Prescription Drug Program
Billing Guide

July 1, 2016

About this guide*

This publication takes effect July 1, 2016, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Name Change	The agency is changing the name of the Provider Guides to Billing Guides.	To align with the agency's new website redesign launching in August
Smoking Cessation Program	Removed information about client eligibility and coverage requirements. Providers should see the Physician-Related Services/Health Care Professional Services Billing Guide for more information about smoking cessation eligibility and coverage.	No change in policy. This information is located in another billing guide.
Are there other limitations and restrictions?	Removed information about limitations and restrictions related to the Smoking Cessation Program. Providers should see the *Physician-Related Services/Health Care Professional Services Billing Guide* for information about the Smoking Cessation Program.	No change in policy. This information is located in another billing guide.
Nicotine replacement therapy (NRT)	Removed information about nicotine replacement therapy. Providers should see the *Physician-Related Services/Health Care Professional Services Billing Guide* for more information about nicotine replacement therapy.	No change in policy. This information is located in another billing guide.
Antipsychotic age and dose limits for children age 17 and younger	Added language to clarify age and dose limits.	Clarification
When can a medication be dispensed more than twice per month or filled early?	Added circumstances for dispensing medications more than twice per month or for filling early.	Policy clarification

How can I get agency provider documents?

To download and print agency provider notices and Washington Apple Health billing guides, go to the agency's Provider Publications website.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available online**.**

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., Washington Apple Health billing guides, fee schedules)	
Private insurance or third-party liability (other than agency-contracted managed care)	
Authorization	
Additional Prescription Drug Program information	See the agency's Pharmacy Information web page
Submitting backup documentation	Backup documentation must be mailed or faxed to: Pharmacy Authorization Section Drug Use and Review PO Box 45506 Olympia WA 98504-5506 Fax: 1-866-668-1214
Technical questions about switch vendor issues or system availability issues	Contact the switch vendor
Where can I find pharmacy document submission cover sheets?	See the agency's document submission cover sheets
Where do I find the agency's maximum allowable fees for services?	See the agency's Rates Development Fee Schedules The prescription drug fee schedule is titled *Pharmacy Special Services, Vaccine Administration, and Compliance Packaging*
General definitions	See Chapter 182-500 WAC

Troubleshooting

If your situation or question is about:	Then you must:
Claim rejection stating "prior authorization required" Claim rejection starting with "pref" or "preferred"	Use *Pharmacy Information Authorization* form 13-835a Fax form to 1-866-668-1214 or call 1-800-562-3022
Early refill, or refill too soon	Call the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022 When you call, you must know: • When was the last fill for this client? • Was this a change in dose from the last fill?
Find out which drugs are on the Washington Preferred Drug List	See the Washington Preferred Drug List web page
Any of the following return messages: • Prior authorization required • Expedited code required and does not meet criteria • Drug exceeds limits	Use *Pharmacy Information Authorization* form 13-835a See the Pharmacy Information web page for: • Expedited authorization criteria • List of drugs with limitations • Special programs in this billing guide Fax form to 1-866-668-1214 or call 1-800-562-3022
Dispensed an emergency supply to a client with an emergency that could not wait	Use *Pharmacy Information Authorization* form 13-835a Fax form to 1-866-668-1214 or call 1-800-562-3022

If your situation or question is about:	Then you must:
Claim rejection stating "client is restricted to one pharmacy"	Find out what pharmacy or doctor this client is restricted to by calling the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022. After selecting a language, say "dial now," then enter extension 15606. The MACSC will be able to help you determine the following: • How to get medically necessary medications to a client restricted to a different pharmacy • Where to report clients abusing their medications • Where to report suspected fraudulent activity
Lost or stolen medications	Find out if the client reported a lost or stolen prescription in the last six months by calling MACSC at 1-800-562-3022.
Expedited Authorization criteria	See the agency's Expedited Authorization List
Other claim or pharmacy-related questions or situations: • What is the appropriate use of NCPDP fields in response to claim edits? • Is this client eligible? • What program is this client on? • Where can clients or doctors' offices call for questions about authorizations or drugs? • What drugs are covered? • What is the Therapeutic Interchange Program? • How do I become an endorsing prescriber? • Where do I find a list of over the counter family planning products?	Call MACSC at 1-800-562-3022 or visit the Pharmacy Information web page

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Active ingredient – The chemical component of a drug responsible for a drug's prescribed/intended therapeutic effect. The agency limits coverage of active ingredients to those with a national drug code (NDC) and those specifically authorized by the agency.

Actual acquisition cost – The actual price a provider paid for a drug marketed in the package size of drug purchased or sold by a particular manufacturer or labeler. The actual acquisition cost is calculated based on factors including, but not limited to:

- Invoice price, including other invoice-based considerations, such as prompt payment discounts.
- Order quantity and periodic purchase volume discount policies of suppliers (wholesalers and manufacturers).
- Membership or participation in purchasing cooperatives.
- Advertising and other promotion and display allowances, free merchandise deals.
- Transportation or freight allowances.

Administer – the direct application of a prescription drug by injection, inhalation, ingestion, or any other means to the body of a patient by a practitioner or at the direction of the practitioner.

Appointing authority – For the evidence-based prescription drug program of the participating agencies in the state-operated health care programs, the following persons act jointly: the Director of the Health Care Authority (HCA or the agency), and the director of the Department of Labor and Industries (L&I).

Automated maximum allowable cost (AMAC) – The rate established by the Medicaid Purchasing Administration (MPA) for a multiple-source drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products, at least one of which must be under a federal drug rebate contract.

Authorization number – A number assigned by the agency that identifies a specific request for approval for services or equipment.

Authorization requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or Medicaid billing guides.

Average wholesale price (AWP) – The average price of a drug product that is calculated from wholesale prices nationwide at a point in time and reported to the agency by the agency's drug file contractor.

Brand name – The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Closed pharmacy network – An arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. (WAC 182-530-7800)

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Combination drug – A commercially available drug including two or more active ingredients.

Compliance packaging – Reusable or non-reusable drug packaging containers.

Compounding – The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

Contract drugs – Drugs manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Covered outpatient drug – A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, and used for a medically accepted indication.

Dispensing fee – The fee the agency sets to pay pharmacy providers for dispensing agency-covered prescriptions. The fee is the agency's maximum payment for expenses involved in the practice of pharmacy and is in addition to the agency's reimbursement for the costs of covered ingredients.

Drug Enforcement Agency (DEA) – the federal agency responsible for enforcing laws and regulations governing narcotics and controlled substances.

Drug file – A list of drug products, pricing, and other information provided to the agency's drug database and maintained by a drug file contractor.

Drug rebates – Payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services.

Drug-related supplies – Non-drug items necessary for the administration, delivery, or monitoring of a drug or drug regimen.

Drug use review (DUR) – A review of covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Emergency kit – A set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the needs of each nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

Endorsing practitioner – A provider who has reviewed the Washington Preferred Drug List (PDL), enrolled (see www.rx.wa.gov) with the Health Care Authority (HCA or the agency), and agrees to allow therapeutic interchange (substitution) of a preferred drug for any non-preferred drug in a given therapeutic class on the Washington PDL.

Estimated acquisition cost (EAC) – The agency's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.

Evidence-based practice center – A research organization designated by the federal Agency for Healthcare Research and Quality (AHRQ) to conduct systematic reviews of all the information used to produce evidence tables and technology assessments that guide health care decisions.

Federal upper limit (FUL) – The maximum allowable payment set by the Centers for Medicare and Medicaid Services (CMS) for a multiple-source drug.

Federally approved hemophilia treatment center – A hemophilia treatment center (HTC) which:

(1) Receives funding from the federal Department of Health and Human Services' Maternal and Child Health Bureau National Hemophilia Program.

(2) Is qualified to participate in 340B discount purchasing as an HTC.

(3) Has a federal Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC website.

(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington State.

(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

Immediate needs – An emergency situation when pharmacists use their professional judgment to determine the quantity to dispense to best meet the client's needs in the emergency.

Generic name – The official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

Less-than-effective drug, or Drug Efficacy Study Implementation (DESI) – Drugs that lack substantial evidence of effectiveness as determined by the Food and Drug Administration (FDA). (WAC 182-530-1050)

Maximum allowable – The maximum dollar amount the agency will reimburse a provider for a specific service, supply, or piece of equipment.

Maximum allowable cost (MAC) – The maximum amount that the agency reimburses for a specific dosage form and strength of a multiple-source drug product.

Medically accepted indication – Any use for a covered outpatient drug:

(1) Which is approved under the federal Food, Drug, and Cosmetic Act.

(2) The use of which is supported by one or more citations included or approved for inclusion in any of the following compendia of drug information:
   (a) The American Hospital Formulary Service Drug Information
   (b) The United States Pharmacopoeia Drug Information
   (c) DRUGDEX Information System

Medically necessary – See WAC 182-500-0005

Modified Unit Dose Delivery System (also known as blister packs or bingo/punch cards) – A method in which each patient's medication is delivered to a nursing facility:

- In individually sealed, single-dose packages or "blisters".
- In quantities for one month's supply, unless the prescriber specifies a shorter period of therapy.

Multiple source drug – A drug marketed or sold by:

- Two or more manufacturers or labelers.
- The same manufacturer or labeler:
  - ✓ Under two or more different proprietary names.

    -or-

  - ✓ Under a proprietary name and a generic name.

National drug code (NDC) – The 11-digit number the manufacturer or labeler and FDA assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The NDC is composed of digits in 5-4-2 groupings. The first five digits comprise the labeler code assigned to the manufacturer by the FDA. The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

Non-contract drugs – Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Non-formulary drug – Medications that are not on the primary insurance plan's formulary (preferred) drug list.

Non-preferred drug – A drug that has not been selected as a preferred drug within the therapeutic classes of drugs on the preferred drug list.

Obsolete NDC – An NDC replaced or discontinued by the manufacturer or labeler.

Other Coverage Code – A billing code that indicates whether or not a client has other insurance coverage. If the client has coverage, use of the code identifies how the claim was processed by the insurance carrier.

Over-the-counter (OTC) drugs – Drugs that do not require a prescription under federal law before they can be sold or dispensed**.**

Pharmacist – A person licensed in the practice of pharmacy by the state in which the prescription is filled.

Pharmacy – Every location licensed by the State Board of Pharmacy in the state where the practice of pharmacy is conducted.

Point-of-sale (POS) – A pharmacy claims processing system capable of receiving and adjudicating claims online.

Poly-prescribing – Multiple prescribers duplicating drug therapy for the same client.

Practitioner – A person who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner.

Preferred drug – Drug(s) of choice within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

Prepay plan – A type of insurance coverage that requires the client to pay at the time of service, and the insurance reimbursement is made to the subscriber/client.

Privately purchased HMO – Indicates a client with a privately purchased HMO insurance policy. ProviderOne indicates that the client is enrolled in a managed health care plan. These clients must comply with the requirements of their plan and are required to use the HMO facilities for their pharmacy services.

Prescriber – A physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs.

Prescription – An order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices, in the course of the practitioner's professional practice, for a legitimate medical purpose.

Prescription drugs – Drugs required by any applicable federal or state law or regulation to be dispensed by prescription only, or that are restricted to use by practitioners only.

Prospective drug use review (Pro-DUR) – A process in which a request for a drug product for a particular client is screened, before the product is dispensed, for potential drug therapy problems.

Reconstitution – The process of returning a single active ingredient previously altered for preservation and storage to its approximate original state. Reconstitution is not compounding.

Retrospective drug utilization review (Retro-DUR) – The process in which a client's drug use is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Service area – An area within 25 miles or 45 minutes from the client's residential address to the pharmacy.

Single source drug – A drug produced or distributed under an original new drug application approved by the FDA.

Skilled nursing facility (SNF) – An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care.
- Rehabilitation services for injured, disabled, or sick clients.
- Health-related care and services to people who require care which can only be provided through institutional facilities and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Systematic review – A specific and reproducible method to identify, select, and appraise all the studies that meet minimum quality standards and are relevant to a particular question. The results of the studies are then analyzed and summarized into evidence tables to be used to guide evidence-based decisions.

Terminated national drug code (NDC) – An NDC that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life.

Therapeutic alternative – A drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile when administered to patients in a therapeutically equivalent dosage.

Therapeutic interchange – To dispense a therapeutic alternative to a prescribed drug when permitted by an endorsing practitioner. See Therapeutic Interchange Program (TIP).

Therapeutic Interchange Program (TIP) – The process developed by participating state agencies under RCW 69.41.190 and 70.14.050 to allow prescribers to endorse the Washington Preferred Drug List, and in most cases, to require pharmacists to automatically substitute a preferred equivalent drug from the list.

Therapeutically equivalent – Drug products that contain different chemical structures but have the same efficacy and safety when administered to a person, as determined by:

- Information from the Food and Drug Administration (FDA).
- Published and peer-reviewed scientific data.
- Randomized controlled clinical trials.
- Other scientific evidence.

True unit dose delivery – A method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage.

Washington Preferred Drug List (Washington PDL) – The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for purchasing drugs in state-operated health care programs.

About the Program

(WAC 182-530-1000)

What is the purpose of the Prescription Drug Program?

The purpose of the Prescription Drug Program is to pay providers for outpatient drugs, devices, and drug-related supplies. The program is governed by federal and state regulations. This billing guide is intended to help providers comply with the rules and requirements of the program.

Basic things to know:
The agency reimburses for medically necessary drugs, devices, and supplies according to rules in Washington Administrative Code (WAC) and the Reimbursement section of this billing guide.

The agency covers outpatient drugs, including over the counter drugs listed in the agency's Medicaid Covered Over-the-Counter Drug List, when:

- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to this rule are described in this billing guide's Compounded Prescriptions section.
- Approved by the Food and Drug Administration (FDA).
- Prescribed by a provider within the scope of the provider's prescribing authority and whose core provider agreement has not been terminated or denied.
- Prescribed for a medically accepted indication.
- Prescribed for an eligible client.
- Not excluded from coverage under WAC 182-501-0050, 182-530-2100, and the Program Restrictions section of this billing guide, specifically the subsection What drugs, devices, and supplies are not covered?

The agency does not cover:

- Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927(d)(2)(K) of the Social Security Act, unless these drugs are used to treat a condition other than sexual or erectile dysfunction and these uses have been approved by the FDA.
- Drugs not approved by the FDA.

- Drugs prescribed for a non-medically accepted indication or dosing level.
- Drugs from a manufacturer without a federal rebate agreement.
- Drugs and indications excluded from coverage by WAC, such as drugs prescribed for the following:
  - ✓ Weight loss or gain
  - ✓ Infertility, frigidity, or impotence
  - ✓ Sexual or erectile dysfunction
  - ✓ Cosmetic purposes or hair growth

What are the provider requirements?

In order to be reimbursed by the agency, the pharmacy must:

- Be properly licensed.
- Have a signed core provider agreement (CPA).
- Follow the guidelines in this billing guide and applicable WAC.
- Retain documentation demonstrating that all other possible payers have been billed appropriately.

The agency may require a pharmacy to:

- Obtain authorization for a drug or product.
- Determine and document that certain diagnosis requirements are met.
- Meet other requirements for client safety and program management.

Abuse of the program

The following practices constitute an abuse of the program and a misuse of taxpayer dollars:

- **Prescription splitting –** Billing inappropriately to obtain additional dispensing fees, for example:
  - ✓ Supplying medication in amounts less than necessary to cover the days prescribed
  - ✓ Supplying medications in strengths less than those prescribed to gain more than one dispensing fee
- **Excessive filling –** Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity (except when the agency specifies a mandatory minimum of an OTC drug)
- **Prescription shorting –** Billing for a drug or supply greater than the quantity actually dispensed
- **Substitution to achieve a higher price –** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug is available (except when the agency identifies a higher-priced drug as preferred)

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What types of identification prove eligibility?

Valid types of eligibility identification:

- A copy of the benefit inquiry screen from ProviderOne
- A printout of a medical identification screen from the client's local DSHS Community Services Office (CSO), Home and Community Service (HCS) office, or the agency
- An award letter from the CSO or HCS
- Medical eligibility verification (MEV) receipt provided by an authorized MEV vendor with an "as of" date within the same month as the date of service

> **Note:** Providers enrolled with ProviderOne can check eligibility by accessing the Provider Portal and choosing eligibility inquiry from the main menu. For information on enrolling, visit the New Provider Enrollment web page.

The computer printout or award letter may be used as valid identification since both list the eligibility information that appears in ProviderOne.

The agency recommends that providers make a photocopy of valid identification when it is presented, in order to have a copy for the file.

Check the identification for the following information:

- Beginning and ending eligibility dates
- The ProviderOne Client ID
- Other specific information (e.g., Medicare, Medicare Part D, private insurance, or managed care coverage, hospice, patient requiring regulation, etc.)
- Retroactive or delayed certification eligibility dates, if any

> **Note:** Do not accept any form of identification that appears to have been altered. Request to see another form of identification.

What if a claim is denied by the point-of-sale (POS) system?

The POS system does not solve the problem of identifying clients who are not currently in the agency's eligibility file. For clients who show as eligible in ProviderOne, but the POS system denies their claims for lack of eligibility, do one of the following:

- **FAX** a copy of the client's benefit inquiry screen in ProviderOne to 1-360-586-1403.
- Mail in a **completed** paper claim with a photocopy of the client's benefit inquiry screen in ProviderOne attached.

The agency will update eligibility information from the copies of the client benefit inquiry screen in ProviderOne within two working days so that claims may be resubmitted.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

See Billing for information regarding clients enrolled in an agency-contracted MCO.

Newborns of clients enrolled in an agency-contracted MCO are the responsibility of the mother's MCO for the first 60 days of life. If the mother changes MCOs, the baby follows the mother's MCO.

> **Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Program Restrictions

(WAC 182-530-2000 (2))

How does the agency determine which drugs to cover?

Coverage determinations for the agency are decided by:

- The agency in consultation with federal guidelines.
- The Drug Use Review (DUR) Board.
- The agency's medical consultants and pharmacists.

If a product is determined to be covered, it will be assigned an authorization status (see Authorization.)

> **Note:** The agency evaluates a request for a drug that is listed as noncovered under the provisions of WAC 182-501-0160 related to noncovered services. The request for a noncovered drug is called a **request for an exception to rule**. See WAC 182-501-0160 for information about exception to rule.

What drugs, devices, and supplies are covered?

(WAC 182-530-2000(1))

The agency covers:

- Outpatient drugs, including over-the-counter drugs listed on the agency's Medicaid Covered Over-the-Counter Drug List, as defined in WAC 182-530-1050, subject to the limitations and requirements within this billing guide, when:
  - ✓ The drug is approved by the Food and Drug Administration (FDA).
  - ✓ The drug is for a medically accepted indication as defined in WAC 182-530-1050.
  - ✓ The drug is not excluded from coverage (see "What drugs, devices, and supplies are not covered?").

- ✓ The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 182-530-7500 which details the drug rebate program.

- Family planning drugs, devices, and drug-related supplies per chapter 182-532 WAC such as:
  - ✓ Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies without a prescription when the agency determines it necessary for client access and safety.
  - ✓ Family planning drugs that do not meet the federal drug rebate requirement in WAC 182-530-7500 on a case-by-case basis.
  - ✓ Contraceptive patches, contraceptive rings, and oral contraceptives, only when dispensed in at least a 12-month supply, unless otherwise directed by the prescriber. There is no required minimum for how many cycles of emergency contraception may be dispensed.

- Prescription vitamins and mineral products, only as follows:
  - ✓ When prescribed for clinically documented deficiencies
  - ✓ Fluoride varnish for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program

- Drug-related devices and supplies as an outpatient pharmacy benefit when they are :
  - ✓ Prescribed by a provider with prescribing authority.
  - ✓ Essential for the administration of a covered drug.
  - ✓ Not excluded from coverage under WAC 182-530-2100.
  - ✓ A product covered under chapter 182-543 WAC that the agency determines should be available at retail pharmacies.

Note: For exceptions to the prescription (prescriber's order) requirement, see Exceptions to the Prescription Requirement.

- Preservatives, flavoring, or coloring agents, only when used as a suspending agent in a compound.

- Over-the-counter drugs to promote smoking cessation, without a prescription, only when the client is:
  - ✓ Age 18 and older.
  - ✓ Participating in an agency-approved smoking cessation program.
- Prescription drugs to promote smoking cessation, only when the client is:
  - ✓ Age 18 and older.
  - ✓ Participating in an agency-approved smoking cessation program.

What drugs, devices, and supplies are not covered?

(WAC 182-530-2100 and 182-530-7500)

The agency does not reimburse under the Prescription Drug Program for drugs and drug-related supplies administered by health care professionals as a component of hospital services, physician-related services, or billed in conjunction with home health services. Reimbursement for drugs and drug-related supplies in these situations may be available when billed under the rules of the related program.

The agency does not reimburse for any of the following under the Prescription Drug Program:

- Nutritional supplements such as shakes, bars, puddings, powders, medical foods, etc. (These products may be reimbursable under the conditions of the Nondurable Medical Supplies and Equipment and Enteral Nutrition programs.)
- Drugs for which the manufacturer has **not signed a rebate agreement** with the federal Department of Health and Human Services (DHHS)
- Drugs considered **less than effective** and withdrawn by the Food and Drug Administration (FDA) as a result of the Drug Efficacy Study Implementation (DESI) review:
  - ✓ Free pharmaceutical samples
  - ✓ Over-the-counter (OTC) drugs and drug-related supplies that have not been prescribed by a provider with prescriptive authority (with the exception of OTC family planning products and OTC smoking cessation products)

- ✓ OTC drugs and drug-related supplies that have been prescribed by a provider whose application for a Core Provider Agreement (CPA) has been denied, or whose CPA has been terminated with cause

- Drugs prescribed for:
  - ✓ Weight loss or gain
  - ✓ Infertility, frigidity, or impotence
  - ✓ Sexual or erectile dysfunction
  - ✓ Cosmetic purposes or hair growth
- Over-the-counter drugs not listed on the agency's covered over-the-counter drug list
- Drugs and drug-related supplies for multiple patient use
- Any drug regularly supplied as an integral part of program activity by other public agencies (such as drugs, vaccines, or biological products available without charge to the client from the Department of Health)
- Products or items that do not have an 11-digit national drug code (NDC)
- Drugs with NDCs which have been designated as obsolete for more than two years
- Drugs with a shelf life that has expired prior to being dispensed
- Drugs which have been terminated or removed from the market
- More than a 34-day supply of any product except:
  - ✓ Drugs when the smallest package size exceeds a 34-day supply
  - ✓ Drugs with special packaging instructions which would require dispense of a quantity that exceeds a 34-day supply
  - ✓ Contraceptive patches, contraceptive rings, and oral contraceptives not used for emergency contraception. These products must be dispensed at a minimum of a 12-month supply, unless otherwise directed by the prescriber.
  - ✓ When the drug is specifically identified as exempt from the 34-day limit
- Any vitamin product other than:
  - ✓ Vitamins determined by the agency to be the least costly therapeutic alternative for the treatment of a client's diagnosed condition

- ✓ When the agency agrees that the vitamin product is the least costly alternative in treating documented vitamin deficiency which has been confirmed by laboratory testing

- Fluoride preparations other than as prescribed for children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program

- Non-preferred drugs in drug classes in the Washington Preferred Drug List (PDL), except as detailed in the Washington PDL

- Drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

  - ✓ Diagnosis-related group (DRG)

  - ✓ Ratio of costs-to-charges (RCC)

  - ✓ OTC products supplied to skilled nursing facility (SNF) residents (unless included in the Washington PDL)

  - ✓ Managed care capitation rates

  - ✓ Block grants

  - ✓ Drugs prescribed for clients who are in the agency's hospice program when the drugs are related to the client's terminal condition

- Drugs prescribed for an indication that is not evidence-based as determined by:

  - ✓ The agency in consultation with federal guidelines

  - ✓ The Drug Use Review (DUR) Board

  - ✓ Agency medical consultants and pharmacist(s)

- Drugs that are:

  - ✓ Not approved by the Food and Drug Administration (FDA)

  - ✓ Prescribed for non-FDA approved indications or dosing, which is not otherwise supported by quality evidence in the recognized compendia of drug information

  - ✓ Unproven for efficacy or safety

- Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee

- Preservatives, flavoring, or coloring agents

- Prescriptions written on pre-signed prescription blanks completed by SNF operators or pharmacists. The agency may terminate the CPA of pharmacies involved in this practice.

- Drugs used to replace those taken from SNF emergency kits

- The cost differential between the least costly dosage form of a drug and a more expensive dosage form within the same route of administration, unless the prescriber designated the costlier dosage form as medically necessary

- OTC or prescription drugs to promote smoking cessation unless the client is age 18 years and older and participating in an agency-approved smoking cessation program

What are the exceptions to the prescription requirement?

(WAC 182-530-2000(4))

The agency reimburses specific OTC family planning drugs, devices, and supplies without a prescription. The following OTC contraceptives may be dispensed without a prescription to any agency client with a current Services Card:

- Condoms (including female condom)
- Vaginal spermicidal foam with applicator and refills
- Vaginal jelly with applicator
- Vaginal creams and gels
- Vaginal suppositories

Emergency contraception (Plan B) is also available without a prescription for females age 18 and older.

Point-of-sale billers must:

Bill the agency fee-for-service using the Product ID Qualifier of 03 in field 436-E1, and the product-specific NDC number in field 407-D7. Use Prescriber ID Qualifier (466-EZ) 01 and Prescriber ID (407-D7) of **5123456787**. Regardless of the contraceptive, bill the NDC as stated on the package.

Hardcopy billers must:

Enter 5123456787 in the Prescriber NPI field.

When does the agency pay for over-the-counter nicotine replacement therapy (NRT)?

The agency reimburses for specific over-the-counter NRT products without a prescription when distributed by an agency-approved smoking cessation program (see Smoking Cessation).

Compliance Packaging

The agency, the Home Care Association of Washington (HCAW), and the Washington State Pharmacy Association (WSPA) developed the following guidelines in a cooperative effort to improve drug therapy outcomes for the most **at-risk** segment of the medical assistance population.

What is included in compliance packaging?

(WAC 182-530-7400(2))

Compliance packaging includes both of the following:

- Reusable, hard plastic containers of any type (e.g., Medisets, weekly minders, etc.)
- Non-reusable compliance packaging (e.g., blister packs, bingo cards, bubble packs, etc.)

How is it determined that a client is eligible for compliance packaging?

(WAC 182-530-7400(1))

Prescribers are encouraged to communicate to high-risk clients the need for compliance packaging if, in their professional judgment, such packaging is appropriate.

Clients are considered high-risk and eligible to receive compliance packaging if they:

- **Do not reside** in a skilled nursing facility or other inpatient facility.

- Have one or more of the following representative disease conditions:

  - ✓ Alzheimer's disease
  - ✓ Blood clotting disorders
  - ✓ Cardiac arrhythmia
  - ✓ Congestive heart failure
  - ✓ Depression
  - ✓ Diabetes
  - ✓ Epilepsy
  - ✓ HIV/AIDS
  - ✓ Hypertension
  - ✓ Schizophrenia
  - ✓ Tuberculosis

-AND-

- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day.
- Demonstrate a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

Prefilling a syringe is not considered compliance packaging. See Special Programs/Services for syringe filling guidelines.

What is required when billing for compliance packaging?

To bill for compliance packaging:

1. Bill on an approved professional services claim form (e.g., paper CMS-1500 claim form, electronic CMS-1500 claim form, or electronic 837-P claim form).
2. Include the NPI of the ordering practitioner in the 'referring' field. The ordering practitioner is the prescriber or pharmacist who determined the client meets compliance packaging criteria.
3. Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.
4. Use the following procedure codes in combination with the appropriate modifier. The agency will deny claims for these procedure codes without the accompanying modifier.

Short Description	HCPCS Code	Modifier	Maximum Allowable Units*
Reusable compliance device or container	T1999	UE	Limit of 4 per client, per year May be billed in combination , but not to exceed a total of 4 per year
Reusable compliance device or container, extra-large capacity	T1999	SC	
Filling fee for a reusable compliance device or container	A9901	SC	Limit of 4 fills per client, per month
Non-reusable compliance device or container	T1999	NU	Limit of 4 fills per client, per month Includes reimbursement for materials and filling time. Bill one unit each time non-reusable compliance packages are filled.

* See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

The agency does not pay for compliance packaging in excess of the limits listed above. Requests for limitation extensions will not be approved.

Does a provider need agency approval to bill for splitting single dose vials?

Yes. Providers must obtain agency approval to bill for splitting single dose vials. To receive agency approval, submit the following documentation by fax to the attention of the Pharmacy Administrator, at 1-360-725-1328:

- Documentation showing all requirements of the United States Pharmacopeia General Chapter 797, Pharmaceutical Compounding - Sterile Preparations regulations are met, including the date of the last laminar flow hood inspection and through date of the certification
- The policy the provider has established regarding IV admixture preparations
- The policy the provider has established regarding when single dose vials are split and how the remainder is to be used
- The billing NPI(s) of the requesting provider

The agency will provide an approval or denial of the provider's request within 10 business days.

Compounded Prescriptions

(WAC 182-530-7150)

What is compounding?

(WAC 182-530-7150(1)(3))

Compounding is the act of combining two or more **active** ingredients or the medically necessary adjustment of therapeutic strengths and/or forms by a pharmacist for a single active ingredient. The agency does not consider drug reconstitution to be compounding. The agency reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and forms of the medically necessary drug.

Note: All compound ingredients must be billed on one claim. Each ingredient must be separately detailed using the National Council for Prescription Drug Programs (NCPDP) Compound Segment. The agency's point-of-sale (POS) system does not accept **highest cost ingredient** compound billing.

Note: The pharmacist must document in the client's file the need for the adjustment of the drug's therapeutic strength or form, or both.

Which ingredients are not reimbursed in compounds?

(See WAC 182-530-7150(2))

- Coloring agents, preservatives, and flavoring agents used in compounded prescriptions **except** when they are necessary as a complete vehicle for compounding (e.g., simple syrup)
- Any product which would not be reimbursable when used outside of a compound, except as detailed on the following page

What additional ingredients are reimbursable in compounds?

- Bulk chemicals which are active ingredients and are considered non-drug items when used outside of a compound
- Vehicles or suspending agents necessary for the completion of the compound

The agency reimburses for compounding ingredients from the following chemical supply companies who have not signed Federal Rebate agreements:

Labeler Code	Company
00395	Humco Labs
00802	Emerson Labs

Note: Other chemical suppliers' products are reimbursable only if they have been reported to the agency's current drug file contractor with a valid 11-digit national drug code (NDC) and the manufacturer has signed a Federal Rebate agreement.

Is authorization required to compound prescriptions?

(WAC 182-530-7150(5)(b) and (c))

No. The agency does not require authorization to compound prescriptions.

Individual ingredients requiring authorization still require authorization when used in a compound, except as previously noted.

The need for authorization of any single ingredient within a compound will cause the entire compound claim to be rejected until authorized, but only the individual ingredient actually requires authorization.

Billing for compounded prescriptions

(WAC 182-530-7150(4) and (5))

- Pharmacies must bill each ingredient used in compounded prescriptions using the 11-digit NDC for each ingredient.
- Bill the **appropriate** quantity used for each ingredient on one claim. **Do not bill the combined total quantity.**
- The agency pays a dispensing fee for each payable ingredient. The agency does not pay separate fees for compounding time or preparation fees.

Note: If a compound is rejected, pharmacies may elect to accept reimbursement for any payable ingredient within the compound by entering an **8** in the Submission Clarification Code field (420-DK).

Hard copy billers must:

- Complete the *Pharmacy Statement (525-106)* form 13-714 using Section 1 for information regarding the entire compound.
- Enter National Drug Code of **00000-0000-00** in Section 1, and individual ingredient NDCs in Section 3.
- Enter "Compound Prescription" in the **Justification/Comments** field.
- Do not complete Section 2. Only one compound may be billed per claim form.

Point-of-sale billers must:

- Enter a Compound Code (field 406-D6) of 2 in the Claim Segment.
- Enter a Product/Service ID Qualifier (436-E1) of 03 in the Claim Segment.
- Enter a Product/Service ID (407-D7) of **00000-0000-00** in the Claim Segment.
- Enter the separate ingredient details using the Compound Segment.

Special Programs and Services

Smoking Cessation Program

For eligibility and coverage requirements, see the *Behavior change intervention-smoking cessation* section in the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Pharmacists with a collaborative practice agreement may provide smoking cessation counseling and prescribe for pregnant clients. For counseling requirements, limitations, billing information, and resources, see the Physician-Related Services/Health Care Professional Services Medicaid Billing Guide.

Are there other coverage limitations and restrictions?

The agency's limitations and restrictions for smoking cessation drugs are as follows:

- The agency will authorize Zyban® (bupropion SR) only if a client does not have a history of seizures or bipolar disorder.
- The agency will authorize Chantix® (varenicline tartrate) only if the client does not have a history of neuropsychiatric symptoms and dosage reductions are based on renal clearance.
- For limits on specific smoking cessation products, see the list of drugs with limitations.
- The agency does not allow combinations within or across smoking cessation drug types.

How does a pharmacy bill the agency for Clozaril/Clozapine and related services?

The agency reimburses pharmacies for Clozaril/Clozapine plus pays a dispensing fee. Bill Clozaril/Clozapine using the appropriate national drug code (NDC) on either the point-of-sale (POS) system or the *Pharmacy Statement* form HCA 13-714.

Any licensed or registered pharmacy with clinical experience in monitoring patient mental and health status may provide and bill for case coordination (medication management) for clients receiving Clozaril/Clozapine.

Persons providing case coordination serve as a focal point for the client's Clozaril/Clozapine therapy. All services must be documented and are subject to quality assurance review. When providing case coordination, providers must:

- Coordinate a plan of care with the:
  - ✓ Client
  - ✓ Client's caregiver
  - ✓ Prescriber
  - ✓ Pharmacy
- Assure services are provided to the client as specified in the plan of care.
- Assure blood samples are drawn according to the Food and Drug Administration (FDA) labeling, blood counts are within normal range, and the client is compliant with the plan of care.
- Follow-up with the client on missed medical appointments.
- Maintain detailed, individual client records to document the client's progress.
- Provide feedback to the prescriber on the client's progress, immediately report abnormal blood counts, and client noncompliance.
- Assure smooth transition to a new case coordinator, when necessary.

Use the following procedure codes to bill for Clozaril/Clozapine related services on an approved professional services claim form (e.g., paper CMS-1500 claim form, electronic CMS-1500 claim form, or electronic 837-P claim form):

Procedure Code	Modifier	Description	Reimbursement
36415		Routine venipuncture	Per the Resource-Based Relative Value Scale (RBRVS) fee schedule
99605	HE	Case coordination for new clients **Prescribed by RSN** must be entered in the comments field when services are provided through an RSN Community Health Center	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule
99606	HE	Case coordination for returning clients. **Prescribed by RSN** must be entered in the comments field when services are provided through an RSN Community Health Center	

Note: Due to close monitoring requirements, the agency allows up to five fills per month.

Emergency contraceptive pills (ECP)

The agency reimburses for emergency contraceptive pills (ECP) through the POS system for female clients in eligible programs as follows:

- Clients age 17 and younger must have a prescription for ECP.
- Clients age 18 and older do not need a prescription for ECP.

To receive reimbursement, pharmacies must bill the agency fee-for-service (FFS) using the specific NDC and Prescriber ID number **5123456787**. It is common practice to dispense two packages at a time, especially for clients using barrier contraceptive methods. Pharmacies are instructed to dispense the quantity requested by the client. Pharmacies that are members of, or subcontract with, managed care plans and are serving a managed care client must bill the

prescription cost to the plan. The agency reimburses pharmacists for ECP plus pays a dispensing fee. Bill for ECP using the appropriate NDC.

Emergency contraception (EC) counseling

When a pharmacist with an EC protocol approved by the Board of Pharmacy prescribes ECPs, the pharmacy may bill the agency for the counseling portion.

Pharmacists performing EC counseling must ensure that a copy of the pharmacist's current approved protocol certificate from the Board of Pharmacy is on file at the pharmacy where the service was performed. Performing EC Counseling without a currently approved protocol is subject to sanction by the Board of Pharmacy. Billing the agency for EC Counseling without a current, approved protocol **on file** is subject to recoupment of payment.

The counseling is a service-related item, not a drug, and must be billed on an approved professional services claim form (e.g., paper CMS-1500 claim form, electronic CMS-1500 claim form, or electronic 837-P claim form).

BILLING ON A CMS-1500 claim form

- Enter the diagnosis code Z30.09 (contraceptive management) in field 24E.
- Use the following procedure code and modifier to bill for EC counseling:

Procedure Code	Modifier	Description	Maximum Allowable Fee
99605	FP	EC Counseling	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

Anti-emetics

Pharmacists with prescriptive authority for emergency contraceptive pills may prescribe and bill for selected anti-emetics only when these drugs are dispensed in conjunction with ECPs. The agency reimburses for the following only when they are prescribed and dispensed in the strength/dose/form listed:

Meclizine hydrochloride	25 mg tablets
Diphenhydramine hydrochloride	25 mg tablets/capsules
Dimenhydrinate	50 mg tablets
Promethazine hydrochloride	25 mg tablets or 25 mg suppositories
Metoclopramide	5 mg, 10 mg tablets
Prochlorperazine	25 mg suppository

What is the Patient Review and Coordination (PRC) Program?

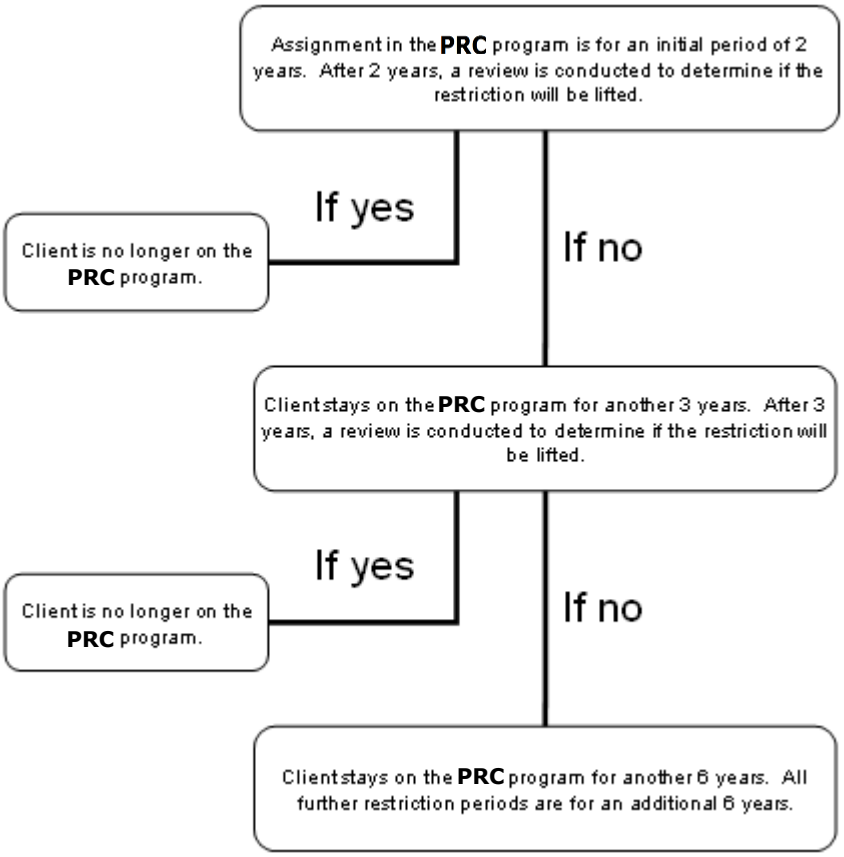
(WAC 182-501-0135(8)(a))

PRC is a health and safety program for fee-for-service (FFS) and managed care clients needing help in the appropriate use of medical services.

Clients assigned to the PRC program are identified as such in ProviderOne.

When a client is initially placed in the PRC program, the agency or managed care organization (MCO) places the client for no less than 24 months with one or more of the following types of health care providers:

- Primary care provider (PCP)
- Pharmacy for all prescriptions
- Prescriber of controlled substances
- Hospital for nonemergency services unless referred by the assigned PCP or a specialist. A client may receive covered emergency services from any hospital
- Another qualified provider type, as determined by the agency or MCO staff on a case-by-case basis



PRC criteria

Agency or MCO staff use the following usage guidelines to initiate a review for PRC placement. A client may be placed in the PRC program when either the client's medical history or billing history, or both, documents any of the following:

- Any two or more of the following conditions occurred for the client in a period of 90 consecutive calendar days in the previous 12 months:
  - ✓ Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice
  - ✓ Had prescriptions filled by four or more different pharmacies
  - ✓ Received ten or more prescriptions
  - ✓ Had prescriptions written by four or more different prescribers not located in the same clinic or practice
  - ✓ Received similar services on the same day not located in the same clinic or practice
  - ✓ Had ten or more office visits

-OR-

- Any one of the following occurred for the client within a period of 90 consecutive calendar days in the previous 12 months:
  - ✓ Made two or more emergency agency visits
  - ✓ Exhibits **at-risk** usage patterns
  - ✓ Made repeated and documented efforts to seek health care services that are not medically necessary
  - ✓ Was counseled at least once by a health care provider, or an agency or an MCO staff member with clinical oversight, about the appropriate use of health care services

-OR-

- The client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the 90-day review period.

-OR-

- The client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous 12 months:
  - ✓ Using health care services in a manner that is duplicative, excessive, or contraindicated
  - ✓ Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice
  - ✓ Being on substance abuse programs such as the alcohol and drug abuse treatment and support act (ADATSA)

(WAC 182-501-0135(6)(a)-(d))

What is the pharmacy's role in the PRC Program?

The assigned pharmacy is a key player in managing the client's prescriptions. The pharmacist will be able to alert the client's primary care physician (PCP), narcotic prescriber, or the agency's PRC staff of misuse or potential problems with the client's prescriptions.

Since pharmaceuticals are an agency-covered service, do not accept cash from clients except for drugs not covered by the agency per WAC 182-502-0160.

A major focus of the PRC Program is education. Educating the client on appropriate use of prescriptions, drug interactions, the importance of maintaining one PCP and pharmacy to manage and monitor one's care are key elements in helping the client appropriately use services.

Clients who have been in the PRC program have shown a 33% decrease in emergency room use, a 37% decrease in physician visits, and a 24% decrease in the number of prescriptions.

What happens if a restricted client goes to a non-assigned pharmacy?

If a restricted client goes to a **non-assigned pharmacy**, the POS system will reject the claim. In the case of a non-emergency situation, the client should be referred back to their assigned pharmacy.

Washington State has the **prudent layman's** law, in which clients can go to the emergency room **if they think** they have a problem and must be seen by the emergency room staff. However, emergency room prescriptions cannot be overridden in the POS system by a non-assigned PRC pharmacy. In this situation, the pharmacist may call the PRC referral line during regular business hours (Monday-Friday, 8 a.m. – 5 p.m.) at 1-360-725-1780 to request an override.

At their discretion in an emergency situation, pharmacists may fill all medications except scheduled drugs, unless verification is made with the prescriber that there is a legitimate medical necessity. Justification for the emergency fill must be provided to the PRC Program the next business day in order for an override to be completed.

For more information, or to report over-utilization of services, contact:

Patient Review and Coordination (PRC) Program
PO Box 45530
Olympia, Washington 98504-5532
Phone: 1-800-562-3022, ext. 15606
FAX: 1-360-725-1969

Visit the agency's Patient Review and Coordination (PRC) Program web page.

How are agency-covered vaccines and vaccine administration fees billed?

- All covered vaccines other than influenza, pneumonia, and Zostavax® must be billed on the CMS-1500 claim form.
- Administration fees must be billed on the CMS-1500 claim form (including influenza, pneumonia, and Zostavax® for clients age 18 and younger). The POS does not have the capability to reimburse for professional services other than dispensing fees.
- The agency reimburses qualified pharmacists for the administration of all agency-covered vaccines for clients on eligible programs.
- The agency does not reimburse for any vaccine available free from the Department of Health (DOH).
- Influenza and pneumonia vaccines for adults (age 19 and older) are reimbursed through the POS system only.

Clients age 18 and younger

The agency pays **only the administration fee** for any vaccine available at no cost from the DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program.

Which vaccines are covered and are they available free from DOH?

To check which vaccines are **free from DOH,** refer to the Injectable Drug Fee Schedule.

Billing for the administration of a vaccine available free from DOH

Bill for the administration of these vaccine(s) with the appropriate procedure code for the vaccine and use modifier SL (e.g., 90707 SL).

Billing for vaccines that are not free from DOH

- Bill for the cost of the vaccine with the appropriate procedure code for the vaccine.
- Bill for the vaccine administration using CPT® codes 90471 (first vaccination) and 90472 (additional vaccinations). The agency limits reimbursement to a maximum of one unit of 90471 and one unit of 90472 per client, for the same date of service.
- The administration codes must be billed on the same claim as the procedure code for the vaccine.
- DO NOT use modifier SL with these vaccines.

How must a pharmacy bill the agency for influenza, pneumonia, and Zostavax® vaccine?

Pharmacists must bill for flu and pneumonia vaccines for clients age 19 years and older with national drug codes (NDCs) through the point-of-sale (POS) system, and for the administration on the CMS-1500 claim form as follows:

Billing for vaccine administration

The agency pays pharmacists for administering influenza, pneumonia, and Zostavax® (shingles) vaccinations only if they have an immunization collaborative practice protocol on file with the Washington State Department of Health (DOH), State Board of Pharmacy. When billing for the administration of an agency-covered vaccine, the pharmacist's NPI must be entered in the **Prescriber ID** field (411-DB).

Note: Pharmacies may **not** use their Pharmacy Location NPI as the Prescriber ID in field 411-DB, or in the Referring/Performing Provider field on 837-P transactions or CMS-1500 claim forms.

Procedure Code	Description	Maximum Allowable Fee
G0008	Administration of influenza virus vaccine	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule
G0009	Administration of pneumococcal vaccine	
90471	Administration of Zostavax® vaccine	

The agency pays pharmacies for procedure codes G0008, G0009 and 90471 (administration codes) when billed with place of service 01 (pharmacy).

Bill the agency for the vaccine administration using only an approved professional services claim form (e.g., paper CMS-1500 claim form; electronic 1500 claim form; or electronic 837-P claim form). Vaccine administrations **cannot** be billed through the pharmacy POS system.

Note: When billing on the CMS-1500 claim form, use the NPI – **do not** use the NCPDP number. Continue to bill the influenza, pneumonia, or Zostavax® vaccine itself through the POS system using the NDC.

Does the agency reimburse for human papillomavirus (HPV) vaccine?

GARDASIL®
The agency reimburses for GARDASIL® (HPV (Types 6,11,16,18) Recombinant Vaccine). See the Immunizations in Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

What form is used to bill for pre-filling syringes?

Fees for pre-filling syringes may be billed on an approved professional services claim form (e.g., paper CMS-1500 claim form; electronic CMS-1500 claim form; or electronic 837-P claim form).

These fees are not billable on POS.

- Each unit billed must be for a two-week supply
- The maximum number of units allowed per month is three

Use the following HCPCS code:

Description	HCPCS Code	Maximum Allowable
Pharmacy compounding and dispensing services (to be used for pre-filling syringes)	S9430	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

Note: If additional fills are necessary for dose adjustment, indicate the comment **Dose adjustment required** in field 19 (**Reserved for Local Use field**) of the CMS-1500 claim form.

If additional fills are necessary due to multiple prescriptions/types, indicate the comment, **Multiple prescriptions/types required** in field 19 (**Reserved for Local Use field**) of the CMS-1500 claim form.

If an emergency fill is necessary resulting in less than a two-week supply, indicate the comment **Emergency fill** in field 19 of the CMS-1500 claim form.

Targeted drug initiatives

The agency has developed targeted drug initiatives to:

- Guide appropriate drug therapy.
- Improve therapeutic outcomes.
- Improve the quality of life for agency clients.

The agency has specific services that:

- Help identify potentially dangerous drug therapy.
- Reduce duplication of therapy.
- Reduce poly-prescribing.
- Assist providers in complex clinical decision-making.

Examples of these services are described below:

ADHD (attention deficit hyperactivity disorder) drug initiatives

The agency promotes the safe and effective use of ADHD medication in children. Specific areas include the use of medication in children younger than age five and appropriate dosing limits in the prescribing of these medications. The agency's ADHD program helps safeguard clients receiving ADHD drugs when:

- The clients are age five and younger.

- The dose exceeds the recommended maximum dosage limits or when drug combinations are prescribed outside the guidelines established by the statewide Mental Health Stakeholders Workgroup in 2006.

Safety Edit – age

Age five and younger

ADHD medications prescribed for children age five and younger require authorization. Prescribers will consult with an agency-designated mental health specialist from the Second Opinion Network (SON). When the patient is already taking the ADHD drug, the agency will authorize continuation for 90 days while the second opinion is taking place. To receive payment for the phone consultation with SON, use procedure code 99441 on the claim.

> **Note:** A SON representative will contact prescribers to schedule the required phone consultation.

Safety Edit – dosage

Dosing limits for clients age five and older:

- For dosing limits, see the list of drugs with limitations.
- Children age 18 and younger require an agency-approved second opinion and agency authorization. Adult doses exceeding the limits require authorization by the Medical Director, or designee, who will review clinical chart notes that must show:
  - ✓ Less risk than usual care.
  - ✓ Less cost to the state.
  - ✓ The next step in reasonable care, including tried and failed FDA dosing.
- Refills above dose limits are authorized until the review is completed.
- Initiation of therapy above dose limits requires review prior to payment.

When the patient is already taking the medication and the authorization request is denied, the agency will allow one additional refill (up to a 34-day supply) of medication for the purpose of tapering the dose to fall within the accepted limits stated above. New prescriptions exceeding the recommended doses for children age 18 and younger require the recommendations of an agency-designated mental health specialist from the Second Opinion Network.

Safety Edit – ADHD drug combinations

- Combinations across drug types (e.g., methylphenidate with amphetamine) require authorization.
- Combinations of Strattera with stimulant ADHD drugs require authorization.

- Continuation of a combination is authorized for a maximum of 30 days while tapering a client off of a drug.

The chart below shows the drugs the Mental Health Stakeholders Workgroup has determined to be duplicative. The squares marked with **an X** indicate the combinations that will require authorization after 34 days of concurrent therapy.

Combinations of medications in two or more ADHD categories				
	Methylphenidate/ Dexmethylphenidate	Amphetamines/ Lisdexamfetamine	Strattera®	Alpha-agonists
Methylphenidate/ Dexmethylphenidate		X	X	
Amphetamines/ Lisdexamfetamine	X		X	
Strattera®	X	X		X
Alpha-agonists			X	

The agency reimburses combinations of short-acting and long-acting forms of the same ADHD drug without authorization. The agency requires the pharmacy to request authorization for a combination of ADHD medications across drug categories. When the pharmacy requests authorization, the agency will contact the prescriber to obtain medical justification for the combination therapy.

Alcohol and Substance Abuse Pilot Project

The agency has expanded its drug and alcohol assessment and treatment services. The agency can better help address the very complex issue of abuse and addiction that some agency clients face.

Starting with a four-county pilot project in Yakima, Clark, Spokane, and Pierce counties, the agency will offer prescribers a set of tools that will help get the necessary care to agency clients with a potential substance or alcohol abuse or dependency issue. The agency can provide a comprehensive listing of services (ER, hospital services, medication profiles, and other services) to medical professionals who have treated the individual clients in the past 12 months. To protect client confidentiality, the information on some clients may be incomplete as the client profile does not contain any mental health diagnosis or any prescriptions typically associated with mental health treatment. Instructions on the last page of the **Tool Kit** detail how to obtain a complete profile. For more important information, see the Tool Kit.

Alpha-Agonist Age and Dose Limits

Based on recommendations by the Pediatric Mental Health Workgroup, the agency requires authorization for alpha-agonists that exceed the agency's dose for clients age 17 and younger.

For dosing limits, see the list of drugs with limitations.

For combined doses of alpha-agonists that exceed the agency's dose limit for clients age 17 and younger, authorization is required.

As part of the authorization process, prescribers are required to engage in a phone consultation with an agency-designated mental health specialist from the Second Opinion Network (SON). To receive payment for the phone consultation with SON, use procedure code 99441 on the claim.

> **Note:** A SON representative will contact prescribers to schedule the required phone consultation.

At the time of the authorization request, continuation of therapy will be approved until the SON consultation process is complete. Agency authorization decisions will be based on the recommendations to the agency by the SON mental health specialist.

> **Note:** Dispensed As Written (DAW) by an endorsing prescriber does not override the PA requirement for exceeding the alpha-agonist dose limits.

Newer anticoagulants

The agency requires authorization for all newer anticoagulants. Newer anticoagulants will be authorized only for the indications, age ranges, and doses currently approved by the Food and Drug Administration (FDA) when first line therapies have proven inadequate to treat or control the patient's condition.

Xarelto® will be authorized without prior authorization for a one-time fill for the following indications and dosages:

- Hip replacement: 10mg once daily for 35 days
- Knee replacement: 10mg once daily for 12 days
- Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE): 15mg twice daily for 21 days

Anticonvulsants, off-label use initiative

The agency requires authorization for off-label use of certain anticonvulsants (Neurontin® or gabapentin, Topamax®, Keppra®, and Gabitril®). The anticonvulsants are all used for treatment of seizures, and the agency has established expedited authorization (EA) codes to allow immediate authorization for this use. Any other use outside of the FDA labeling requires the pharmacy to call the agency's Authorization toll-free telephone number 1-800-562-3022.

The agency does not require authorization for all first-line anticonvulsant drugs used for seizure disorders, such as phenytoin and carbamazepine.

EA codes and criteria:

Drug	Code	Criteria
Gabitril® (tiagabine)	036	Treatment of seizures
Keppra® (levetiracetam)	036	Treatment of seizures
Neurontin® (gabapentin)	035 036 063	Treatment of post-herpetic neuralgia Treatment of seizures Treatment of diabetic peripheral neuropathy
Topamax®/Topamax® Sprinkle (topiramate)	036 045	Treatment of seizures Migraine Prophylaxis

Antidepressants, therapeutic duplication

It is routine to have a client on more than one antidepressant drug when in the process of changing antidepressants, in order to taper from one drug while starting another. This process can take as long as two months, but after that, it is inadvisable to maintain a client on duplicative therapies. **Multiple antidepressants with same/similar mechanisms of action are likely to cause increased side effects with little or no increase in efficacy.** In fact, it is possible for the drugs to compete, interfering with the efficacy of one or both drugs.

Based on the determination of a state-wide workgroup of mental health experts, the agency requires authorization for duplication of therapy which has lasted longer than a two-month taper period (68 days) for the classes listed in the chart below. The chart is presented as a cross reference of drugs the workgroup has determined to be duplicative. The squares marked with an X indicate the combinations that will require authorization after 68 days of concurrent therapy. The blanks indicate appropriate combinations that may be reimbursed.

Class	SSRI	NaSSA	NDRI	SARI	SNRI
SSRI (Selective Serotonin Reuptake Inhibitor)	X			X	X
NaSSA (Noradrenergic and Specific Serotonergic Antidepressant)		X		X	
NDRI (Norepinephrine/Dopamine Reuptake Inhibitor)			X		
SARI (Serotonin Antagonist Reuptake Inhibitor)	X	X		X	
SNRI (Serotonin Norepinephrine Reuptake Inhibitor)	X				X

SSRI – citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine HCl, paroxetine mesylate, sertraline, vilazodone
NaSSA – mirtazapine, vortioxetine
NDRI – bupropion
SARI – nefazodone
SNRI – desvenlafaxine, duloxetine, levomilnacipran HCl, venlafaxine

Duplication sometimes can occur when multiple prescribers are unaware that duplicative care for the same client is taking place. In an effort to help prescribers coordinate care for clients, the agency provides information to each prescriber involved when inappropriate duplication of antidepressants is found. The agency requests that health care practitioners coordinate with each other to establish a plan for the client's care.

Antipsychotic age and dose limits for children age 17 and younger

For all clients age 17 and younger, the agency requires authorization for antipsychotics that exceed maximum dose for the client's age group. The agency's age and dose limits are based on recommendations by the Pediatric Mental Health Workgroup. As part of the authorization process, prescribers are required to engage in a phone consultation with an agency-designated mental health specialist from the Second Opinion Network (SON). To receive payment for the phone consultation with SON, use procedure code 99441 on the claim.

For dosing limits, see the list of drugs with limitations.

Antipsychotic therapeutic duplication for children age 17 and younger

To reduce the therapeutic duplication of antipsychotic drugs prescribed for children age 17 and younger, the agency requires authorization after 60 days of continued use. As part of the authorization process, prescribers are required to participate in a second opinion review process with an agency-designated Mental Health Specialist from the Second Opinion Network (SON).

During the review process, continuation of a combination may be authorized for up to 60 days, to allow the prescriber to complete the SON review or to taper a client off a drug.

Oral, Transdermal, and Intra-Vaginal Contraceptives

The agency requires oral and transdermal contraceptives to be dispensed in a 12-month (13 cycles) supply (See WAC 182-530-2000 (1)(b)(iii)). For the purposes of dispensing these contraceptive products, **12-month** (13 cycles) means a 365-day supply.

Any prescription currently written for a specific quantity less than a 12-month (13 cycles) supply, regardless of how many refills are currently available, cannot be dispensed as a 12-month (13 cycles) supply without confirming a change to the order with the prescriber. The agency encourages pharmacies to request prescription changes. For prescriptions written with a dispensing quantity less than a 12-month supply, the agency encourages pharmacies to contact the prescriber to request a change in the dispensing quantity. If the prescriber is unwilling to change the dispensed quantity, you may submit the claim using EA code 85000000364 to receive payment for the shorter days' supply as indicated on the prescription.

For prescriptions written with a dispensing quantity less than a 12-month supply and the client does not want all dispensed at once, you may submit the claim using EA code 85000000365 to receive payment for the shorter days' supply as indicated on the prescription.

For prescriptions written with a dispensing quantity less than a 12-month supply and the pharmacy is unwilling to contact the prescriber and request a dispensing quantity change, you may submit the claim using EA code 85000000366 to receive payment for the shorter days' supply as indicated on the prescription.

Note: When submitting a claim with an EA code, you must document on the prescription the code that was used and the reason.

Cough and cold drug coverage

The agency restricts coverage of drugs used to treat cough and colds to those drugs listed on the Covered Cough/Cold Product List. The agency bases its decision on which drugs to place on this list using evidence of efficacy and safety and current best practices.

OTC drugs used to treat cough and colds which are not on the **Covered Cough/Cold Product List** are noncovered and may be billed directly to the client as a non-prescribed OTC. **Prescription drugs** used to treat cough and colds which are not on the **Covered Cough/Cold Product List** may be purchased by the client with a signed waiver. (See **Billing the Client**, WAC 182-502-0160 and Coordination of Benefits.)

Generics first (GF)

The agency requires that a preferred generic drug be used as a client's first course of treatment within specific drug classes on the Washington Preferred Drug List (PDL). Only clients who are new to a drug class will be required to start on a preferred generic product. When a client has not received a drug in one of these drug classes within 180-days prior to the date of the fill, the agency's POS system will reject claims for both non-preferred and preferred brand name drugs as well as non-preferred generic drugs.

If the brand name drug has been prescribed by a non-endorsing practitioner, or by an endorsing practitioner who has not indicated Dispense As Written (DAW), the brand will **not** be covered by the agency. If the prescriber is an endorsing practitioner, and Therapeutic Interchange is allowed in the drug class, the product should be switched to a preferred drug. Otherwise, when requested to do so by POS return messaging, contact the prescriber to request a change of the prescription to a preferred generic drug.

If the prescription is signed "DAW" by an endorsing practitioner for a drug within a GF drug class, contact the agency to request authorization. The agency will provide the endorsing practitioner with an opportunity to justify the medical necessity for starting the client on a brand name drug or a non-preferred generic as their first course of therapy.

The agency will cover only preferred generic drugs as a client's first course of therapy within the following drug classes:

- ACE inhibitors
- Atypical antipsychotics
- Attention Deficit Hyperactivity Disorder (ADHD) drugs
- Beta blockers
- Long-acting opioids
- Nasal corticosteroids

- Newer antihistamines
- Newer sedative/hypnotics
- Nonsteroidal anti-inflammatory drugs (NSAIDS)
- Proton pump inhibitors (PPI)
- Second generation antidepressants
- Skeletal muscle relaxants
- Statin-type cholesterol-lowering agents

Inhaled Corticosteroid (ICS)/Long-acting Beta Agonist (LABA) combination drugs

The agency requires authorization for medications in this drug class to verify that a clinically appropriate stepwise treatment plan has been followed which reflects an accurate assessment of disease severity for the treatment of asthma or Chronic Obstructive Pulmonary Disease (COPD).

ICS/LABA products will be approved only for clients within age limits as indicated by FDA labeling.

The agency may approve the use of ICS/LABA combination products in patients with:

- Asthma not adequately controlled by a trial with an ICS as monotherapy.
- COPD not adequately controlled by a trial of a bronchodilator as monotherapy.
- Asthma or COPD whose disease severity warrants initiation of treatment with two maintenance drugs.

According to the National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma, inhaled corticosteroids (ICS) are the preferred and most effective long-term control medication for treatment of persistent asthma. Leukotriene receptor antagonists (LTRAs) are an alternative but not preferred therapy for mild persistent asthma and can also be used as adjunctive therapy with ICSs. For preventing exercise-induced bronchoconstriction, the Expert Panel recommended that short-acting beta-agonists (SABAs) as the drug of choice.

See the American Academy of Allergy, Asthma, and Immunology (AAAAI) practice parameters for more information, including information regarding the use of intranasal corticosteroids as the most effective medication class for controlling symptoms of allergic rhinitis. In most studies, intranasal corticosteroids are more effective than the combined use of an antihistamine and an LTRA for seasonal allergic rhinitis. There is also no significant difference in efficacy between LTRA and antihistamines, with loratadine as the usual comparator.

Medication assisted treatment (MAT)

Authorization is required for some medications used for the treatment of substance use disorders. The agency requires prescribers to follow clinical best practices for all medication assisted treatment (MAT), including those that do not require authorization. The Washington Prescription Monitoring Program must be accessed and reviewed for each client before or at the time of induction. A complete medical history, including information detailing the client's current and past history of drug or alcohol dependency and treatment, as well as any current or past history of mental health diagnoses and treatment, is required along with a physical exam appropriate to the client's clinical presentation and method of use. For all ongoing treatment that will continue for longer than six months, prescribers must complete form HCA 13-333 *Medication Assisted Treatment Patient Status.*

Prescribers

Authorization is required for Washington Apple Health clients to receive some MAT products. See Apple Health's Drug Coverage Criteria for a listing of medications and authorization requirements. To request authorization for a client to receive MAT:

For initial treatment:

- Read *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment*. Providers should become familiar with agency requirements for office-based substance use disorder treatment prior to requesting authorization for MAT.

- Select the *Medication Assisted Treatment Request* form for the drug being prescribed. Complete and sign this form.

- Fax the completed *Medication Assisted Treatment Request* form to the pharmacy that will be filling the prescription and dispensing to the client. Alternately, the provider can provide the form to the client to hand deliver to the client's pharmacy of choice.

For ongoing treatment longer than six months:

- Providers must complete form HCA 13-333 *Medication Assisted Treatment Patient Status* for all MAT treatment that continues beyond six months of therapy, including medications that do not require authorization. This form must be completed every six months while the client is receiving MAT and maintained in the patient's records for later audit and review by HCA. The requirement to maintain this document applies for all Apple Health clients regardless of managed care enrollment.

Pharmacies

To submit a request for MAT, providers must:

- Complete the agency's *Pharmacy Information Authorization* form 13-835A as for any other authorization request.
- Attach the appropriate *Medication Assisted Treatment Request* form as supporting documentation to the *Pharmacy Information Authorization* form 13-835A.

- Fax both documents to the agency at: (866) 668-1214. The *Pharmacy Information Authorization* 13-835A must be the first document in the fax transmission.
- Authorization requests will not be reviewed until all necessary documents are received by the agency. Obtain all completed forms prior to requesting authorization.

Drug Specific Criteria

See the agency's Medication-Assisted Treatment (MAT) page for:

- *Clinical Guidelines and Coverage Limitations for Medication-Assisted Treatment (MAT)*
- *Medication-Assisted Treatment* forms
- Other drug-specific criteria.

See the agency's Medicaid Forms page for the *Pharmacy Information Authorization* form 13-835A as well as the forms listed above.

Mental health polypharmacy

Mental health experts participated in the agency's Mental Health Drug Initiative Stakeholder Workgroup to determine the threshold for clinical review and select which drugs are recognized as mental health drugs (see the agency's list of recognized mental health drugs).

The agency requires authorization for concurrent therapy with five or more mental health drugs for clients who are age 17 and younger.

As part of the authorization process, prescribers are required to engage in a phone consultation with an agency-designated mental health specialist (MHS) from the Second Opinion Network (SON). Agency authorization decisions are based on the recommendations to the agency by the SON MHS.

Note: A SON representative will contact prescribers to schedule the required phone consultation.

At the time of the authorization request, continuation of the concurrent therapy will be approved until the SON consultation process has been completed.

Authorization for proton pump inhibitors (PPIs)

The agency requires authorization for the continued use of proton pump inhibitors (PPIs) for more than 90 consecutive days. Clients receiving a PPI for more than 90 days may be candidates for "step-down" therapy.

Prescribers should:

- Reevaluate therapy for clients diagnosed with Gastroesophageal Reflux Disease (GERD) and negative findings on endoscopy.
- Consider discontinuing the PPI or step-down to ranitidine, a Histamine-2 Receptor Antagonist (H2RA) medication.

What does the Narcotic Review Project do for clients?

The agency's Narcotic Review Project reduces misuse of narcotics in clients considered at "high risk" of abuse or misuse of narcotic prescriptions. This program can assist providers in this complex area of medicine. The key to the program is keeping prescribers informed about their patients' use of narcotics by faxing information to the prescriber who wrote the latest prescription.

Pharmacy Authorization staff fax the patient's recent narcotic profile (12-months of all narcotic prescriptions and prescriber names) to the prescriber who wrote the latest prescription. After the prescriber reviews the profile and makes a decision whether to continue with the prescription or not, the prescriber faxes the form back to Pharmacy Authorization, and the prescription is authorized or not authorized, depending on the prescriber's response.

If the prescriber believes that the patient's pattern of narcotic usage is medically necessary and does not show abuse or misuse, the patient's case is reviewed by the agency's Drug Use Review Team, and a decision is made whether to remove the patient from the authorization requirement.

For more information about drug abuse prevention or treatment, contact the Washington Recovery Help Line at 1-866-789-1511, or call the state Behavioral Health and Service Integration (BHSI) 1-877-301-4557 and ask for the regional administrator for a specific county for help to access public care. If a provider believes a client may need help for drug abuse, refer the client to the Help Line.

How were the opioid dosing guidelines developed?

These guidelines were developed by the Interagency Workgroup on Practice Guidelines (the Department of Corrections, Department of Health, Department of Labor and Industries, Department of Social and Health Services, and the Health Care Authority) in collaboration with actively practicing physicians who specialize in pain management. The guidelines are to assist

the practitioner in prescribing opioids in a safe and effective manner. The guidelines do not apply to the treatment of cancer pain or end-of-life (hospice) care.

For more information, see the Washington State Agency Medical Directors' Group (AMDG) Opioid Dosing Guidelines.

Does the agency cover over-the-counter (OTC) drugs?

The agency has reviewed and determined that the OTC drugs on the "Covered Over-the-Counter Drug List" list are the least costly therapeutic alternatives for medically accepted indications. (WAC 182-530-2000(1)(d))

Visit the Medicaid Coverage Lists for more information.

Note: OTC family planning products and OTC drugs used to treat cough and colds are governed under different rules and have their own coverage lists.

OTC drugs not included on any agency Covered Drug List are noncovered and may be billed directly to the client as a non-prescribed OTC.

Sedative/hypnotic restrictions for children

Sedatives and hypnotics in children age 18 and younger are limited to a one-time authorization of less than five doses in a 30-day period.

Step therapy for inhaled long-acting beta agonist/corticosteroid combination drugs

The agency requires authorization for inhaled long-acting beta agonist/corticosteroid combination drugs when there is no record in the agency's payment system that the client has had a previous trial of an inhaled corticosteroid medication.

The agency requires documentation of **one** of the following:

- The client tried and failed inhaled corticosteroid monotherapy.
- Disease severity warrants initiation with two maintenance therapies.
- The client is being treated for airflow obstruction associated with Chronic Obstructive Pulmonary Disease (including emphysema and chronic bronchitis).

Black box warning for these combination drugs state that long-acting beta agonists may increase the risk of asthma-related death. The FDA-approved prescribing information for the inhaled long-acting beta agonist/corticosteroid combinations states that for the indication of asthma, the combination should be used only for patients:

- Whose disease is not adequately controlled on other asthma-controller medications (e.g., low- to medium- dose inhaled corticosteroids).

- Whose disease severity clearly warrants initiation of treatment with two maintenance therapies, as found in the Agency for Healthcare Research and Quality (AHRQ) report.

Where is information available for Synagis®?

For information on Synagis, see the *Drugs Professionally Administered* section in the agency's current Physician Related Services/Health Care Professional Services Billing Guide.

What does emergency fill mean?

Emergency fill means that the dispensing pharmacist used their professional judgment to meet a client's urgent medical need and dispensed the medication to the client prior to receiving reimbursement from the agency.

The agency guarantees claim payment for an emergency fill. If the agency rejects an electronic claim for an emergency fill, contact the agency with the information that the claim is for an emergency fill.

If the dispensing pharmacist decides that the client has an urgent medical need, the following steps are required:

- Determine the quantity necessary to meet the client's urgent medical need (up to a 34-day supply)
- Dispense the medication to the client
- Request an emergency fill by using either of the following two options:

  - ✓ Calling Pharmacy Authorizations at 800-562-3022 ext. 15483
  - ✓ Faxing a request for an emergency fill authorization to 1-866-668-1214

Contact the agency within seven calendar days or before filling the medication again (whichever is sooner). Medical necessity requirements will be applied to any future fills of the same medication, but will be waived to ensure payment of the emergency fill.

Does the agency pay for hemophilia - and von Willebrand-related products for home administration?

(WAC 182-531-1625)

The agency does not pay for hemophilia- and von Willebrand-related products for administration in the home when dispensed through and billed by retail or specialty pharmacies. The agency pays for hemophilia- and von Willebrand-related products shipped to fee-for-service clients **only** when the products are provided through a qualified hemophilia treatment center of excellence (COE).

> **Note:** If a client has not yet established a care relationship with a qualified hemophilia COE, but an initial appointment has been scheduled, specialty pharmacy providers may contact the agency to request an authorization to continue to dispense product to the client. The pharmacy must call the agency's Pharmacy Authorization Section at 800-562-3022, extension 15486.

What are the criteria to become a Qualified Hemophilia Center of Excellence (COE)?

To become a qualified hemophilia COE, a hemophilia center must meet all of the following:

- Have a current core provider agreement in accordance with WAC 182-502-0005
- Be a federally approved hemophilia treatment center (HTC) as defined in Definitions and meet or exceed all Medical and Scientific Advisory Council (MASAC) standards of care and delivery of services
- Participate in the public health service 340B provider drug discount program and be listed in the Medicaid exclusion files maintained by the federal Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA)
- Submit a written request to the agency to be a qualified hemophilia treatment center of excellence and include proof of the following:
  - ✓ U.S. Centers for Disease Control (CDC) and prevention surveillance site identification number
  - ✓ Listing in the hemophilia treatment center (HTC) directory
  - ✓ Receive written approval including the conditions of payment and billing procedures from the agency

To be recognized as a qualified hemophilia COE, submit a written request to:

Hemophilia Treatment COE
Health Care Authority – Health Care Services
PO Box 45506
Olympia WA 98504-5506

Why is there an annual documentation requirement?

To remain a qualified hemophilia COE, the hemophilia COE must annually submit both of the following to the agency:

- Copies of grant documents and reports submitted to the Maternal and Child Health Bureau/Human Resources and Services Administration/Department of Health and Human Services, or to their designated subcontractors

- Proof of continued federal funding by the National Hemophilia Program and listing with the regional hemophilia network and the CDC

To view the list of qualified Centers of Excellence (COE) for hemophilia treatment, see the agency's current Physician-Related Services/Health Care Professional Services Billing Guide.

Authorization

Note: Authorization does not guarantee payment. All administrative requirements (client eligibility, claim timeliness, etc.) must be met before the agency reimburses,

When does the agency require authorization?

(WAC 182-530-3000(2))

Pharmacists are required to obtain authorization for some drugs and drug-related supplies **before** providing them to the client. Other drugs require authorization only when specific limits on dosage, quantity, usage, or duration of use are exceeded. The agency may also require **situational** authorization that is not directly related to the product being dispensed. These situations include, but are not limited to:

- Early refills
- Therapeutic duplications
- Client's whose usage patterns are under review
- More than four prescriptions or prescription refills per calendar month for the same product in any of the following categories:
  - ✓ Antibiotics
  - ✓ Anti-asthmatics
  - ✓ Schedule II and III drugs
  - ✓ Anti-neoplastic agents
  - ✓ Topical preparations
  - ✓ Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations
- More than two prescriptions or prescription refills per calendar month for any other product

The agency reviews authorization requests for medical necessity. The requested service or item must be covered within the scope of the client's program.

Exception: In emergency situations, pharmacists may fill prescription drugs that require authorization without receiving an authorization number prior to dispensing.

Note: To receive reimbursement, justification for the emergency fill must be provided to the agency no later than seven days after the fill date.

How do I obtain authorization?

To obtain authorization for drug products requiring authorization, providers may:

- Fax a *Pharmacy Information Authorization* form 13-835A to the agency at 1-866-668-1214.
- Call the agency at 1-800-562-3022.

What information must a pharmacist have ready before calling the agency for an authorization number?

When calling for an authorization number, pharmacists must have the following information ready:

- Previous authorization number, if available
- Pharmacy NCPDP #
- Pharmacy NPI#
- Rx #
- Quantity and day's supply
- Tried and failed
- Client's ProviderOne Client ID
- National Drug Code (NDC) being dispensed
- Prescriber's name and specialty (if known)
- Prescriber's phone and fax number
- Date(s) of dispense
- Justification for the requested service:
    - ✓ The medical need for the drug and/or dosing (sig)
    - ✓ The diagnosis or condition of the client
    - ✓ Other therapies that have been tried and failed in the treatment of the same condition

The agency may request additional information, depending on the drug product.

Who determines authorization status for drugs in the agency's drug file?

(WAC 182-530-3100(1))

For drugs in therapeutic classes included in the Washington Preferred Drug List (PDL), authorization status is determined by its designation as preferred or non-preferred.

For drugs **not** in therapeutic classes included in the PDL, agency pharmacists, medical consultants, and the Drug Use Review Team evaluate drugs to determine authorization status of the drug file. The agency may consult with an evidence-based practice center, the Drug Use Review (DUR) Board, or participating agency providers in this evaluation.

How is authorization status determined for drugs in the agency's drug file?

(WAC 182-530-3200(2) and (3))

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the agency pharmacist(s) a written request and all of the following supporting documentation:

- Background data about the drug
- Product package information
- Any pertinent clinical studies
- Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process
- Any additional information the manufacturer considers appropriate

The agency evaluates a drug based on, but not limited to, the following criteria:

- Whether the manufacturer has signed a federal drug rebate contract agreement
- Whether the drug is a less-than-effective drug
- The drug's risk/benefit ratio
- Whether like drugs are on the agency's drug file and a less costly therapeutic alternative

- Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage
- The drug's potential for abuse
- Whether outcome data demonstrate that the drug is cost effective

What authorization status may be assigned to a drug?

The agency may determine that a covered drug is:

- Covered without restriction
- Requires authorization
- Requires authorization when exceeding the agency-determined limitations

Decisions regarding restrictions are based on, but are not limited to:

- Client safety
- FDA-approved indications
- Quantity
- Client age and/or gender
- Cost

Note: Visit the agency's current List of Drugs with Limitations for information about drugs with limits. Physicians and pharmacists should monitor the use of these drugs and counsel patients when they exceed the limit. Authorization is required in order to exceed these limits.

How are drugs added to the agency's drug file?

(WAC 182-530-3000(2) and (3))

The agency's drug file is maintained by Medi-Span® (a drug file contractor). Manufacturers must report their products to Medi-Span® for them to be included in the agency's drug file for potential coverage and reimbursement.

Is there a list of drugs that do not require authorization?

See the agency's current Expedited Authorization Codes and Criteria Table (EA) list for drugs that do not require authorization.

Note: Products on the EA list are **subject to all other coverage rules**.

When can a medication be dispensed more than twice per month or filled early?

(WAC 182-530-3000(5)(b))

The agency allows medications to be dispensed more than twice per month under the following circumstances:

- Up to four prescription fills or refills per calendar month for the same product in any of the following categories:

  - ✓ Antibiotics
  - ✓ Anti-asthmatics
  - ✓ Schedule II and III
  - ✓ Anti-neoplastic agents
  - ✓ Topical preparations

- Up to six prescription fills or refills per calendar month of products containing buprenorphine which are FDA indicated for treatment of opioid dependence.

- The prescription is written for short days-supply because the client's prescriber is monitoring the client (examples: a client is suicidal, at-risk for potential drug abuse, suffers cognitive impairment that makes medication management difficult, or has compliance issues)

A pharmacy may allow multiple fills or early refills under the following circumstances:

- A client's prescription has been lost, stolen, or destroyed (only once every six months, per medication)
- A client needs a take-home supply of medication for school or camp, or for skilled nursing facility clients
- A client needs a refill sooner than originally scheduled due to a dosage change by the prescriber, and it does not require a third fill in the month, a pharmacist may override a "refill too soon" reject using DUR codes. The pharmacist must document the dosage change. For more information on the use of DUR codes, see What is the prospective drug use review (pro-DUR) used for?

For any other circumstance, the provider must contact the agency's Pharmacy Authorization Section to request approval and an authorization number. (See Resources Available.)

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If clients residing in a skilled nursing facility (SNF) have their prescription lost or stolen, the replacement prescription is the responsibility of the SNF. Clients who have trouble managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

Hard copy billers must enter one of the following justification descriptions in the ***Justification/Comments*** field on the *Pharmacy Statement (525-106)* form 13-714.

Point-of-Sale billers must enter one of the following codes in the **Claims Segment, Prior Authorization Type** Code (461-EU) field.

Justification Description	Code
Lost or Stolen Drug Replacement	5
School or Camp	8
Monitoring	8
Suicidal Risk (SR)	8
Take Home Supply (Skilled Nursing Facility Client)	8

Can clients receive early refills or extended days' supply for travel?

(WAC 182-530-3000(5)(b))

The agency will not approve early refills or prescriptions filled for over a 34-day supply for clients who will be out of the area. Early refills for the purpose of travel are considered to be services rendered for a future date. Clients may elect to self-pay for an early refill or a larger

days' supply, as they are not considered Medicaid eligible for the future service at the time of fill.

It is also possible to help clients who will be out of the area to receive refills covered by the agency at a time they are due for a regular refill. Providers may assist clients with any of the following options:

- If clients will not be out of state, they may have their prescription filled at any agency-contracted pharmacy throughout Washington or border areas of Idaho and Oregon.
- Clients may arrange with a pharmacy to refill their prescription at the appropriate time, and have a relative or other designee pick up the prescription for them. The client's designee may then ship the medication to the client at their own expense.
- A pharmacist can make arrangements with the client to ship the medication from the pharmacy. The cost of shipping is not billable to the agency and will not be covered. Shipping is at the pharmacy's expense or the client's expense if a signed consent is on file.
- Some chain stores have the ability to "transfer stock," billing the prescription from a local Washington pharmacy, while having the medication dispensed from a store in another part of the country.

Is authorization required for brand name drugs?

Prescribers and pharmacies should prescribe and dispense the generic form of a drug whenever possible. Authorization may be required for reimbursement of brand name drugs at brand name pricing when any generic therapeutic equivalent is available. If the brand name drug is prescribed instead of a generic therapeutic equivalent, the prescriber must provide medical justification for the use of the brand name drug to the pharmacist. Authorization is based on medical need, such as clinically demonstrated, observed, and documented adverse reactions which have occurred when generic therapeutic equivalents have been used.

Substitute generic drugs for listed brand name drugs when both of the following are true:

- They are approved by the FDA as therapeutically equivalent drugs.
- They are permitted by the prescribing physician under current state law.

To request authorization, call the agency at: 1-800-562-3022.

What is an exception to rule (ETR)?

The process used by the agency to consider the appropriateness of a noncovered item when that service is specifically needed for that client because their clinical needs are so different than the rest of the population.

Providers may request an ETR to request coverage for a noncovered service by contacting the agency and providing the necessary information for the program to make a decision in each client's individual case.

For detailed requirements regarding ETR requests for a noncovered product (see WAC 182-501-0160).

What is expedited authorization (EA)?

(WAC 182-530-3200(4))

The agency's EA process is designed to eliminate the need to request authorization from the agency. The intent is to establish authorization criteria and associate these criteria with specific codes, enabling providers to create an "EA" number when appropriate.

How is an EA number created?

To bill the agency for drugs that meet the expedited authorization criteria on the following pages, the pharmacist must create an 11-digit EA number. The first 8 digits of the EA number must be **85000000.** The last 3 digits must be the code number of the diagnosis/condition that meets the EA criteria.

Hardcopy billers must enter the EA Number in the **Authorization Number** field on the *Pharmacy Statement (525-106)* form 13-714.

Point of Sale billers must enter the EA Number in the **Claims Segment, Prior Authorization Number Submitted** field.

Example: The 11-digit EA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **85000000002** (85000000 = first eight digits, 002 = diagnosis/condition code).

Reminder: EA numbers are only for drugs listed in the Expedited Authorization Code and Criteria Table. EA numbers are not valid for any of the following:

- Other drugs requiring authorization through the Prescription Drug Program.
- Waiving the State Maximum Allowable Cost (SMAC) or Automated Maximum Allowable Cost (AMAC) price.
- Authorizing the third or fifth fill in the month.

Note: Use of an EA number does not exempt claims from edits, such as per-calendar-month prescription limits or early refills.

EA guidelines:

- **Diagnoses -** Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet the conditions for EA. Drug claims submitted without an appropriate diagnosis/condition code for the dispensed drug are denied.

- **Unlisted Diagnoses -** If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EA list, additional justification is required. The pharmacist must request authorization by either one of the following:

  - ✓ Phone 1-800-562-3022
  - ✓ Fax 1-866-668-1214

- **Documentation** - Dispensing pharmacists must write both of the following on the original prescription:

  - ✓ The full name of the person who provided the diagnostic information
  - ✓ The diagnosis/condition and/or the criteria code from the attached table

Reimbursement

What in general does the agency need to process a reimbursement for services?

- **Remember** the agency is a taxpayer-funded program and the payer of last resort - meaning providers must pursue all other possible medical coverage first. See Coordination of Benefits for more information.

- The agency is required to be a prudent purchaser on behalf of the taxpayer. Drug reimbursements are subject to federal upper limit (FUL) payment rules (see Reimbursement), and the agency is permitted to pay for outpatient drugs only when the manufacturer has a signed drug rebate contract with the federal Department of Health and Human Services (DHHS). See Drug Rebate Program for more information.

- Bill the agency the usual and customary charge using the complete 11-digit national drug code (NDC) from the dispensing container.

- Accurately report the quantity dispensed, using the appropriate metric or metric decimal quantity for the product.

- Delivery of a service or product does not guarantee payment. For example, the agency does not reimburse when:

  - ✓ The request for payment is not presented within the 365-day billing limit. (See Billing)
  - ✓ The service or product is not medically necessary or is not reimbursable by the agency.
  - ✓ The client has third party coverage and the third party pays as much as, or more than, the agency allows for the service or product.
  - ✓ The service or product is covered in the managed care capitation rate.
  - ✓ The service or product is included in the Nursing Home per diem rate.
  - ✓ The client is no longer eligible or isn't eligible for the drug being dispensed.
  - ✓ A prescription has been used to meet a client's financial obligation towards spenddown.

How does the point-of-sale system (POS) establish reimbursement rates?

(WAC 182-530-7000)

The agency's reimbursement for a drug dispensed by a pharmacy is adjudicated by the POS system. POS reimburses at the lowest of the appropriate rates for the product. Depending upon the status of the drug, POS reimburses for the:

- Estimated Acquisition Cost (EAC) plus a dispensing fee.
- State Maximum Allowable Cost (SMAC) plus a dispensing fee.
- Federal Upper Limit (FUL) plus a dispensing fee.
- Automated Maximum Allowable Cost (AMAC) plus a dispensing fee.
- Provider's usual and customary charge to the non-Medicaid population.
- Actual Acquisition Cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Services (PHS) Act and dispensed to medical assistance clients.

Note:

- If the pharmacy provider offers a discount, rebate, promotion or other incentive that directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to the agency for the prescription. (Example: A $5.00 off coupon for purchases elsewhere in the store.)

- Any drug or product provided free to the general public must also be provided free to the Medicaid customer.

How does the agency use the estimated acquisition cost (EAC)?

(WAC 182-530-8000)

The agency uses estimated acquisition cost (EAC) for drugs not otherwise covered by FUL, SMAC, or AMAC rates. The agency selects the source for reference pricing and determines the calculation to be used for estimated acquisition (EAC) cost.

Currently, the EAC is calculated at a rate established by a survey of invoice and acquisition costs or a discount off the average wholesale price (AWP) for either of the following:

- For single source drugs and multiple source drugs with fewer than five manufacturers/labelers, the automated discount from AWP is 16%.

- For multiple source drugs with five or more manufacturers/labelers, the discount from AWP is 50%.
- For selected single source drugs, EAC may be set at a rate established by survey of acquisition costs.

How are federal upper limits calculated?

(WAC 182-530-8050)

Federal Upper Limits (FUL) for multiple source drugs are calculated by DHHS, Centers for Medicare and Medicaid (CMS). The agency is required to comply with the federal limits.

FUL rules are being revised in response to the federal Deficit Reduction Act and are currently in draft circulation for comment.

Note: For more information, see CMS Federal Upper Limits.

Drugs subject to FUL may also be subject to other agency pricing methodologies. The agency reimburses the lower of EAC, SMAC, AMAC, FUL, or usual and customary charges.

How is the automated maximum allowable cost (AMAC) calculated?

(WAC 182-530-8150)

The agency's POS payment system calculates an AMAC price for all multiple source drugs not currently on the SMAC list.

The AMAC is calculated using one of the following methods:

- Reimbursement for all drugs with the same ingredient, form, and strength is at the third lowest priced drug or AWP minus 16%, whichever is less.
- For drugs with five or more manufacturers or labelers, the AMAC price is AWP minus 50%.

When is the state maximum allowable cost (SMAC) applied?

(WAC 182-530-8150)

The SMAC may be applied to specific, equivalent multiple-source drugs. If applied, the agency reimburses both the brand name and generic drugs at the MAC price.

The SMAC may be waived for:

- Preferred drugs
- Some **Dispense as Written** (DAW) prescriptions
- Limited other circumstances

Visit the most up-to-date SMAC list.

How is tax computed?

Tax is computed by the POS system for items that the Washington State Department of Revenue determines to be taxable.

What are the agency's dispensing fees?

(WAC 182-530-7050)

The agency uses a three-tier dispensing fee structure with an adjusted fee allowed for pharmacies that participate in the Unit Dose programs. Listed below are the agency's dispensing fee allowances for pharmacies:

High-volume pharmacies (over 35,000 Rx/yr) $4.24/Rx
Mid-volume pharmacies (15,001-35,000 Rx/yr) $4.56/Rx
Low volume pharmacies (15,000 Rx/yr and under) $5.25/Rx
Unit dose systems $5.25/Rx

A provider's dispensing fee is determined by the volume of prescriptions the pharmacy dispenses for all customers, not just Apple Health (Medicaid) clients.

Providers are required to respond to an annual prescription count survey.

Return the annual prescription count survey to:
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562

Does the agency pay dispensing fees for non-drug items?

(WAC 182-530-7050)
The agency does not pay a dispensing fee for non-drug items, devices, or supplies unless the agency determines that the drug file is not maintaining prices sufficient to cover product cost.

How is the drug rebate program used?

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates that states claim federal financial participation (FFP) **only** for outpatient prescription drugs supplied by a drug manufacturer who has entered into a **drug rebate contract** with the Department of Health and Human Services.

Note: Providers must bill the actual and complete 11-digit NDC for the drug dispensed and the actual quantity, using the appropriate unit of measure.

Using an incorrect NDC or inaccurate reporting of a drug quantity will cause the agency to report false drug rebate calculations to manufacturers.

Note: To download the agency's version of the Federal List of Drug Manufacturers Participating in the Centers for Medicare and Medicaid (CMS), visit the agency's Drug Rebate Program list.

Billing

What are the general instructions for billing?

- Providers must follow the billing requirements found in the agency ProviderOne Billing and Resource Guide.
- Bill the agency your usual and customary charge using the complete 11-digit NDC from the dispensing container.
- Report the actual quantity dispensed using the appropriate metric or metric decimal quantity for the product.
- Remember that the agency is the payer of last resort. See "Coordination of Benefits" later in this section. **(Claims paid inappropriately when other coverage is available may be recouped.)**
- Clients who are enrolled in an agency managed care plan are eligible for pharmacy services under their designated plan. **Bill the plan first.**

Note: When another insurer or an agency managed care plan requires authorization for a drug, perform all steps necessary to obtain the authorization. Requiring authorization is not the same as a denial of coverage.

What is the requirement regarding tamper-resistant prescription pads?

(RCW 18.64.500)

All written prescriptions, including OTC medications, must be written on a tamper-resistant prescription pad or paper that has been approved by the Pharmacy Quality Assurance Commission for use. Both RCW 18.64.500 and 42 U.S.C. 1936b(i)(23) require prescription pads and paper to have at least one feature from **each** of the below characteristics to be considered tamper-resistant to prevent the prescription from being changed:

- **No copying:** For example, pantographs that reveal the word "VOID" when copied
- **No altering:** For example, chemical stains or an altered background reveal attempts at ink or toner removal

- **No counterfeiting:** For example, pads have a watermark and cannot be reproduced

Prescription pads and paper that have met all industry-recognized characteristics have a seal of approval affixed to the paper. This requirement must be met for all written prescriptions, regardless if the client is enrolled in a managed care plan.

Prescriptions that are telephoned, faxed, or sent electronically to the pharmacy are exempt from the state and federal requirements. Pharmacists receiving non-compliant, written prescriptions are encouraged to verify the prescription with the prescriber.

What about emergency dispensing?

Pharmacists are allowed to dispense a prescription written on non-compliant paper as long as the pharmacy receives verification from the prescriber by telephone, fax, or email within 72-hours of filling the prescription. Federal controlled substance laws must continue to be met when prescribing or dispensing Schedule II drugs.

What about Medicaid clients with retroactive certification?

To submit a claim for a Medicaid client retroactively certified for Medicaid, a pharmacy must reimburse the client in accordance with WAC 182-502-0160.

What are the documentation and records retention requirements?

The pharmacist must document that the prescriber was contacted by telephone, fax, or email to verify that the legitimacy of the prescription written on non-compliant paper **before** it was dispensed. Prescription records, including documentation for non-compliant prescriptions, must be kept for six years according to WAC 182-502-0020.

What is needed for prescription transfers between pharmacies?

The pharmacy accepting a prescription transfer from another pharmacy only needs to obtain a telephone call or fax from the transferring pharmacy in order to confirm the authenticity of the tamper-resistant prescription.

What is the time limit for billing?

(WAC 182-502-0150)

The agency requires providers to submit initial claims and adjust prior claims in a timely manner. The following are the agency's timeliness standards for initial claims, resubmitted claims, and for claim adjustments in the Prescription Drug Program. For more information on timelines for billing, refer to the agency ProviderOne Billing and Resource Guide.

Medicare Part B crossover claims
If Medicare Part B allows the claim, it is no longer billable as a Prescription Drug Program claim through the point-of-sale (POS) system. A claim allowed by Medicare Part B is billable as a crossover claim on a CMS-1500 claim form within six months of the date that Medicare processes the claim. Providers can rebill or resubmit a crossover claim up to two years from Medicare's process date. If Medicare denies payment of the claim, the agency requires the provider to meet the agency's initial 365-day requirement for the initial claim. If a provider has billed Medicare but has not received a response, the provider must still bill the agency within 365 days of the date of service to establish timeliness.

Resubmitted claims and adjustments
The agency allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within 15-months of the date the service was provided to the client. Claims may be resubmitted, modified, or adjusted by the pharmacy electronically for 365 days from the date dispensed. Resubmissions, modifications, or adjustments between 12 and 15 months old must be submitted as a hardcopy claim on an appropriate agency form. Hardcopy claims and adjustments over 365 days old must include the TCN of the original timely transaction. After 15-months, the agency does not accept a prescription drug claim for resubmission, modification, or adjustment.

Reversals
The agency allows pharmacies to reverse any prescription drug claim with a timely TCN within 15 months of the date the service was provided to the client. A *Pharmacy Adjustment Request* form HCA 13-715 must be submitted if a pharmacy wishes to reverse a transaction that can no longer be reversed electronically from the pharmacy's own system. This includes all three of the following:

- Reversals between 12 and 15 months from the dispensing date
- "Lost" transactions (paid claim not found in the pharmacy's own system)

- Claims older than the pharmacy's own system will allow them to reverse

Overpayments that must be refunded to the agency
The 15-month period allowed for resubmission of claims above **does not apply** to overpayments that a prescription drug provider must refund to the agency. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. **Do not submit a claim adjustment.** Questions regarding overpayments may be directed to the MPA Cash Control at 360-725-1279.

Client's responsibility
The agency does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements, resulting in the claim not being paid by the agency (see Billing a Client.)

What is the national provider identifier (NPI) requirement?

Pharmacy providers are required to provide the pharmacy and prescriber National Provider Identifiers (NPIs) on all prescription drug claims.

The agency requires a prescriber to provide its individual NPI (Type 1) with prescription drug orders that are written, transmitted, called in, or faxed. This NPI requirement applies to all providers who write prescription orders for drugs.

The prescriber NPI must be for an individual (Type 1) rather than an organization (Type 2). The ProviderOne POS does not recognize Type 2 NPIs for organizations (such as hospitals) as valid prescribers.

The following are examples of how to report the practitioner's individual NPI (Type 1) with prescription orders:

- An emergency room practitioner must report his or her individual NPI (Type 1), not the supervising practitioner's NPI with a prescription order.

- Each practitioner in a teaching hospital must report his or her individual NPI (Type 1) with a prescription order that is submitted to the dispensing pharmacy.

Hard copy billers must enter a valid Type 1 NPI in the Prescriber NPI field on the *Pharmacy Statement (525-106)* form 13-714.

Point-of-Sale billers:

- Enter 01 in the Service Provider ID Qualifier field (202-B2)
- Enter your NPI in the Service Provider ID field (201-B1)
- Enter 01 in the Prescriber ID Qualifier field (466-EZ)
- Enter the prescribers NPI in the Prescriber ID field (411-DB)

What is needed to bill for filling a newborn prescription?

Pharmacies can submit prescription claims for newborns using the mom's ProviderOne Client ID and the mom's birthdate.

Hard copy billers must indicate **"Baby using Mom's ProviderOne Client ID"** in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

Point-of-Sale billers: Enter "**2**" in the **Insurance Segment, Eligibility Clarification Code field.**

When is a pharmacy allowed to bill a client?

(WAC 182-502-0160)

A pharmacy may bill a fee-for-service client for a noncovered prescription if the client and provider complete and sign an *Agreement to Pay for Healthcare Services* form HCA 13-879.

The provider may NOT bill the client for any service which is potentially covered with prior authorization, unless that authorization has been requested and denied.

The agency asks that pharmacists use their professional judgment when accepting cash for noncovered services. If the pharmacist believes that a prescription may not be medically necessary for the client (such as a noncovered early refill for large volumes of narcotics), the pharmacist has no obligation to accept cash payment and may refuse service to the client.

Note: A common billing complaint is the pharmacist misinterpreting a POS message as a denial and charging the client instead of calling the agency for authorization. Remember that it is the pharmacist's responsibility to call the agency for authorization when the pharmacist receives an authorization message from the POS system.

Who is eligible?

The POS system does not solve the problem of identifying clients who are not currently in the agency's eligibility file. It is not appropriate to charge a client cash if the client is currently eligible on the Benefit Inquiry Screen in ProviderOne. For a client whose benefit inquiry screen in ProviderOne shows that the client is eligible, but claims deny in the POS system for lack of eligibility, take one the following steps:

- **FAX** a copy of the client's benefit screen from ProviderOne to Claims Entry at 866-668-1214.
- Mail in a **completed** paper claim with a photocopy of the benefit inquiry screen from ProviderOne attached.

The benefit inquiry screen in ProviderOne will be updated within two working days in order for claims to be resubmitted. Do not fax **claims** to this number.

See Billing the Client WAC 182-502-0160.

What services are billed for hospice clients?

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated by the designated hospice agency (be sure to call the hospice agency to find out what must be billed under hospice) and attending physician **only**.

Services **not** related to their terminal illness may be provided to clients on a fee-for-service basis. When billing for hospice clients and the service is **not** related to the terminal illness (be sure to call the hospice agency to find out what medications are not related to the hospice diagnosis or end-of-life care needs), use the following billing procedures:

> **Hard copy billers** must enter "**K**" in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form 13-714.
>
> **Point-of-Sale billers** must enter "**11**" in the **Patient Segment, Patient Residence** (384-4X) field.

Do not use this procedure for dates the client is not on hospice services. Be sure to check with the hospice agency before using the "K" or "11".

Does the agency reimburse for a client's prescriptions when enrolled in an agency-contracted managed care plan?

Eligible medical assistance clients enrolled in an agency contracted managed care organization (MCO) must have their prescriptions filled at a pharmacy contracted with the MCO. If a pharmacy is not contracted with the MCO, the client must be referred to an MCO-contracted pharmacy.

The agency reimburses for drugs dispensed to clients enrolled in an agency-contracted managed care plan **only** when a managed care contract excludes the drug or pharmaceutical supply and the product is otherwise reimbursable fee-for-service. The following may be billed fee-for-service to the agency:

- Prescriptions written by **dentists or related to dental health**
- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed **following a voluntary termination of pregnancy**
- Hemophilia and von Willebrand-related products when used for administration in the home.
- Immune modulators and anti-viral medications to treat chronic Hepatitis C virus (HCV) infection
- Prescriptions written by practitioners working for a non-MCO-contracted health department, or a non-MCO-contracted Family Planning agency with the therapeutic classifications listed below:

Family planning agencies may prescribe contraceptives, drugs for sexually-transmitted diseases (STD), excluding HIV, when related to the client's family planning method, and drugs related to a sterilization procedure within the following therapeutic drug classes:

- Analgesics
- Antibiotics
- Anti-emetics
- Antifungals
- Anti-infectives
- Anti-inflammatories
- Contraceptive drugs/devices

Health departments may prescribe drugs for STD (excluding HIV), tuberculosis, and prescription contraceptives within the following therapeutic drug classes:

- Antibiotics
- Anti-emetics
- Anti-infectives
- Contraceptive drugs/devices
- Tuberculosis drugs

Billing for managed care clients

Hard copy billers must enter the following comment in the **Justification/ Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

Managed Care Exclusion

Point-of-Sale billers must enter "**2**" in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

Pharmacists must document on the original prescription the reason for billing fee-for-service. All fee-for-service rules apply, including authorization requirements.

What drugs may be prescribed for Family Planning Only and TAKE CHARGE clients?

Family planning agencies may prescribe the following drugs related to family planning and contraceptives within the following therapeutic drug classes to Family Planning Only or TAKE CHARGE clients:

Contraceptives and Drugs	
Contraceptives, oral, including emergency contraception	Macrolides
Contraceptives, injectables	Antibiotics, misc. other
Contraceptives, transdermal	Quinolones
Contraceptives, intravaginal	Cephalosporins – 1st generation
Contraceptives, intravaginal, systemic	Cephalosporins – 2nd generation
Contraceptives, implantable	Cephalosporins – 3rd generation
Vaginal lubricant preparations	Absorbable Sulfonamides
Condoms	Nitrofuran Derivatives

Diaphragms/cervical caps	Antifungal Antibiotics
Intrauterine devices	Antifungal Agents
Vaginal antifungals	Anaerobic antiprotozoal – antibacterial agents
Vaginal Sulfonamides	
Vaginal Antibiotics	
Tetracyclines	

The agency covers anti-anxiety medications before a sterilization procedure and pain medications after a sterilization procedure for Family Planning Only and TAKE CHARGE clients as follows:

Anti-anxiety Medication – Before Sterilization Procedure

Medication	Maximum Number of Doses
Diazepam	2
Alprazolam	2

Pain Medication – After Sterilization Procedure

Medication	Maximum Number of Doses
Acetaminophen with Codeine #3	12
Oxycodone HCl/Acetaminophen 5/500	12
Hydrocodone Bit/Acetaminophen	12
Oxycodone HCl/ Acetaminophen	12

When billing for the covered preoperative anti-anxiety medications and postoperative pain medications for TAKE CHARGE or Family Planning Only clients:

Hard copy billers must enter "**Family planning sterilization medication**" in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

Point-of-Sale billers must enter "**6**" in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

Does the agency reimburse for skilled nursing facility (SNF) clients?

The agency does not reimburse for over-the-counter (OTC) drugs when the client resides in an SNF unless the drugs are on the Washington Preferred Drug List (see Therapeutic Interchange Program (TIP)) or the agency's Covered Over-the-Counter Drug List. Reimbursement for OTC drugs is included in the SNF per diem.

How are medications filled for SNF clients on leave?

SNF clients on leave should have their additional maintenance prescriptions filled for the duration of the leave. If the client leaves weekly, prescriptions should be filled for a one-month supply.

SNFs should determine which one of the following methods will be followed when a SNF client goes on leave:

- The client may take the prescription medication home and keep it there for use during SNF absences.
- The client may return the prescription medication to the SNF following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

Both of these practices are in accordance with state pharmaceutical regulations.

Hard copy billers must indicate **weekend pass** or **take home/leave supply** in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

Point-of-sale billers: Enter 8 in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

What is an emergency kit?

The **emergency kit** is a set of limited pharmaceuticals furnished to an SNF by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each SNF's client population and is for use during those hours when pharmacy services are unavailable.

Medications supplied from the emergency kit are the responsibility of the SNF.

What unit dose delivery systems are recognized by the agency?

(WAC 182-530-7350)

The agency recognizes two types of **Unit Dose Delivery Systems** for SNFs:

- True Unit Dose Delivery System
- Modified Unit Dose Delivery System

Eligible unit dose providers receive the unit dose dispensing fee when dispensing in-house unit dose prescriptions. The term **in-house unit dose** applies to bulk pharmaceutical products that are packaged by the pharmacy for unit dose delivery. Providers receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to Reimbursement for agency Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?

(WAC 182-530-5100(1))

To be eligible for a unit dose dispensing fee from the agency, a pharmacy must:

1. Notify the agency in writing of its intent to provide unit dose service
2. Specify the type of unit dose service to be provided
3. Identify the SNF or facilities to be served
4. Indicate the approximate date unit dose service to the facility or facilities will commence
5. Sign an agreement to follow the agency requirements for unit dose reimbursement

For information on becoming a unit dose provider, contact Provider Enrollment (see Resources Available).

How do pharmacies bill the agency under a unit dose delivery system?

(WAC 182-530-5100(2), (3), and (4))

Under a unit dose delivery system, a pharmacy must bill the agency only for the number of drug units actually used by the agency client in the skilled nursing facility (SNF).

It is the unit dose pharmacy provider's responsibility to coordinate with the SNFs to ensure that the unused drugs the pharmacy dispensed to the facility for distribution to an agency client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment form or claims reversal of the charge to the agency for the cost of all unused drugs returned to the pharmacy from the SNF on or before the 60th day following the date the drug was dispensed. This adjustment must conform to the SNF's monthly log.

Exception:

> Unit dose providers are not required to credit the agency for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

Hard copy billers must indicate "**In-house unit dose**" in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

Point-of-sale billers: Enter "3" in the **Claim Segment, Unit Dose Indicator** (429-DT) field.

Who is responsible for the cost of repackaging a client's bulk medications?

(WAC 182-530-5100(5))

The cost of repackaging is the responsibility of the SNF when repackaging is done for either of the following reasons:

- To conform to the SNF's delivery system
- For the SNF's convenience

Pharmacies may not charge clients or the agency a fee for repackaging a client's bulk medications in unit dose form.

What records do SNF pharmacies need to keep?

(WAC 182-530-5100(6) and (7))

The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each SNF served, including, but not limited to the following information:

- Facility name and address
- Client's name and ProviderOne Client ID
- Drug name/strength
- National Drug Code (NDC)
- Quantity and date dispensed
- Quantity and date returned
- Value of returned drugs or amount credited
- Explanation for no credit given or nonreusable returns
- Prescription number

Upon request, the pharmacy must submit copies of these monthly logs to the agency. The agency may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to the agency?

(WAC 182-530-5100(8))

When the pharmacy submits the completed annual prescription volume survey to the agency, it must include an updated list of SNFs served under unit dose systems.

What additional records do pharmacies need to keep?

(WAC 182-530-5000)

In addition to the record keeping requirements found in the agency ProviderOne Billing and Resource Guide, pharmacies must comply with the following:

Provision of prescription drugs

Keep any specifically required documents for the provision of prescription drugs, including but not limited to:

- Authorizing an order (prescription)

- Name of person performing the service (dispensing pharmacist)
- Details of medications and/or supplies prescribed or provided including NDC, name, strength, and manufacturer
- Drug Use Review (DUR), intervention, and outcome documentation
- Expedited authorization (EA) documentation
- Proof of fill

Proof of delivery

- When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the item(s) delivered.
- When a provider mails an item to the client, the provider must be able to furnish proof of delivery, including a mail log.
- When a provider uses a delivery/shipping service to deliver items, the provider must be able to furnish the following proof of delivery documentation:
  - ✓ The delivery service tracking slip with the client's name or a reference to the client's packages, the delivery service package identification number, and the delivery address
  - ✓ The supplier's shipping invoice with the client's name, the shipping service package identification number, and a detailed description
- When a client or the client's authorized representative picks up the prescription, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the items delivered.
- Make proof of delivery records available to the agency, upon request.

Coordination of Benefits

How are client resources applied?

The agency is required by federal regulation to determine the liability of third-party resources available to agency clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, the agency may make reimbursement for the balance if the insurance payment is less than the agency's allowed amount.

It is the provider's responsibility to bill the agency appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated in ProviderOne.
- The point-of-sale (POS) system alerts the provider to a client's insurance.
- The provider believes insurance is available.
  (See WAC 182-501-0200)

The Insurance Carrier List and carrier information is available on the agency website at http://www.hca.wa.gov/medicaid/billing/documents/hcarrier.txt. The information can be downloaded and printed or used as a reference.

The agency's billing time limit is 365 days, but an insurance carrier's time limit to bill may be different. It is the provider's responsibility to meet the insurance carrier's billing time limit prior to receiving any payment by the agency. The provider should not bill the agency with an **Other Coverage Code** if the claim was denied by the insurance carrier for late filings.

Other Coverage Codes

Why are Other Coverage Codes important?

The agency POS system alerts a provider when a client has other insurance. When a provider submits a claim through the POS system, and the agency files indicate that a client has insurance, **the agency will deny the claim. Then the provider must bill the client's insurance before using the Other Coverage Codes.**

The provider's weekly Remittance and Status Report (RA) show that the claim is denied with the Explanation of Benefits (EOB) 090. The EOB states **"Bill your claim to the insurance company as instructed. For questions call 800-562-3022."** The insurance carrier information is printed on the RA for the provider's reference.

When may providers use Other Coverage Codes?

The following chart lists situations in which other insurance is available, gives some direction to the provider, and explains which **Other Coverage Codes** to enter. In all of the situations described below, the pharmacy must bill the other insurance **before** using an **Other Coverage Code.**

The chart also provides information about documentation. Pharmacy providers who submit their claims through the POS system are not required to submit third-party documents. However, the provider must have these documents available for audit purposes. **Examples of the documentation that would justify the provider's use of an Other Coverage Code are listed below.**

Contact Coordination of Benefits (COB) at 800-562-3022 for any situations that are not listed below. See POS for values and definitions of the **Other Coverage Codes.**

A removable summary of the following table is available at the end of the Coordination of Benefits Frequently Asked Questions section.

Situations	Explanation/ Solution	Other Coverage Code
The insurance has made payment to the pharmacy **(An EOB or electronic transmission from insurance identifying the insurance paid amount)**	Bill balance to the agency	**2**

Situations	Explanation/ Solution	Other Coverage Code
Insurance allowed amount of the prescription is less than or equal to the copay **(An EOB or an electronic transmission from insurance identifying both the insurance allowed and co-pay amounts)**	Bill the agency	**4**
The prescription must be filled by mail order **(Contract verification that the prescription must be filled by mail order; or denial from insurance stating mail order)**	Bill the agency	**3**
The plan only covers a new prescription **(An EOB or electronic transmission from insurance showing only new prescriptions covered)**	Bill refills to the agency	**3**
The insurance carrier applied the claim charges to the client's deductible **(An EOB or electronic transmission from insurance identifying the claim amount was applied to the deductible)**	Bill the agency	**4**
The client's insurance plan maximum annual benefit has been met **(An EOB or electronic transmission from insurance identifying the annual benefit has been met)**	Bill the agency	**4**
The insurance denied the medication as a noncovered drug. Clarify if denial is for noncovered or nonformulary drugs. If nonformulary, third-party payment procedures must be followed **(An EOB or electronic transmission identifying the drug is noncovered or include a copy of the contract drug exclusion list)**	Bill the agency	**3**
The client has a discount card **(Verification of discount card or denial from insurance stating "discount card")**	Bill the agency	**3**
Capitated service agreement with insurance carrier **(Group Health and Kaiser pharmacies only)**	Bill the agency	**8**
Medicare Part D copay The agency does not provide coverage for Medicare Part D medication copayments. Medicare Part D copayments is the responsibility of the client **(For questions, call the agency Customer Service Center at 1-800-562-3022)**		

Note: For questions on the use of **Other Coverage Codes** or acceptable documentation, call Coordination of Benefits at 1-800-562-3022.

If one of the previously listed situations occurs, providers may resubmit the claim entering an **Other Coverage Code** into the POS system to bypass the edit for other insurance coverage.

Inappropriate use of Other Coverage Codes may result in an audit of your POS claims and recoupment of improper payments.

> **Note:** In instances where the primary insurance has made payment, the normal 34-day supply limit may be exceeded.

Clients with privately purchased HMO insurance

A client with privately purchased health maintenance organization (HMO) insurance will have an **HI, HO, or HM** identifier on the client benefit inquiry screen in ProviderOne. The client is required to use the HMO facilities for pharmacy services. If services are provided that are not covered by the HMO plan, the claim may be submitted to the agency for processing.

Situations may occur when a client is out of the HMO service area or HMO coverage is not accessible, a pharmacy provider may proceed to meet the client's immediate needs.

Billing

Pharmacy providers who submit their claims through the POS system are not required to submit insurance EOB documents. **However, documentation must be retained and kept by the provider for audit purposes.** (See WAC 182-502-0020)

Primary insurance billing exceptions

Primary insurance billing exceptions listed below are examples of third-party situations and how they are processed in the POS system. All amounts billed to the insurance and to the agency must be usual and customary charges, except for capitated copayments.

What does the provider do if a third-party liability question arises after COB hours?
Situations may occur when a client is asking to fill a prescription, a question arises and it is outside of COB's regular business hours. After making reasonable attempts to access the primary insurance coverage, proceed with filling what is necessary to meet the client's immediate needs. "Immediate needs" means pharmacists using their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. The pharmacy must contact COB within seven days for billing assistance.

Examples may include:

- The agency indicates that the patient has insurance, but the coverage cannot be identified and the patient does not provide it.

- The patient has HMO private insurance or has a closed pharmacy network.

What does the provider do if the client's coverage is prepay?
Contact COB for billing assistance if the client's coverage is prepay. Prepay means the client's identified insurance coverage policy requires the client to pay at the time of service, and the insurance reimbursement is made only to the subscriber. Do not bill the insurance and do not bill the agency with an **Other Coverage Code**. Prepay is defined on a case-by-case basis.

How is authorization obtained for non-formulary or noncovered drugs?

Pharmacists are required to obtain prior authorization from the insurance carrier for non-formulary drugs before providing the drugs to the client. When the denial reason is related to a non-formulary drug, the pharmacy may need to coordinate with the prescriber and/or the insurer to authorize an alternative drug or get the insurer to cover the prescription as prescribed. **Do not use an Other Coverage Code**. The pharmacy must meet all third-party billing requirements prior to billing the agency.

Noncovered drugs are not to be confused with non-formulary drugs. It is the provider's responsibility to correctly determine if the drug is noncovered or non-formulary with the primary insurance carrier. Noncovered drugs may be billed to the agency using the **Other Coverage Code 3.**

Coordination of Benefits Frequently Asked Questions

How is prescription drug coverage verified and who processes the prescriptions?
Ask the client for an insurance card, Services Card, or both. If the client benefit inquiry screen indicates the client has an insurance carrier and you do not know where to submit the claims, contact the insurance carrier. Verify there is retail prescription coverage with the insurance carrier and ask where to submit claims. When you submit a claim through the POS system and no **Other Coverage Code** has been entered, you will be notified if the client has prescription coverage.

To find insurance carrier contact information, visit insurance carrier contact information.

What if a client's insurance states there is no coverage or the insurance coverage has ended?
If there is no coverage or the coverage has ended, notify COB at 800-562-3022.

What if a client's insurance plan cannot identify the client?
If the insurance carrier cannot identify the client, contact COB at 800-562-3022 to verify the cardholder identification and the plan being billed are the same as on file with COB. We will assist you with verifying the client's prescription coverage or update COB records if the client does not have coverage.

What is discount only or mail order only coverage?
Discount only or mail order only coverage means insurance does not reimburse for any prescriptions filled at retail pharmacies.

- If a client has **discount only or mail order only** benefits, the agency does not consider this a primary insurance. Bill the agency.

- If you bill the agency and we deny the claim to bill the insurance carrier, and you believe the client has **discount only** coverage, contact COB.

Note:

- Some clients have **mail order only** on certain prescriptions, requiring them to use mail order when they refill prescriptions on an ongoing or regular basis.
- Insurance carriers may refer to mail order as "maintenance". For example, some plans consider mail order to be maintenance when a certain prescription is refilled more than two times. Bill the insurance carrier first. If the claim is denied by insurance to use mail order, then bill the agency with an **Other Coverage Code 3**.

Why would a claim be paid at zero or denied by insurance?
If the reason the claim was paid at zero cannot be verified, contact the insurance carrier and find out why the claim was paid at zero or denied. If there are questions about why the claim was denied or paid at zero after contacting the insurance carrier, contact COB.

What if the insurance states copay is 100% or claim is paid at zero?
Contact the insurance carrier. Examples of when the insurance states copay is 100% are:

- A prepay plan. **Prepay** means the client's insurance coverage requires the client to pay at the time of service, and the insurance reimbursement is made to the subscriber. In this instance, reverse your billing to the primary insurance, and call COB for billing assistance at 1-800-562-3022. Do not bill the insurance, and do not bill the agency with an **Other Coverage Code.**

- Less than copay, benefits are exhausted, or any other paid at zero response. Bill the agency using **Other Coverage Code 4.**

How are after hour services billed?
After hours services means prescriptions filled outside of COB regular business hours. After making reasonable attempts to meet the primary insurance carrier's billing requirements, proceed with filling what is necessary to meet the client's immediate needs.

What is "meeting client's immediate needs?"
Immediate needs means pharmacists are to use their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. Contact COB within 7 days for billing assistance. Examples may include:

- The agency indicates the client has insurance, but you cannot identify the coverage.
- The client has HMO private insurance or has a closed pharmacy network.

What is the service area?
Service area means the nearest pharmacy that accepts the insurance within 25 miles or 45 minutes in one direction from the client's address.

What if POS will not accept an Other Coverage Code, or a field is not provided to enter an Other Coverage Code?
Contact your pharmacy software or switch vendor.

Why does a claim get a rejection code missing/invalid code?
If there is a rejection code DV, you have indicated that insurance made payment by entering 2 in the Other Coverage Code field, but the payer amount was entered as 0.00.

If there is a rejection code E8, an insurance payment was entered, but a 2 in the Other Coverage Code field was not.

Verify the insurance carrier has made payment, and enter the amount in the **other payer** amount field. If there is no insurance payment, **do not enter a 2** in the Other Coverage Code field; contact the insurance carrier to find out why the payment was not made. If you have verified the insurance amount paid and the payment amount is not displayed on the POS system, contact your software or switch vendor.

If the claim does not go through, is entering $.01 in the insurance paid field allowed?
No. Enter an amount only if $.01 or another amount is the actual amount paid by the insurance. Entering any amount paid by the insurance carrier other than the actual amount paid could be considered fraudulent.

When can Other Coverage Code 8 be used?
For non-Medicare Part D billing, the agency allows only pharmacy providers that have a capitated service agreement with an insurance carrier to use this **Other Coverage Code**. At this time, only Group Health and Kaiser are known to have capitated service agreements.

How is a claim submitted to the agency when the insurance allowed amount is less than or equal to the copay amount?
The copay is the amount that private insurance has determined the person with the private insurance coverage is expected to pay per prescription.

Note: Eligible Medicaid clients with private insurance are not expected to pay a copay. When the insurance allowed or payable amount is less than or equal to the copay amount, the insurance non-payment reason is less than the copay. Bill the agency, after you bill the insurance. Use a 4 in the **Other Coverage Code** field.

What is a closed pharmacy network?
A closed pharmacy network means an insurer restricting prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy not included on the exclusive list (WAC 182-502-0130 (3)(a)).
The agency may pay for the prescription without requiring the client to use a participating network pharmacy ONLY in the following situations:

- When the prescription is not covered by the policy.
- If the client is out of the service area.
- If you provided medications to meet a client's immediate need for services.

If you are not a participating pharmacy, do not bill with an **Other Coverage Code** prior to contacting COB.

Does the agency require clients to use pharmacy providers that are contracted with the client's private insurance carrier?
The agency requires clients to use pharmacy providers contracted with their private insurance carrier. Clients with managed care private insurance will have an HM, HI, or HO identifier on the client benefit inquiry screen in ProviderOne.

If the insurance carrier provides pre-pay plan coverage for noncontracted pharmacy providers, contact COB for billing assistance.

If a pharmacy is not contracted and the coverage is not pre-pay, the agency may pay for the prescription without requiring the client to use a contracted pharmacy ONLY in the following situations:

- When the prescription is not covered by the policy
- If the client is out of the service area
- If you provided medications to meet a client's immediate need for services

Do not bill with an **Other Coverage Code** prior to contacting COB.

What if a client's insurance coverage requires paper billing and the pharmacy only bills electronically?
The pharmacy must meet all third-party billing requirements prior to billing the agency.

If the insurance coverage is a pre-pay plan for paper billers, contact COB for billing assistance. Do not bill with an **Other Coverage Code** prior to contacting COB.

How are paper bills submitted to the agency after the primary insurance has been billed?
While POS billing is preferred, pharmacies who submit their claims to the agency on paper must enter any amount paid by the primary insurance in the **insurance paid amount** field and the

primary insurance processing details in the **justification/comments** section on the *Pharmacy Statement (525-106)* form HCA 13-714.

If the client is enrolled in an agency-contracted MCO and private insurance, is the MCO billed for the service or the private insurance?
If a client is enrolled in an agency-contracted managed care organization (MCO) **and** also has private insurance for the date of service, the pharmacy bills the MCO. Contact the MCO for billing assistance and information about the primary coverage.

If I bill the insurance carrier and the denial reason is "plan limits exceeded," can I bill the agency with an Other Coverage Code?
If the client has exceeded their insurance benefit, it is appropriate to bill the agency with an **Other Coverage Code 3**. The pharmacy must meet all third-party billing requirements prior to billing the agency.

How do I bill if the insurance carrier requires authorization?
The primary insurance carrier requirements must be met. Contact the insurance carrier for authorization review, and to determine if, and how the medication is covered by the insurance plan. If the primary insurance carrier's authorization process has been followed to completion and authorization is denied, bill the agency with **Other Coverage Code 3**.

The insurance carrier requires authorization. The prescriber will not provide information to the pharmacy or insurance carrier and authorization cannot be obtained. Can the agency be billed directly?
No. The insurance carrier requirements must be met. It is not appropriate to bill the agency with an **Other Coverage Code** unless the billing conditions of the insurance carrier have been met.

How long does documentation need to be kept? (WAC 182-502-0020)
Providers are required to make documentation available to the agency for six years from the date of service. Pharmacy providers who submit their claims through the POS system are not required to submit third-party EOB documents. However, the provider must retain documentation for audit purposes.

The client has insurance coverage through multiple carriers. Am I required to bill all potential payers? (WAC 182-501-0150)
Yes. It is the provider's responsibility to seek timely reimbursement from a third-party when a client has available third-party resources.

How do you bill clients who are eligible for both Medicare and Medicaid?
Some Medicaid clients are also eligible for Medicare Part B or Part D benefits. Bill Medicare first. The following instructions will assist in billing for dual eligible clients.

Medicare Part B

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Medicare Part B cover some drugs and drug-related supplies. When you have a client who is eligible for both Medicaid **and** Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier **first**. Medicare is the primary payer of claims.

The agency cannot make direct payments to clients to cover the deductible and coinsurance amount of Medicare Part B. The agency **can** pay these costs to the provider on behalf of the client when:

- The provider accepts assignment.
- The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount.

The agency will pay up to Medicare's allowable, or the agency's allowable, whichever is less.

ProviderOne will indicate whether or not the client is Medicare-eligible.

What about clients covered under the Categorically Needy Program or Medically Needy Program, as well as Qualified Medicare Beneficiaries?

- If Medicare ***and*** Medicaid cover the service, the agency will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If Medicare **and not Medicaid** pays for the product, the agency will pay the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicaid covers the service and Medicare does not cover the service, the agency will reimburse for the service.

Part B—Medical Insurance

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and are furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service, it may not be covered by Part B. Medicare Part B also covers a limited number of other types of drugs. (Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision.) For more information visit the Medicare coverage database website.

What about Medicare Part B medications (that are not covered through Part D)?
After Medicare Part B has processed the claim, and if Medicare has allowed the medication, in most cases Medicare will forward the claim to the agency for any supplemental Medicaid payment. When the words, **"Claim information forwarded to Medicaid,"** appear on the Medicare remittance notice, it means that the claim has been forwarded to the agency or a private insurer.

- If **Medicare Part B has paid** for a medication and the Medicare crossover claim does not appear on the agency Remittance and Status Report within 30 days of the Medicare statement date, bill the agency.

  A claim must be submitted to the agency within 6 months of the Medicare statement date, in addition to billing the agency within 365 days of the date of service to establish timeliness.

- If **Medicare Part B has denied** a medication, bill the agency through the POS system using the appropriate DUR result of service code. Claims may also be billed on the Pharmacy Statement form and must have the Medicare denial letter or Explanation of Benefits (EOMB) attached.

Note: When Medicare denies a service that requires authorization, the agency waives the **prior** requirement, but authorization is still required.

Bill Medicare's coinsurance and deductible using the CMS-1500 claim form.

Medicare Part D

Are copayments covered?
Medicare Part D copayments are the responsibility of the client.

What prescription drugs are covered?
Medicare Part D-covered drugs are:

- Biological products
- Insulin and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze)
- Vaccines
- Drugs that are:
  - ✓ Available only by prescription
  - ✓ Used and sold in the United States
  - ✓ Used for a medically accepted indication

Certain drugs or classes of drugs, or their medical uses, are excluded by law from Medicare Part D coverage. Visit the Medicaid Covered Drugs for Part D Dual Eligibles for more information.

While these drugs or uses are excluded from basic Medicare Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare.

What if Medicare denies a prescription as non-formulary?
When the client is covered by Medicare Part D, Medicaid does not pay for any prescriptions that are the responsibility of Medicare Part D. Contact the prescription drug plan for authorization for non-formulary drugs. Due process under the Medicaid appeal rules such as an administrative hearing and Exception to Rule are not available to the client under this circumstance.

Helpful hyperlinks
- List of medications that the agency will cover
- Medicare Part D website
- The agency's Medicare website
- SHIBA website: http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/
- CMS website: http://www.cms.gov/

✂ (You may remove this page for ease of use.)

Agency Other Coverage Code Summary

Situations	Explanation/Solution	Other Coverage Code
The insurance has made payment to the pharmacy	Bill balance to the agency	**2**
Insurance allowed amount of the prescription is less than or equal to the copay	Bill the agency	**4**
The prescription must be filled by mail order	Bill the agency	**3**
The plan only covers a new prescription	Bill refills to the agency	**3**
The insurance carrier applied the claim charges to the client's deductible	Bill the agency	**4**
The client's insurance plan maximum annual benefit has been met	Bill the agency	**4**
The insurance denied the medication as a noncovered drug. Clarify if denial is for noncovered or non-formulary drugs. If non-formulary, third-party payment procedures must be followed.	Bill the agency	**3**
The client has a discount card	Bill the agency	**3**
Capitated service agreement with insurance carrier	Bill the agency	**8**
Medicare Part D copay	**Medicare Part D is not covered**	

Note: For questions on the use of **Other Coverage Codes** or acceptable documentation, call the agency at 1-800-562-3022.

Pharmacy Statement Form HCA 13-714

What are the general instructions for billing?

The boxes on the *Pharmacy Statement (525-106)* form HCA 13-714, are referred to as **fields.** Complete all of the fields on the form to ensure prompt processing of your claims. Fields left blank may result in denial of payment or the return of your Pharmacy Statement as incomplete. The following fields are required for your submitted form to be processed as a claim:

- NPI Number
- Patient Identification
- Prescription Number
- Refill Code
- Date Filled
- National Drug Code

Those fields that are required for billing are marked with an asterisk (*) on the following pages. The agency will return incomplete forms submitted to the agency with one or more required fields left blank to the billing pharmacy.

Note: Hardcopy claim submission is required for rebilling a claim between 12 and 15 months beyond the date of dispense, and any reversal that the pharmacy cannot submit electronically via point-of-sale.

Provider Name and Address – Enter your name and address as recorded by the agency.

***NPI Number -** Enter your National Provider Identifier. If this field is left blank, the form will be returned unprocessed.

***Patient Identification –** Copy the ProviderOne Client ID as it appears on the client's Services Card. If this field is left blank, the form will be returned unprocessed.

Patient Name and Address – Enter the client's last name, first name and middle initial. Enter the client's address.

***Prescription Number** – Assign in sequence with regular prescriptions filled by the pharmacy. The original prescription number may be used for refills, or a new number may be assigned. If this field is left blank, the form will be returned unprocessed.

***Refill Code –** Enter the sequentially assigned two-digit number where 0 represents the original dispense and 1 – 99 represent subsequent refills on the same Prescription Number. If this field is left blank, the form will be returned unprocessed.

Date Written – Enter the date on which the prescriber wrote/ordered the prescription. If this field is left blank, the claim will be denied.

***Date Filled** – Enter the date the prescription was dispensed to the client. If this field is left blank, the form will be returned unprocessed.

Quantity Filled – Enter quantity dispensed to the client. If this field is left blank, the claim will be denied.

Estimated Days Supply – Enter the estimated days' supply for the quantity dispensed at the prescribed *Sig.* If this field is left blank, the claim will be denied.

***National Drug Code (NDC)** – Enter the manufacturer's complete 11-digit NDC **from the dispensing container.** For compound claims, enter the NDC of the primary active ingredient.

All digits, including zeros, must be entered. The three sections in the NDC field **must** have numbers entered in the correct section. The **labeler code** portion of the 11-digit NDC will always consist of five numeric characters; the **product code** portion consists of four numeric characters; and the **package size** will be two numeric characters.

Sample number: 12345-6789-10

12345 = labeler code
6789 = product code
10 = package size

For compound prescriptions, enter NDC 00000-0000-00 in Section 1, and individual ingredient NDCs in Section 3.

If this field is left blank, the form will be returned unprocessed.

Drug Name – Enter the drug name and strength.

Prescriber's NPI – Enter the 10-digit National Prescriber Identifier of the prescriber. Be sure to use the **unique individual provider identification number.** Do not complete with a group billing number. If this field is left blank, the claim will be denied.

Prescription (directions for use) – Enter the **Sig.**

Authorization Number – Enter the 11-digit authorization number or Expedited Authorization number if applicable.

Generic – Enter an "X" under **Yes** if generic substitution is permitted by the prescriber. Enter an "X" under **No** if the prescriber has indicated the order should be **Dispensed As Written.**

Justification/Comments – Enter values or descriptions using this guide. Enter any other information applicable to this prescription.

Total Charge – Enter your Usual and Customary charge (U&C), including your dispensing fee. Do not include tax.

Insurance Paid Amount – Enter any amount paid by insurance**. Do not enter the co - payment amount here.** (See Coordination of Benefits)

Balance Due – Enter the amount due after deducting any insurance.

Section 3

For compound claims:

Name – Enter the drug name and strength.

NDC – Enter the manufacturer's complete 11-digit NDC **from the dispensing container.**

Quantity – Enter the quantity of the individual ingredient used in the compound. Measure the quantity used according to the uncompounded unit of measure. Do not measure the quantity by compounded volume.

Cost – Enter your usual and customary charge for the individual ingredient.

Billing and Claim Forms

How is the CMS-1500 claim form completed?

The agency's webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- DDE Professional claim
- DDE Professional with Primary Insurance
- DDE Medicare Crossover Claim

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

What is point-of-sale (POS)?

The agency's POS system is a real-time pharmacy claims processing system which uses the National Council for Prescription Drug Programs (NCPDP) version D.0 format. Each claim submission, reversal, or re-bill that is successfully transmitted via a switch vendor is captured and appears on the weekly Remittance and Status Report (RA). Track each transaction and reconcile the RA completely before contacting the agency.

What do the POS rejection codes mean?

The agency's POS system uses NCPDP D.0 reject codes. Although these codes have meaning within the NCPDP standard, the agency's POS system returns a message of explanation with any claim rejection. As the complexity of prescription drug benefit management increases, it is important for the agency to provide clear explanations of denial in real time. It is also important for pharmacies to read these messages so they can take appropriate action when serving mutual clients. The agency returns reject messages up to 80 characters in length, viewable within most POS applications. If providers do not know how to access these reject messages, they must contact their software vendor for assistance.

Agency providers cannot accept payment from clients for any service potentially covered under the client agency benefit. See the Billing section within this guide. **It is important for providers to understand that a claim rejection through the POS system is not necessarily a denial of service.** Some claim rejections represent a final denial by the agency, while others may indicate additional steps are necessary to determine coverage for the product or service.

The chart below outlines categories of potential reasons for claim rejection, rather than specific rejection messages.

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
The message starts with 'TIP'	Therapeutic Interchange Program is required under Senate Bill 6088; Chapter 29, Laws of 2003 See the *Washington Preferred Drug List* section in this guide	The pharmacist must substitute a preferred drug for the non-preferred drug prescribed, unless the prescription is ordered Dispense As Written (DAW)	Not a denial of service If the prescription is a DAW, resubmit claim with Product Selection Code of 1 If not DAW, dispense a preferred therapeutic alternative within the same drug class
The message starts with "Preferred" or "Pref"	Product prescribed is non-preferred for agency clients	See the Washington Preferred Drug List Consult prescriber to determine whether a preferred alternative can be prescribed If the medication cannot be changed to a preferred alternative, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency
Detail of missing or invalid codes. (Any standard NCPDP D.0 reject code which states "M/I")	A required field has been left blank, or an invalid value has been submitted in a field that could affect claim adjudication	Correct claim and resubmit	Not a denial of service. A claim must be re-submitted with valid values to determine coverage

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
Drug Use Review (DUR) edits (NCPDP D.0 reject code 88)	Pro-DUR editing has found a potential therapy problem	If claim information is correct, the pharmacist should use professional judgment or confer with the prescriber to determine the appropriateness of therapy If therapy is appropriate, NCPDP pro-DUR codes can be used to indicate what professional intervention occurred	Dependent on result of professional services If appropriate, DUR codes have been entered, and the claim is still rejected, call Pharmacy Authorizations at 1-800-562-3022 to request assistance An agency representative will determine whether authorization is required, or if service has been denied
Labeler Has No Federal Rebate Agreement	The manufacturer has not chosen to make its products available for dispense to agency clients	Dispense an equivalent product from a manufacturer who participates in the Federal Rebate Program	Not a denial of service An equivalent product must be substituted and the claim resubmitted with the new NDC

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
States 'Maximum' or 'Minimum' in relation to quantity, days supplied, client age, fills per month, etc.	The agency has established therapeutic parameters for the use of the product. Claims may be authorized outside of those conditions See list of drugs with limitations	Verify accuracy of the submitted claims information. If all information is accurate, contact prescriber to consider alternate therapies within FDA indications. If prescriber still feels that the product should be dispensed as prescribed, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency
States that a product is 'not billable through POS', states 'Bill as a professional service'; or 'Refer to DME/Non-DME Washington Apple Health billing guides	The product is a potentially covered benefit, but not considered part of the client's prescription drug benefit	Consult appropriate Washington Apple Health billing guide and bill as a professional service on a CMS-1500 claim form, or comparable HIPAA compliant electronic claim format	Not a denial of service Benefit may be payable as Durable Medical Equipment, Enteral Nutrition, or a professional service
Expedited Authorization Code Required	See Authorization. The product has an expedited code available for authorization if specific criteria are met	Consult Expedited Authorization List in Authorization. If criteria are met, resubmit claim with appropriate EA code in the Prior Authorization Number Submitted field (462-EV). If criteria are not met, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
States that a product or situation is **NONCOVERED and** does not provide a toll free number	The product or situation is not a covered benefit for the client	Work with the client's prescriber to find an alternate covered therapy which meets the client's medical needs	Yes. The requested service is denied. If originally prescribed therapy has not been changed, POS denial as noncovered can be considered final
Contains a toll free number, or message is not otherwise addressed above	Product or situation requires Authorization or other review by the agency	Pharmacy calls the toll free number indicated to request authorization or assistance	Not a denial of service, unless the request for authorization is denied in writing by the agency

What is the prospective drug use review (pro-DUR) used for?

The agency provides pro-DUR screening as a feature of the POS system. Early Refill, High Dose, Low Dose, and Therapeutic Duplication edits post and claims are rejected when potential drug therapy problems are identified. Once pharmacists have conducted their professional review, the agency-recognized NCPDP DUR Reason for Service, Professional Service, and Result of Service codes can be used to respond to the pro-DUR edits.

When appropriate, enter one of the NCPDP DUR codes from each of the categories in the appropriate POS field. Entering DUR codes will not automatically bypass DUR screening. The agency considers different codes to be appropriate for different situations. Only a combination of codes appropriate to address the potential therapy problem will satisfy the DUR screening process.

By placing the information on the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. POS claim coding is subject to review and audit by the agency.

The agency does not provide additional reimbursement for DUR services. DUR coding is supported for the purpose of ensuring potential drug therapy problems are addressed by a health care professional.

Hardcopy (paper) claims must note the appropriate DUR codes in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714, if applicable.

What is the national drug code (NDC)?

The NDC is an 11-digit code assigned to all pharmaceutical products by the labeler or distributor of the product under FDA regulations. (See WAC 182-530-1050)

> **Note:** When submitting claims to the agency the provider must use the actual, complete 11-digit NDC from the dispensing container.
> (See WAC 182-530-5000(1)(b))

The agency accepts only the 5-4-2 NDC format. **All 11 digits, including zeros, must be entered**. The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

NCPDP Version D.0 claim format

In order to comply with the Health Insurance and Accountability Act (HIPAA) requirements, **the agency requires all pharmacy providers to use NCPDP Version D.0 claim format** when submitting point-of-sale (POS) claims. See the Payer Specification Sheet for more information.

General information

The NCPDP Version D.0 claim format:

- Defines the record layout for real-time prescription claim transactions between providers and processors.
- Is a variable format.
- Accepts up to four transactions per transmission (except when billing compounds, only one transaction is allowed per transmission).

What transaction segments are supported?

Transaction header segment
The transaction header segment is mandatory on all transactions and all fields within the segment are mandatory. The transaction header segment tells the system where to send the claim, what type of submission it is, how many transactions, who is submitting the claim, date of service, and the vendor certification number.

Patient segment
The patient segment is mandatory for all transaction types. The NCPDP standard requires the submission of Date of Birth (304-C4) and Patient Gender Code (305-C5) fields. The agency requires submission of the Patient Residence (384-4X) field depending on the situation. When appropriate and necessary for claim adjudication, use the following values in the Patient Residence field:

01 - To indicate the client resides at home, in an assisted living facility, group home, or adult family home
02 - To indicate the client resides in a skilled nursing facility
11 - To indicate a hospice patient whose claim is unrelated to their terminal condition
12 - To indicate an ITA claim

Insurance segment
The insurance segment is mandatory on all transactions except reversals (B2).

This segment contains data describing the ProviderOne Client ID. The client's ProviderOne Client ID is required in the Cardholder ID field, and Patient Relationship Code should be set to 1.

Claim segment
The claim segment is mandatory on all billing (B1, B2, B3), and some authorization (P1, P2) transactions. This segment contains data relating to the dispensing of the actual prescription, or when authorization is requested. Some fields are required only for billing transactions. The claim segment is also used to identify a partially filled prescription, and some fields are required only when submitting a partial fill.

Prescriber segment
The prescriber segment contains data describing the prescriber and is required on all authorization (P1, P2, P3, P4) or billing transactions with the exception of Reversals (B1, B3). The mandatory/required fields are the Segment Identification, Prescriber ID Qualifier, and Prescriber ID. For authorization transactions, prescriber last name and phone number are also required.

COB/other payment segment
This segment may be required in some situations when billing or rebilling if the pharmacist or The agency indicates other coverage. The COB/Other Payments Segment contains information indicating the presence of other payers or insurers.

Use the Other Coverage Code field in the Claim Segment to indicate insurance coverage information. Refer to Other Coverage Codes.

DUR/PPS segment
The DUR/PPS segment contains data for the resolution of DUR rejections.

Pricing segment
The pricing segment is required on all incoming billing and rebilling transactions (B1, B3). This segment contains data describing how the product is to be priced. The mandatory fields are: Segment Identification, Ingredient Cost Submitted, Usual and Customary Charge, and Gross Amount Due.

Compound segment
This segment is required for the multi-line submission of compounds. The compound segment may only be submitted on billing or rebilling. This segment is not sent on claim reversals. Information describing the compound ingredients is included here. If the segment is submitted the following fields are required: Segment Identification, Compound Dosage Form Description Code, Compound Dispensing Unit Form Indicator, Compound Ingredient Component Count, Compound Ingredient Drug Cost, and Compound Ingredient Basis of Cost Determination. The following fields are also required, and may be repeated for multiple ingredients: Compound Product ID Qualifier, Compound Product ID, and Compound Ingredient Quantity. The agency will reimburse a dispensing fee for each payable ingredient. Each line will be adjudicated separately and will be subject to all applicable edits, including authorization. Compounds may not be submitted as a partial fill. If a pharmacy chooses to receive reimbursement only for the payable ingredients within a compound, a value of 8 in the Submission Clarification Code field from the claim segment must be entered.

Prior authorization segment
The prior authorization segment is situational and only required on authorization transactions (P1, P2, P3, P4). When submitting an authorization transaction, the following fields are required: Segment Identification, Request Type, Request Period Date-Begin, Request Period Date-End, and the Basis of Request. No other fields within this segment are captured or supported.

Therapeutic Interchange Program

(Senate Bill 6088; Chapter 29, Laws of 2003)

What is the Therapeutic Interchange Program?

The Therapeutic Interchange Program (TIP) is a process developed by the Department of Social and Health Services, the Health Care Authority (HCA or the agency), and Labor and Industries to allow physicians and other prescribers to endorse the Washington Preferred Drug List (PDL). TIP is intended to streamline administrative procedures and make prescription drugs more affordable to Washington residents and state health care programs. TIP applies only to drugs on the Washington PDL prescribed by an endorsing practitioner and not to other drugs requiring authorization.

What is an endorsing practitioner?

An **endorsing practitioner** is a provider who has reviewed the Washington PDL, signed up as an endorsing provider, and agrees to allow therapeutic interchange of a preferred drug for any non-preferred drug in a given therapeutic class. (See http://www.rx.wa.gov)

What does this mean to pharmacies?

When an endorsing practitioner issues a prescription to a medical assistance client for a non-preferred drug on the Washington PDL, the filling pharmacist must dispense the preferred drug in that therapeutic class in place of the non-preferred drug. When this therapeutic interchange is made, the pharmacist must notify the endorsing practitioner of the specific drug and dose dispensed.

When are substitutions not required?

In some instances, the endorsing practitioner may determine that the non-preferred drug is medically necessary and instruct the dispensing pharmacist to dispense the non-preferred drug as written (DAW). When an endorsing practitioner indicates "**DAW**" on a prescription for a non-preferred drug, the agency will not require authorization, and the dispensing pharmacist will dispense the non-preferred drug as prescribed.

Exemptions from TIP
Senate Bill 6088 exempts the following drug classes from TIP when the drug classes are placed on the Washington PDL:

- Antipsychotic
- Antidepressant
- Chemotherapy
- Antiretroviral
- Immunosuppressive
- Immunomodulator/antiviral drugs used to treat hepatitis C for which an established, fixed duration of therapy is prescribed for 24-weeks but no more than 48 weeks. (See RCW 69.41.190)

Not all of these drug classes are on the Washington PDL, and unless the drug class is on the Washington PDL, it is not eligible for the continuation of therapy privilege.

Continuation of therapy privilege for exempted drug classes
Pharmacists must not substitute a preferred drug if the prescription is for a refill or continuation of therapy in any of the exempted drug classes on the Washington PDL.

What if a non-endorsing practitioner issues a prescription for a non-preferred drug?

When a **non-endorsing** practitioner issues a prescription for a non-preferred drug, the agency requires authorization, and the dispensing pharmacist must fax a completed *Pharmacy Information Authorization* form HCA 13-835A to 866-668-1214, or call the agency at 800-562-3022 to request authorization by providing medical justification. See the Washington PDL or go to the agency's Pharmacy Information website for further information.

How does the pharmacy bill for a DAW prescription written by an endorsing practitioner?

- **Hard copy billers** must enter "**DAW**" in the **Justification/Comments** field on the *Pharmacy Statement (525-106)* form HCA 13-714.

- **Point-of-sale billers** must enter "**1**" in the Dispense as Written (DAW)/Product Selection Code field.

Washington Preferred Drug List

What is the Washington Preferred Drug List?

(WAC 182-530-4100)

The Health Care Authority (the agency) and Labor & Industries (L&I), have developed a list of preferred drugs within a chosen therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness. The drugs within a chosen therapeutic class are studied by an evidence-based practice center (EPC). A written report on the comparative safety, efficacy, and effectiveness from the EPC is evaluated by the Washington State Pharmacy and Therapeutic Committee which makes recommendations to state agencies regarding the selection of the preferred drugs on the Washington Preferred Drug List (PDL).

What is the process to obtain drugs on the Washington PDL?

- Prescription claims for **preferred drugs** submitted to the agency are reimbursed without authorization requirements unless the drug requires authorization for the following:
  - ✓ Safety criteria
  - ✓ Special subpopulation criteria
  - ✓ Limits based on age, gender, dose, or quantity
- Prescription claims for **non-preferred drugs** submitted to the agency are reimbursed without authorization requirements when written by an endorsing practitioner who has indicated "DAW" on the prescription unless the drug requires restrictions for safety. (WAC 182-530-4150)
- Prescription claims for **non-preferred drugs** submitted to the agency are reimbursed only after authorizing criteria are met if written by a non-endorsing practitioner.
- **Pharmacies** must call the agency for authorization when required. Call 1-800-562-3022.

What are the authorization criteria to obtain a non-preferred drug?

- For most drug classes on the Washington PDL, the authorization criteria is that the client must have tried and failed, or is intolerant to, at least one preferred drug. Drugs may have criteria that go beyond these basic criteria.

- Drugs that are in drug classes on the Washington PDL that have not been studied by the evidence-based practice centers and have not been reviewed by the P&T committee will be treated as non-preferred drugs and will require authorization.

The agency requires pharmacies to obtain authorization for non-preferred drugs when a therapeutic equivalent is on the Washington PDL.

Note: The agency changed the format for multiple drug listings. A slash (/) is used to denote multiple forms of a drug. For example: "Cardizem® /CD/LA/SR" represents immediate release Cardizem, as well as the CD, LA, and SR forms. A hyphen (-) is used to indicate combination products. For example: "benazepril-HCTZ" represents the combination product of benazepril and hydrochlorothiazide, rather than benazepril AND the combination product.

Where is the Washington Preferred Drug List?

See the agency's Washington Preferred Drug List web page.