class
  - At least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication
- Drug/Disease contraindications
- Drug interactions

- Incorrect dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse or misuse
- Preferred drug status

Medicaid distributes criteria and standards to providers in Medicaid Provider Notices and Bulletins.

Pharmacists must respond to prospective DUR alerts to continue claims processing through HP.

Pharmacies without computers must screen based on guidelines provided by the Alabama State Board of Pharmacy Practice Act and criteria and standards endorsed by Medicaid's DUR Board.

National Council for Prescription Drug Programs (NCPDP) Standards

Pharmacy claim telecommunication standards dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert. Displaying these fields to the pharmacist facilitates communication when health care providers discuss the potential therapeutic problems discovered by online prospective DUR.

This section explains DUR fields and information, lists standard response fields and codes, shows example DUR alert messages, and lists DUR alerts in order of priority.

Field Name	***Information Displayed in the Field***
Conflict Code	Alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria ER = Early Refill TD = Therapeutic duplication DD = Drug Interaction EQ = Excessive Quantity
Clinical Significance/Severity Index Code	Indicates database-assigned significance of the conflict. 0 = Not applicable 1 = Major 2 = Moderate 3 = Minor
Other Pharmacy Indicator	Informs the pharmacist of the originating location of the claim with which the incoming drug claim conflicts. 0 = Not applicable 1 = Your Pharmacy 3 = Other Pharmacy
Previous Date of Fill	The last recorded date of the active medication in the patient's history file with which the incoming drug claim conflicts.
Quantity of Previous Fill	Quantity of previously filled prescription with which the incoming drug claim conflicts
Database Indicator	Identifies source of DUR conflict information 0 = Not applicable 1 = First DataBank. 4 = Processor Developed
Other Prescriber Indicator	Identifies the prescriber of the previously filled prescription with which the incoming drug claim conflicts. 0 = Not applicable 1 = Same Prescriber 2 = Other Prescriber
Free Text Message	30-character field that transmits decoded information regarding the DUR conflict.

To respond to an alert, the pharmacist must enter the corresponding codes to describe the action taken on the alert in the response fields. For a claim that generates multiple alerts, the pharmacist's response indicates that each alert has been considered and the response should be applied to all alerts generated by this claim.

The pharmacist should respond to alerts with the appropriate conflict code. For example, enter TD for Therapeutic Duplicate in response to a therapeutic duplication alert.

Do not change any claim information such as the NDC code or Quantity unless you are indicating your change with the appropriate Outcome Codes listed in the table below**.** Changing claim information could cause your claim to deny online.

Response fields and codes are listed in the following table:

Response Field	***Response Codes***
Conflict Codes	HD – High Dose ER – Early Refill LR – Late Refill DD – Drug-Drug Interaction TD – Therapeutic Duplication PS – Product Selection
Intervention Codes	M0 – Prescriber consulted P0 – Patient consulted R0 – Pharmacist consulted other source
Outcome Codes	1A - Filled As Is, False Positive 1B - Filled Prescription As Is 1C - Filled, with Different Dose 1D - Filled, with Different Directions 1E - Filled, with Different Dose 1F - Filled, with Different Quantity 2A - Prescription Not Filled 2B - Not Filled, Directions Clarified

NOTE:

Intervention codes contain the number zero, not the letter O. Using the letter O will cause your claim to deny online.

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. Examples of standard content of DUR messages are presented below. These may differ from the message actually displayed on the pharmacist's computer screen.

Example DUR Alert Messages	
On April 2, 1998, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving welrfar in prescribed by the same physician and filled at another pharmacy:	
CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980315 (March 15, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin
On April 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:	
CONFLICT CODE:	ER - OVERUTILIZATON
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980301 (March 1, 1998)
QUANTITY OF PREVIOUS FILL:	90
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
The pharmacist attempts to dispense a refill of levothyroxine on May 15, a date equal to greater than 125 percent of previous prescription's days supply:	
CONFLICT CODE:	LR - UNDERUTILIZATION
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980401 (April 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
On May 12, the pharmacist attempts to dispense flurazepam to a patient with an active prescription for triazolam:	
CONFLICT CODE:	TD - THER. DUPLICATION
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980501 (May 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	2 = Other Prescriber
MESSAGE:	Triazolam
The pharmacist attempts to dispense acetaminophen w/codeine, three tablets every 4 hours (dose exceeds usual adult daily maximum):	
CONFLICT CODE:	HD - HIGH DOSE
DATABASE INDICATOR:	1 = First DataBank
The pharmacist attempts to dispense an NDC that is not a preferred drug.	
CONFLICT CODE:	PS - PRODUCT SELECT OPPORTUNITY
DATABASE INDICATOR:	4 = Processor Developed

The system displays up to three DUR alerts for a prescription. To access additional alerts pertaining to the prescription, the pharmacist may call the HP Help Desk at 1(800) 456-1242.

Multiple alerts on a prescription are prioritized according to the following hierarchy:

1. Drug-drug interactions
2. Therapeutic duplication
3. Overutilization (early refill)
4. Incorrect dose (high dose)
5. Underutilization (late refill)
6. Preferred drug

Retrospective DUR

The retrospective DUR Program reviews, analyzes and interprets patterns of recipient drug usage through periodic examination of claims data to

identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.

27.3 Prior Authorization and Referral Requirements

Pharmacy providers must contact Health Information Designs (HID) at 1(800) 748-0130 for overrides and prior authorization of drugs requiring prior approval. Only HID can issue prior authorizations and overrides.

HID should respond within 24 hours of receipt of requests for prior authorization and overrides. In cases of emergency, HID will make provisions for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug.

Federal Law also makes a provision for a 72-hour supply by using the following authorization number: 0000999527. This number is to be used only in cases of emergency. Utilization of this code will be strictly monitored and recoupments will be initiated when the code is found to have been used inappropriately.

27.3.1 Hemophilia Management Standards of Care

In order to be paid for providing blood clotting factor to Alabama Medicaid recipients, the provider must agree to provide, at the minimum, the following clinically appropriate items and services to their patients with hemophilia and blood clotting factor-related diseases:
(1) Home or office delivery of blood clotting factor and supplies. All shipments/delivery of clotting factor, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment.

(2) Educational materials and programs.

(a) The provider shall develop a training library at each enrolled provider location with materials for patient use, to include but not limited to, audio, video, electronic, and written materials.

(b) The provider shall offer educational materials to patient or family/caregiver at minimum at initiation of participation with the provider, yearly during the in-home assessment, and upon the request of Medicaid, the prescribing physician, or patient or family/caregiver. Topics of education shall include, but not be limited to, specific patient and family/caregiver education aimed at preventing injury that would result in a bleed, self-administration and reconstitution of blood clotting products.

(3) Medically necessary ancillary supplies required to perform the actual IV administration of clotting factor. Supplies may be billed to Medicaid through the Durable Medical Equipment (DME) program. In addition, sharps containers and any other necessary biohazardous waste containers shall be provided, as well as pickup and disposal of waste containers according to national, state and local biohazardous waste ordinances.

(4) Emergency telephone support 24 hours a day, 7 days a week to ensure patients are directed appropriately for care in emergent situations.

(5) For the purposes of this Rule and the Alabama Medicaid Agency hemophilia management standards of care, “clinical staff trained in

hemophilia and related blood clotting factor related diseases" is defined as follows:

(a) Pharmacists are required to obtain a minimum of 2 Continuing Education (CE) credit hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

(b) Nurses and social workers are required to obtain a minimum of 4 Continuing Education (CEU) hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

Continuing education must be specific to hemophilia or related blood clotting factor-related diseases and recognized by a state or national hemophilia or bleeding disorder education/support group (for example: Hemophilia Federation of America or the National Hemophilia Association).

(6) Emergency delivery of blood clotting factor within 24 (with a target of less than 12) hours of the receipt of a prescription for a covered person's emergent situation, or notification of the patient with an existing valid prescription. Emphasis should be placed during patient education of the importance of keeping an adequate supply on hand and self-administration for emergent situations.

(7) A pharmacist, nurse, and/or a case representative assigned to each patient. A case representative shall maintain, at a minimum, monthly telephone contact with the patient or family/caregiver to include, but not limited to:

-Inquiry regarding patient's current state of well-being

-Assessment of patient/family compliance/adherence, and persistence with the medical treatment plan

-Incidence of adverse events

-Incidences of supply or equipment malfunctions

-Home inventory check of factor and supplies

-Confirmation of next delivery date

Case representatives may include administrative support staff, but must coordinate with clinical staff (as described in (5) above) in the event a clinical issue should arise.

(8) Compliance programs.

(a) The provider must assess patient adherence on monthly telephone contact (see (7) above) and on all in-home visits by a pharmacist, nurse, or case manager.

(b) The provider must verify the amount of clotting factor the patient has on hand prior to each dispense. Blood clotting factor and related products are not to be sent to the patient on an auto-ship basis. The provider shall discourage "stockpiling" of product.

(c) The number of bleeds and infusions from the prior shipment shall be tracked to validate the need for additional product or non-compliance with the medical treatment plan.

(9) Notification of product recalls or withdrawals.

(a) Any stock of recalled medications/equipment/supplies shall be removed from stock and quarantined immediately.

(b) Any recalled items dispensed to patients shall be retrieved and quarantined; notification to patients must occur within 24 hours of the recall receipt.

(c) The prescribing physician shall be notified of a medication recall. A prescription for an alternative product shall be obtained, if necessary.

(10) Visiting clinical services.

(a) At minimum, an initial and subsequent yearly in-home assessment of the patient, family/caregiver, and environment shall be conducted by a nurse or pharmacist trained in blood clotting factor related diseases.

(b) Additional in-home assessments of the patient, family/caregiver, and environment deemed necessary by the physician or patient situation shall be conducted.

(c) Visits may be provided directly by the provider or by arrangement with a qualified local home health care agency. All hemophilia-related clinical staff must be trained in hemophilia and bleeding disorder related diseases.

(11) A registered pharmacist trained in blood clotting factor related diseases to perform assay to prescription management. Variance in assay to prescription/target dose should not exceed +/- 10%.

(12) Adverse drug reaction and drug interaction monitoring and reporting.

(a) Pharmacists shall counsel the patient or family/caregiver in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to encourage appropriate medication use, promote realistic therapy expectations, help recipients manage or minimize expected adverse effects and encourage compliance.

(b) Pharmacists shall report any issues or concerns related to the patient's medications to the physician. For significant events, utilization of the FDA 3500 MedWatch voluntary reporting form is encouraged.

(13) Continuation of Care. The provider shall not present any bill to or collect any monies from a covered Medicaid recipient with whom the provider has agreed to the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia, except as follows:

(a) to collect the copayments/coinsurance amounts the covered person is required to pay under the terms defined by Medicaid, or

(b) if the service/product has been deemed "non-covered" and the recipient has been notified in advance as outlined in the Alabama Medicaid Agency Administrative Code and Provider Billing Manual.

Upon discontinuation of services by the provider, the provider shall, at a minimum, coordinate for another designated health care provider to provide services to covered persons, prior to withdrawal of any hemophilia-related services from the home of any covered person. The provider shall continue to provide services and supplies to a covered individual until the individual obtains an alternate source of services and supplies. Every effort shall be made by the provider (including notification to the Medicaid Director of Pharmacy) to find an alternative provider to ensure that the coordination of care/transition follows the minimum standards of care as set forth in this document.

(14) The Alabama Medicaid Agency (or its designated representative), to ensure clinically appropriate services are being given to hemophilia patients, shall monitor providers of blood clotting factor by prospective and retrospective audits, as well as administer a patient/family/caregiver satisfaction survey to include, but not limited to, measurement of:

(a) staff availability

(b) staff knowledge

(c) timeliness of deliveries

(d) accuracy of supplies and equipment

(e) overall satisfaction

If a provider does not meet one or more of the standards for care, as outlined in this Rule, the Alabama Medicaid Agency shall provide a written notice of that determination, with an explanation therefore, to the provider. The provider will not be reimbursed for blood clotting factor or hemophilia related services until the provider meets the standards as approved by the Agency.

27.4 Cost Sharing (Copayment)

Copayment amounts vary and are described in this section. **Copayments do not apply to services provided for pregnant women, long term care (nursing home) residents, emergencies, recipients under 18 years of age, or family planning**.

Copayments do not apply to Native American Indians that present an “active user letter” issued by Indian Health Services (IHS). The provider must enter a value of ‘4’ in the prior authorization type code field indicating co-pay exemption for a Native American Indian with an active user letter.

A provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost sharing (copayment) amount imposed.

- If the physician has indicated on the prescription that the recipient is pregnant, enter “P” in the copay block.

NOTE:
Do not enter a dollar amount in the copay block.

The copayment schedule is based on the total charge amount (ingredient cost plus dispensing fee):

Pharmacy Charge	*Copay Amount*
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

NOTE:

Copayment amount should be collected on the original prescription as well as any refills.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by HP
- Automated Voice Response System (AVRS) at 1(800) 727-7848
- Contacting the HP Provider Assistance Center at 1(800) 688-7989

Appendix B, Electronic Media Claims Guidelines, provides an overview of the HP Provider Electronic Solutions software, which providers may use to verify recipient eligibility and submit claims. Instructions for requesting the software are also included in this appendix.

Providers who use a billing service may be able to verify eligibility through the billing service's software, providing the service obtained a copy of the vendor specification. Please refer to Appendix B for contact information.

Appendix L, AVRS Quick Reference Guide, provides instructions for using AVRS to verify recipient eligibility. Providers can obtain a faxed response verifying eligibility by following the instructions provided.

27.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Pharmacy providers who bill Medicaid claims electronically receive the following benefits:

- Faster claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Most pharmacy claims are submitted electronically for online adjudication. Claims filed electronically use Provider Electronic Solutions software from HP or Point of Sale proprietary pharmacy software.

NOTE:

When filing a claim on paper, an XIX-DC-10-093 pharmacy claim form is required.

Paper claims may also be filed. The pharmacist must initiate a two-part Medicaid Pharmacy Claim. The pharmacy must retain the original claim for State and audit purposes, and submit a duplicate claim to HP for payment. HP will furnish pharmacy claim forms upon request. Pharmacy claim forms can be purchased from HP for $35.44 per 1,000 forms. Claim forms will be mailed after receipt of payment.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

27.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Pharmacy providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

27.5.2 Diagnosis Codes

Diagnosis Codes do not apply when filing the pharmacy claim form.

27.5.3 Procedure Codes and Modifiers

Procedure Codes and Modifiers do not apply to Pharmacy billing.

27.5.4 Place of Service Codes

Place of service codes do not apply when filing the pharmacy claim form.

27.5.5 Required Attachments

Attachments are not required for pharmacy claims.

27.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
XIX-DC-10-093 Claim Filing Instructions	Section 5.6
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

27.7 Alabama Medicaid Pharmacy Questions and Answers (Q&A)

The Medicaid Pharmacy Q&A has been developed to provide guidance and clarification on pharmacy issues. Questions may be submitted to:

Medicaid Program Management, Fax (334) 353-7014

Responses will be published in the quarterly Medicaid Pharmacy Newsletter.

Are original prescriptions and signatures required for all drugs?

Medicaid requires original, signed prescriptions for Schedule II drugs. Schedule III, IV, and V drugs may be called in, as allowed by state pharmacy regulations.

Can I make a therapeutic or strength substitution without calling the prescribing physician?

No. Alabama State law requires the pharmacist to have the approval of the prescribing physician before dispensing anything other than what has been indicated on the prescription. If the physician has indicated product selection is allowed, the pharmacist may dispense generic substitution without subsequent contact with the physician.

What is the appropriate action when a physician writes a prescription that exceeds the Medicaid monthly dosing units?

When a prescription is denied for excessive quantity or monthly limit exceeded, claims will deny. In order to receive an override, providers (either the pharmacy or physician) should contact the HID help desk at 1(800) 748-0130 for consideration of an override.

Can I "split bill" a prescription if the prescribed quantity exceeds the maximum units allowed?

If a prescription to be paid by Medicaid exceeds the maximum unit limit allowed, the physician or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the pharmacist can charge the recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. Note: A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

How long is a prescription valid?

In accordance with state law, controlled substance prescriptions, for schedule III-V, may be refilled up to five times within six months from the original issue date. Non-controlled prescriptions are reimbursable by Medicaid for up to 12 months from the date of the original dispensing date.

Can I receive authorization for additional refills from the prescribing physician after the 12 months have expired?

No. A new prescription should be obtained after 12 months from the date of the original dispensing date. Medicaid will make payment for up to 5 refills on an original prescription for Control III-V prescriptions and 11 refills on non controlled prescriptions.

Why is it important that I bill the exact NDC number dispensed if the product is a generic?

According to the State Board of Pharmacy, pharmacies dispensing controlled substances and submitting claims with different NDC numbers would have problems with the Drug Enforcement Agency (DEA). Additionally, Medicaid provider contracts require that claims be submitted accurately. Under federal law, manufacturers rebate Medicaid for use of their drugs. When an NDC is submitted on a claim that is not the actual NDC dispensed, Medicaid may incorrectly invoice the manufacturer for the

rebate. Rebate dollars provide a significant source of money to offset pharmacy benefit costs. Therefore, NDC numbers reported on pharmacy claims should be the exact NDC number dispensed to the patient.

Can referrals be made to the Medicaid Agency when a provider believes a recipient is defrauding the program?

Yes. Any information regarding inappropriate and/or illegal drug-related activity by Medicaid recipients can be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**. All complaints are researched. If evidence is found to support recipient abuse or fraud, recipients can be locked in to one physician and one pharmacy or removed from the Medicaid program.

Does Medicaid make payment for benefits when a patient is in a state or county correctional facility?

Medicaid benefits are not available for individuals who are inmates of public institutions as defined by CFR 435.1009. It is the responsibility of the correction facility to provide medical care. Incarcerated recipients still receiving Medicaid benefits may be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**.

If a provider receives multiple dispensing fees for the same patient, same drug and strength within the same month, will the additional dispensing fees be recouped?

Medicaid auditors look specifically for providers who split 30-day prescriptions into shorter time periods and amounts. Intentionally splitting prescriptions to receive multiple dispensing fees is fraud and monies paid will be recouped. Multiple dispensing fees within the same month for the same patient and same drug are acceptable if the provider has documentation supporting the need for multiple dispensings. Example: A child needs a 10 mg tablet for school and a 20 mg tablet for home to take at night; the provider should have in his documentation prescriptions for both.

If a provider is audited and can not produce documentation while Medicaid auditors are in the store, is there a period of time allowed to provide the documentation before recoupments are initiated?

If an auditor requests documentation that is not present in the provider's facility, the provider should indicate to the auditor where the documentation is and when it can be provided for review. If additional information is needed by the state as a result of discrepancies identified in an audit, the provider should submit the requested information within 30 days of the request. Failure to submit documentation within 30 days may result in recoupment.

Is it important to bill the correct days supply?

Yes, days supply is an instrumental portion of a legitimate claim. Retroactive audits may consider the day supply billed, along with quantity of medication billed, in regards to the original prescription. Day supply billed should be clinically appropriate according to the physician's instructions on the prescription.

Can a pharmacy provider advertise waived copays for their Medicaid patients?

No. Advertising the waiver of or routinely waiving Medicaid copayments is a prohibited remuneration under Section 22-1-11, Code of Alabama and 1128B of the Social Security Act (SSA). Please refer to the Provider Manual, Chapter 7 "Understanding your rights and responsibilities as a provider", Section 7.1.7 "Provider Certification" for more information on offering incentives and advertising discounts.

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