Washington State Health Care Authority

Washington Apple Health (Medicaid)

Prescription Drug Program Billing Guide

July 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2025,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide are governed by the rules found in Chapter 182-530 WAC.

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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Managed care enrollment	Revised section to include a second exception in the first paragraph regarding clients eligible to receive Reentry Initiative services	To clarify managed care enrollment policy for clients eligible to receive Reentry Initiative services
Reentry Initiative	Added new section	**Effective for dates of service on and after July 1, 2025**, HCA covers a limited set of services for incarcerated individuals through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington state.
When can a medication be dispensed more than twice per month or filled early?	Added information for refills related to reentry from a carceral setting	New policy

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Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Finding HCA documents (e.g., Washington Apple Health billing guides, fee schedules)	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability (other than HCA-contracted managed care)	See HCA's ProviderOne Resources webpage
Authorization	See HCA's ProviderOne Resources webpage
Additional Prescription Drug Program information	See HCA's Pharmacy webpage
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 1-833-991-0704
Technical questions about switch vendor issues or system availability issues	Contact the switch vendor
Where can I find pharmacy document submission cover sheets?	See HCA's document submission cover sheets

Topic	Resource Information
Where do I find HCA's maximum allowable fees for services?	See HCA's **Provider billing guides and fee schedules** The prescription drug fee schedule is titled *Pharmacy Special Services, Vaccine Administration, and Compliance Packaging*
General definitions	See **chapter 182-500 WAC**

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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* (HCA 13-835A) form. See Where can I download HCA forms? Fax form to 1-833-991-0704 or call 1-800-562-3022
Find out which drugs are on the Apple Health Preferred Drug List	See the Apple Health Preferred Drug List webpage
Any of the following return messages: **Prior authorization required,** **Expedited code required and does not meet criteria, or** **Drug exceeds limits**	Use *Pharmacy Information Authorization* (HCA 13-835A) form. Where can I download HCA forms? See the Pharmacy webpage for: • Expedited authorization criteria • Special programs in this billing guide Fax form to 1-833-991-0704 or call 1-800-562-3022
Dispensed an emergency supply to a client with an emergency that could not wait	Use *Pharmacy Information Authorization* (HCA 13-835A) form Fax form to 1-833-991-0704 or call 1-800-562-3022
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. 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
Expedited Authorization criteria	See HCA's Expedited Authorization List
Is this client eligible?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage

If your situation or question is about:	Then you must:
What program is this client on?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
Where can clients or doctors' offices call for questions about authorizations or drugs?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
What drugs are covered?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
What is the Therapeutic Interchange Program?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
How do I become an endorsing prescriber?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
Where do I find a list of over-the-counter family planning products?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage
How do I request a change in reimbursement?	• Complete *Pharmacy Information Authorization* (HCA 13-835A) form following the instructions on the form. For a reimbursement change request, indicate 522 for Pharmacy Rates in field #1 – Org. • Provide a copy of the invoice relevant to the drug on the submitted claim. Invoice must show name and strength of drug, NDC, quantity, purchase date, and purchase price. • Fax a completed *Pharmacy Information Authorization* (HCA 13-835A) form as the first page, followed by the invoice and supporting documentation. (See **Where can I download HCA forms**?)

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC and WAC 182-530-1050 for a complete list of definitions for Washington Apple Health.

340B program - The federal program that requires drug manufacturers participating in the Medicaid Drug Rebate Program (MDRP) to provide covered outpatient drugs to enrolled "covered entities" at or below the ceiling price, as described in 42 U.S.C. § 256b. This requirement is described in section 340B of the Public Health Service Act and codified in 42 U.S.C. § 256b.

340B provider or **PHS-qualified covered entity** - Any provider including, but not limited to, a clinic, facility, hospital, pharmacy, or program listed in 42 U.S.C. § 256b as eligible to purchase, dispense, or administer outpatient drugs through the 340B program, that has submitted its valid Medicaid provider number(s) or national provider identification (NPI) number to the public health service (PHS), health resources and services administration (HRSA), office of pharmacy affairs (OPA), and has registered with and been approved by OPA.

340B maximum allowable cost (340B MAC) - The maximum amount HCA reimburses a participating 340B Public Health Services (PHS)-qualified covered entity to purchase, dispense, or administer a covered outpatient drug, device, or drug-related supply.

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

Actual acquisition cost (AAC) –-The true cost paid for a specific drug or drug product in the package size purchased, including discounts, rebates, charge backs that affect the provider's invoice price, and other adjustments to the price of the drug, device, or drug-related supply, excluding dispensing fees.

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.

Apple Health Preferred Drug List (PDL) - The list of preferred drugs and restrictions that is used by all HCA-contracted managed care plans and fee-for-service (FFS).

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 HCA), and the director of the Department of Labor and Industries (L&I).

Authorization number – A number assigned by HCA 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.

Automatic refills - Any prescription refill the pharmacy initiates without a request from the client.

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. (See 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 – See "Professional dispensing fee."

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 HCA'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 – Nondrug 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), is enrolled in the Washington Prescription Drug Program, 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.

Evidence-based practice center – A research organization designated by the federal Agency for Healthcare Research and Quality (AHRQ) to develop report and technology assessments on topics relevant to clinical and other health care organizations and delivery issues.

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:

- Receives funding from the federal Department of Health and Human Services' Maternal and Child Health Bureau National Hemophilia Program.
- Is qualified to participate in 340B discount purchasing as an HTC.
- 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.
- Is recognized by the Federal Regional Hemophilia Network that includes Washington State.
- 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)**.**

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

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

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

- Which is approved under the federal Food, Drug, and Cosmetic Act.
- 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:
    - The American Hospital Formulary Service Drug Information
    - The United States Pharmacopoeia Drug Information
    - 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 for which there is at least one other drug product sold in the United States that is pharmaceutically equivalent and bioequivalent, as determined by the Food and Drug Administration.

National average drug acquisition cost (NADAC) – A national benchmark published by the Centers for Medicare and Medicaid (CMS). The NADAC is based on a monthly survey of invoice costs paid by retail community pharmacies across the United States.

National drug code (NDC) –The eleven-digit numerical code that includes the labeler code, product code, and package code.

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 within a therapeutic class of drugs on the Apple Health preferred drug list (PDL) that has not been selected as a preferred drug.

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

Other Coverage Code – A billing code that indicates whether 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 Washington State Department of Health 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, advanced registered nurse practitioner (ARNP), 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, during the practitioner's professional practice, for a 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.

Professional dispensing fee – The fee HCA or its designee pays pharmacists and dispensing providers for covered prescriptions. The fee pays for costs more than the ingredient cost of a covered outpatient drug when a covered outpatient drug is dispensed. (See WAC 182-530-1050 for full definition.)

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

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:

HCA reimburses for medically necessary drugs, devices, and supplies according to rules in Washington Administrative Code (WAC) and the **Reimbursement** section of this billing guide.

HCA covers outpatient drugs, including over-the-counter drugs listed in HCA's **Apple Health Preferred 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**?

HCA 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?

To be reimbursed by HCA, 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.

HCA 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 professional 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 professional dispensing fee
- **Excessive filling** – Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity (except when HCA 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 HCA identifies a higher-priced drug as preferred)

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections – select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".

- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare

dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAC) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

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.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's **American Indian/Alaska Native webpage**.

Program Restrictions

How does HCA determine which drugs to cover?

Coverage determinations for HCA are decided by:

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

If a product is determined to be covered, it may require **authorization**.

> **Note:** HCA 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?

HCA covers:

- Outpatient drugs, including over-the-counter drugs, vitamins, and minerals listed on HCA's **Apple Health Preferred 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 HCA 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 indicated by the prescriber or requested by the client. If less than a 12-month supply is requested, providers may use an **expedited authorization (EA) code from the Apple Health EA list** to dispense less than a 12-month supply. There is no minimum quantity of emergency contraception required to 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 HCA 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.
- Nicotine replacement products, over-the-counter and prescription drugs to promote tobacco/nicotine cessation, *with a prescription*, when prescribed by a provider with prescriptive authority.

What drugs, devices, and supplies are not covered?

HCA 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.

HCA 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) because 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 (except for OTC family planning products)
- Prescription and 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 listed as noncovered on HCA's **Apple Health Preferred 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 one year
- Drugs with a shelf life that has expired prior to being dispensed
- Drugs purchased under section 340B of the Public Health Service (PHS) Act when dispensed by contract pharmacies
- Drugs which have been terminated or removed from the market
- More than a 34-day supply of any product except:
    - Drugs included on HCA's Apple Health Preferred Drug List that allow a 90-day supply
    - 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 indicated by the prescriber or requested by the client.

- Any vitamin product other than:
  - Vitamins listed as covered on HCA's **Apple Health Preferred Drug List**
  - Vitamins determined by HCA to be the least costly therapeutic alternative for the treatment of a client's diagnosed condition (including vitamin deficiencies which are medically necessary to treat and 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
- 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)
  - Managed care capitation rates
  - Block grants
  - Drugs prescribed for clients who are in HCA'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:
  - HCA in consultation with federal guidelines
  - The Drug Use Review (DUR) Board
  - HCA 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 when not used as a suspending agent in a compound
- Prescriptions written on pre-signed prescription blanks completed by SNF operators or pharmacists. HCA may terminate the CPA of pharmacies involved in this practice
- Drugs used to replace those taken from SNF emergency kits

What are the exceptions to the prescription requirement?

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

- Condoms (including condoms)
- Vaginal spermicidal foam with applicator and refills
- Vaginal spermicidal jelly with applicator
- Vaginal spermicidal creams and gels
- Vaginal spermicidal suppositories
- OTC emergency contraception
- Oral contraceptives OTC

Point-of-sale billers must: Bill HCA 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), with the prescriber, pharmacy, or pharmacist NPI. Regardless of the contraceptive, bill the NDC as stated on the package.

Washington State Health Care Authority

Prescription Monitoring Program (PMP)

Providers must check the Prescription Monitoring Program (PMP), as required by WAC 182-530-1080.

How do providers and facilities register, access, and use the PMP?

See the Department of Health's Prescription Monitoring Program webpage for information about PMP registration, access, and use. This webpage also includes information about integration for facilities, pharmacies, and electronic health records (EHR) systems.

When is a provider required to check the PMP?

Prescribers must check the PMP before prescribing any controlled substance. This check must be completed no more than ten days before prescribing a controlled substance.

Dispensing pharmacists must check the PMP no later than two days after dispensing a controlled substance.

May a delegate complete the PMP review?

The prescriber or dispensing pharmacist may delegate the retrieval of the client's PMP information to anyone in their practice setting with authorization to access the PMP. The prescriber or dispensing pharmacist must be the person to review the client's current prescriptions, including any prescriptions not paid for by Apple Health.

How is the PMP retrieval and review documented?

The prescriber and dispensing pharmacist must document in the client's medical record (the client's chart notes and pharmacy profile) the date and time the information was retrieved and the date and time it was reviewed. If the prescriber and dispensing pharmacist work together in the same facility, the client's clinical and pharmacy records must document the date and time of the PMP information retrieval and the date and time both the prescriber and the dispensing pharmacist reviewed the PMP information.

Are there exceptions to reviewing the PMP?

Providers or their delegates must make a good faith effort to retrieve the PMP information. If, after a good faith effort, retrieval is not possible, the provider or delegate must document the date and time of the attempt(s) and reason they were unable to retrieve the information.

Is the PMP review required for all clients?

The PMP review is required for clients enrolled in an Apple Health managed care organization (MCO) or fee-for-service (FFS) program. This includes dual-eligible clients (those with Medicare and Medicaid) and clients with third-party liability (TPL), where Apple Health is the secondary payer.

The PMP review is **not** required when a client is:

- Receiving hospice or palliative care
- Receiving treatment for cancer
- A resident of a long-term care facility
- A resident of a facility where frequently abused drugs are dispensed through a contract with a single pharmacy

Can the PMP reviews be audited?

Yes. HCA may audit prescribers' and pharmacists' compliance with the PMP review requirements as authorized by Section 5042 of the Support Act and WAC 182-530-1080.

Compliance Packaging

HCA, 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?

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?

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.

Managed care clients who meet these criteria are eligible to have compliance packaging paid for under fee-for-service (FFS) when one or more medications packaged are covered under the FFS benefit. Packaged medications may include a combination of medications paid for by the client's managed care organization and medications paid under FFS, as long as a paid FFS claim exists for at least one medication included in the packaging. To bill HCA through FFS for compliance packaging that meets these conditions, enter the appropriate expedited authorization (EPA) code on the claim.

What is required when billing for compliance packaging?

To bill for compliance packaging:

- Bill electronically on an approved professional claim. See HCA's ProviderOne Billing and Resource Guide for general billing instructions.
- 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.
- Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.
- Use the following procedure codes in combination with the appropriate modifier. HCA 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	Limit of 4 per client, per year May be billed in combination but not to exceed a total of 4 per year
Filling fee for a reusable compliance device or container	T1999	TS	Limit of 4 fills per client, per month

Short Description	HCPCS Code	Modifier	Maximum Allowable Units*
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

HCA does not pay for compliance packaging more than the limits listed above. Requests for limitation extensions will not be approved.

> **Note**: For MCO clients who are eligible for compliance packaging through FFS, pharmacies must enter expedited authorization (EA) code 870001421 on the billing form in the *Authorization Number* field, or in the *Authorization* or *Comments* section when billing electronically.

Billing for single-dose vials

When a drug is packaged in a single-dose vial that cannot be used for multiple injections, HCA reimburses for the entire quantity of the drug or biological contained in the vial. HCA requires providers to use the smallest vial size available from the manufacturer(s) containing the amount necessary for administration. Unused product discarded as waste is covered in addition to the quantity administered, up to the maximum number of allowed units for the vial size used. HCA considers the entire vial to have been used in providing services to the client and will reimburse accordingly.

> **Note**: The actual National Drug Code (NDC) that was dispensed must be used when submitting a claim. The number of units contained within each vial must be billed as a single claim. (See WAC 182-530-5000(1)(b).)

For information on billing for single-dose vials on medical claims, see Billing for single-dose vials (SDV) in the Physician-Related Services/Health Care Professional Services Billing Guide.

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

Yes. Providers must obtain HCA approval to bill for splitting single-dose vials. To receive HCA approval, submit the following documentation to the Apple Health

Pharmacy Program at **applehealthpharmacypolicy@hca.wa.gov**, with the subject line "Request for approval – splitting single-dose vials:"

- 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

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

Washington State Health Care Authority

Compounded Prescriptions

What is compounding?

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. HCA does not consider drug reconstitution to be compounding. HCA 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. HCA's point-of-sale (POS) system does not accept **highest cost ingredient** compound billing.

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?

The following ingredients are not reimbursed in compounds:

- 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?

The following 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

Is authorization required to compound prescriptions?

No. HCA does not require authorization to compound prescriptions.

Individual ingredients may require authorization. The need for authorization of any single ingredient within a compound will cause the entire compound claim to be rejected.

Billing for compounded prescriptions

For accepted field values, see the compound segment of HCA's payer sheet. All compounded prescriptions must include the following:

- The compound code (field 406-D6) of 2
- A dosage form description code (field 450-EF)
- A compound dispensing unit form indicator
- A compound ingredient component count
- A compound product ID qualifier of 03 = NDC
- The 11-digit NDC for each ingredient included
- The compound ingredient quantity
- The compound ingredient drug cost

HCA pays a professional dispensing fee for each payable ingredient. HCA 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 a **08** in the Submission Clarification Code field (420-DK).

Special Programs and Services

Can pharmacists or pharmacies bill for COVID-19 tests for Apple Health (Medicaid) clients?

Yes. Pharmacies may bill over the counter (OTC) COVID-19 tests with or without a prescription for clients.

Limitations

HCA limits OTC COVID-19 tests to a total of two tests, per client, per month.

> **Note:** If additional tests are needed, pharmacy providers may submit a prior authorization (PA) request to HCA.

Reimbursement

HCA requires an adjudicated pharmacy claim to reimburse pharmacies for an OTC COVID-19 test.

Billing

- Pharmacies must bill claims through the point-of-sale system.
- Pharmacies may not bill for test administration of an OTC COVID-19 test; these tests are to be used by the patient in the home setting.
- To bill for OTC COVID-19 tests, pharmacies must follow the National Council for Prescription Drug Programs (NCPDP) standard and use the national drug code (NDC) or universal product code (UPC) found on the package.
- Pharmacies may submit claims with single packs (1 test) or multi-pack test kits (2 tests), equaling a total of 2 OTC COVID-19 tests per month. For example:
  - 1 Single pack kit (1 test) –2 kits per calendar month allowed
  - 1 Multi pack kit (2 tests) – 1 kit per calendar month allowed

No Prescription

When there is no prescription:

- For clients in managed care, contact the client's managed care plan for billing instructions.
- For fee-for-service clients, pharmacies must use the following prescriber information:
  - Prescriber ID Qualifier (466-EZ): 01
  - Prescriber ID (407-D7): Pharmacy or pharmacist NPI

Does HCA cover Tobacco/Nicotine Cessation Program services?

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

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

How does a pharmacist bill HCA for Clozaril/Clozapine related services?

Any licensed or registered pharmacist 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 review. When providing case coordination, providers must:

- Coordinate a plan of care with all the following:
  - Client
  - 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.

See HCA's ProviderOne Billing and Resource Guide for general billing instructions. Use the following procedure codes to bill for Clozaril/Clozapine related services on an approved electronic professional claim:

CPT® Code	Modifier	Description	Reimbursement
36415		Routine venipuncture	Per the Resource-Based Relative Value Scale (RBRVS) fee schedule
99605	HE		See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule
99606	HE		See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

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

How does a pharmacy bill HCA for emergency contraceptive pills?

For members enrolled with an agency-contracted managed care organization (MCO), the pharmacy must be the MCO. HCA reimburses for emergency contraceptive pills (ECPs) through the point-of-sale (POS) system for clients in eligible programs. OTC ECPs may be dispensed with or without a prescription. Some ECPs are prescription only and require a prescription.

To receive reimbursement for OTC ECPs that were not prescribed, pharmacies must do the following:

- Bill using the specific 11-digit NDC for the product
- Use pharmacy or prescriber's NPI in the prescriber ID field

Pharmacies are instructed to dispense the quantity requested by the client. HCA reimburses pharmacies for products plus a professional dispensing fee.

See the Family Planning Billing Guide for more information on covered services.

Does HCA reimburse pharmacists for emergency contraception (EC) counseling?

Yes. When a pharmacist has an EC protocol approved by the Washington State Department of Health and they are the prescriber for the EC pills, the pharmacist may bill HCA for the counseling.

Pharmacists performing EC counseling must ensure that a copy of their current approved protocol certificate from the Washington State Department of Health is on file at the pharmacy where the service was performed. Billing HCA for EC counseling without a current, approved protocol **on file** is subject to recoupment of payment.

EC counseling is a service-related item and must be billed on an electronic professional claim. When billing HCA, include the following:

- The diagnosis code Z30.09 (contraceptive management)
- The procedure code 99605 and modifier FP

What is the Patient Review and Coordination program?

The Patient Review and Coordination (PRC) program 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, HCA or the managed care organization (MCO) places the client for no less than 24 months with services restricted to being provided by one or more of the following types of health care providers assigned to the client:

- 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 HCA or MCO staff on a case-by-case basis

At the end of placement periods, the PRC program conducts utilization reviews to determine if restriction will be removed. If the restriction is removed, the client is no longer considered in the PRC program and placement assignments are removed. If PRC placement is NOT removed, the client stays in the PRC program for another 3 years~~,~~ and a utilization review is conducted when the placement period is complete. If PRC placement is NOT removed, the client will remain in the PRC program for another 6 years. All further restriction periods are for an additional 6 years.

What are the PRC criteria?

(See WAC 182-501-0135(7)(a)-(d))

HCA or MCO staff use the following utilization 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)

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 HCA's PRC staff of misuse or potential problems with the client's prescriptions.

Since pharmaceuticals are an HCA-covered service, do not accept cash from clients except for drugs not covered by HCA under 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 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 1-800-562-3022 extension 15606 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 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 HCA's Patient Review and Coordination (PRC) Program webpage.

What vaccines are covered through pharmacies?

HCA covers vaccines according to the current Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations and guidelines for adults and children.

Pharmacies may bill the following vaccines with national drug codes (NDCs) through the point-of-sale (POS) pharmacy system:

- Abrysvo for ages 19 and older*
- Anthrax
- Arexy for ages 60 and older
- Cholera
- COVID-19 for ages 19 and older*
- Dengue
- Influenza for ages 19 and older*
- Japanese Encephalitis
- Monkeypox for ages 19 and older*
- mRESVIA® for ages 60 and older
- Penbraya for ages 19 and older*
- Pneumococcal/Pneumonia for ages 19 and older*
- Shingles for ages 50 and older
- Typhoid
- Yellow Fever

All other covered vaccines must be billed on a professional claim. Refer to the Professional Administered Drug Fee Schedule for the list of covered vaccines by CPT® code.

*** For clients age 18 and younger,** HCA does not reimburse for any vaccine that is available free from the Department of Health (DOH) through the Universal Vaccine Distribution Program and the federal Vaccines for Children (VFC) program. HCA pays only the administration fee for any vaccine available at no cost from DOH. To check which vaccines are available through the VFC program, refer to the Professional Administered Drug Fee Schedule.

How do pharmacies bill for the vaccine?

Pharmacy claims for vaccines must be submitted with the national drug codes (NDCs) through the point-of-sale (POS) pharmacy system. The pharmacist's national provider identifier (NPI) must be entered in the **Prescriber ID** field (411-DB).

Note: Pharmacies may **not** use their pharmacy location NPI as the NPI entered in the **Prescriber ID** field (411-DB).

How do pharmacies bill for vaccine administration?

For vaccine claims billed through the point-of-sale (POS) pharmacy system, pharmacies must bill the vaccine administration using the incentive amount submitted (438-E3) field. **Do not submit a separate claim for vaccine administration.**

Note: HCA reimburses for vaccine administration when administered by a pharmacy technician or a pharmacy intern under the immediate supervision of a pharmacist with an ancillary utilization plan (AUP) approved by the Pharmacy Quality Assurance Commission. When billing for these services, enter the pharmacist who delegated the task as the servicing provider in the Prescriber ID field (411-DB).

For vaccines available through the VFC program for clients age 18 and younger:

- Bill a professional claim using the pharmacy billing taxonomy of 193200000X and include the place of service.
- Bill with the appropriate **vaccine product CPT® code** for each given and use **modifier SL** (e.g., 90707 SL).
- Bill the appropriate administration procedure code for the vaccine given.
    - For vaccine administration CPT® codes, refer to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Well-Child Program Billing Guide.

For vaccines not available through the VFC program (clients age 18 and younger) or for clients 19 years of age or older:

- Bill a professional claim using the pharmacy billing taxonomy of 193200000X and include the place of service.
- Bill with the appropriate **vaccine administration CPT® code.** In the comments or billing note section of the claim, add: Vaccine billed through pharmacy POS.
- DO NOT use modifier SL with these vaccines.
- For vaccine administration CPT® codes, refer to the Physician Related Services/Health Care Professional Services Billing Guide. Maximum allowable vaccine administration fees are listed on the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging Fee Schedule.

What diabetic supplies does HCA cover on a pharmacy POS claim?

HCA covers diabetic supplies through the pharmacy point-of-sale system as follows:

- Diabetic test strips and lancets:
  - For children, age 20 and younger, as follows:
    - Insulin dependent, 300 test strips and 300 lancets per client, per month. EA is required.
    - Noninsulin dependent, 100 test strips and 100 lancets per client, per month.
  - For adults age 21 and older:
    - Insulin dependent, 100 test strips and 100 lancets per client, per month. For pharmacy POS, EA is required.
    - For noninsulin dependent, 100 test strips and 100 lancets per client, every 3 months.
  - For pregnant women with gestational diabetes or had diabetes prior to pregnancy, HCA pays for the quantity necessary to support testing as directed by the client's physician, up to 60 days postpartum. For pharmacy POS EA is required.
- Syringes and needles.
- Alcohol wipes.
- For other covered diabetic supplies, see the **Medical Equipment and Supplies Billing Guide** for more information on covered products and services related to diabetic supplies.

For expedited codes and criteria, see HCA's **Expedited Authorization List**.

Are blood pressure monitors covered through pharmacies?

HCA covers blood pressure monitors through the pharmacy point-of-sale system. Coverage is limited to one monitor per client every three years.

See the **Medical Equipment and Supplies Billing Guide** for more information on limitations and coverage related to blood pressure monitors and supplies.

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

Fees for pre-filling syringes may be billed on a professional claim.

These fees are not billable through 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 Fee
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

ADHD (attention deficit hyperactivity disorder) safety edits

HCA promotes the safe and effective use of attention deficit hyperactivity disorder (ADHD) medication. HCA requires PA for prescriptions for clients receiving ADHD drugs when exceeding the recommended maximum dosage limits or when ADHD therapy duplications occur.

For clients age 17 and younger, see HCA's Second Opinion Program webpage for more information on additional PA requirements.

Second Opinion Program

The Second Opinion Program is designed to improve prescribing practices of psychotropic medications used to treat children ages 17 and younger. In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, HCA established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers.

The guidelines include, but are not limited to, the following:

- Alpha-agonist age and dose limits
- Antidepressant therapy duplications
- Antipsychotic age and dose limits
- Antipsychotic therapy duplications
- Attention deficit hyperactivity disorder (ADHD) age and dose limits
- ADHD therapy duplications
- Insomnia medications
- Polypharmacy (includes five or more psychotropic drugs)

As part of the authorization process, a prescriber must engage in a telephone consultation with an HCA-designated mental health specialist from the Second Opinion Network (SON). A SON representative will contact the prescriber to schedule the required phone consultation. To receive payment for the telephone

consultation with SON, bill HCA on a professional services claim using procedure code 99441.

At the time of the authorization request, HCA will approve continuation of pre-existing drug therapy until the SON consultation process is complete. HCA authorization decisions will be based on the recommendations to HCA by the SON mental health specialist.

For more information on the second opinion program and the pediatric mental health guidelines, see HCA's **Second Opinion Program** webpage.

Oral, Transdermal, and Intra-Vaginal Hormonal Contraceptives

HCA requires oral, intra-vaginal, and transdermal hormonal contraceptives to be dispensed in a 12-month supply (See WAC **182-530-2000** (1)(b)(iii)), unless otherwise indicated by the prescriber or requested by the client. For the purposes of dispensing these contraceptive products, **12-month** means a 365-day supply. If less than a 12-month supply is indicated or requested, providers may use an expedited authorization code from the **Apple Health EA list** to dispense less than a 12-month supply. There is no minimum quantity of emergency contraception required to be dispensed.

> **Note**: When submitting a claim with an EA code, you must document on the prescription the code that was used and the reason. Lack of documentation will result in recoupment if audited.

Cough and cold drug coverage

HCA restricts coverage of drugs used to treat cough and colds to those drugs listed as covered on the **Apple Health Preferred Drug List**. HCA 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, listed as noncovered on the Apple Health Preferred Drug List, may be billed directly to the client as a non-prescribed OTC.

Prescription drugs used to treat cough and colds, listed as noncovered on the **Apple Health Preferred Drug List,** may be purchased by the client with a signed waiver. (See Billing the Client, WAC **182-502-0160** and **Coordination of Benefits**.)

Medications for Opioid Use Disorder (MOUD)

HCA's Clinical Guidelines and Coverage Limitations for Medications for Opioid Use Disorder (MOUD) and links to the request forms can be found on HCA's **Apple Health (Medicaid) Drug Coverage Criteria** webpage.

Voluntary treatment

For clients eligible in a voluntary recipient aid category (RAC), some prescriptions for related treatment will require retro-authorization. To request payment for prescriptions related to voluntary treatment that require authorization, contact applehealthpharmacypolicy@hca.wa.gov and include the following information:

- Client name (first and last)
- Client date of birth
- Client ProviderOne ID
- Date of service
- Drug name
- Drug NDC
- Drug quantity, days' supply, and directions for use
- Prescriber name and NPI
- Pharmacy name and NPI

For more information on voluntary treatment and voluntary RAC, please see HCA's Mental Health Services Billing Guide.

Authorization for proton pump inhibitors (PPIs)

HCA limits proton pump inhibitors (PPIs) to one tablet/capsule per day for 60 days during any 12-month period. HCA may authorize more than 60 days per 12-month period or more than one tablet/capsule per day for patients taking certain medications or who have one of the following chronic medical conditions:

Chronic medical conditions include:

- Pathological gastric acid hypersecretion, such as Zollinger-Ellison syndrome
- Barrett's esophagus
- Esophageal stenosis/stricture or Schatzki ring
- Recent erosive/ulcerative esophagitis or duodenal/gastric ulcer

Concurrent medications include:

- Chronic NSAID use (including aspirin greater than or equal to 325 mg per day)
- Chronic low-dose aspirin with history of a GI bleed
- Chronic high-dose systemic steroid
- Antiplatelet or anticoagulant
- Bisphosphonate where there are pre-existing esophageal disorders
- Pancreatic enzyme
- Cancer Therapies

Prescribers should:

- Re-evaluate therapy for patients diagnosed with GERD.
- Gradually reduce the dose of the PPI over 30 days and discontinue, using an H2RA, to reduce the occurrence of rebound acid reflux.
- Discuss with their patients the guidelines on the management and treatment of GERD.
- Consider endoscopy for patients unable to control symptoms caused by GERD after 8 weeks of PPI treatment followed by a 30-day cross-taper to an H2RA.

The American College of Gastroenterology (ACG) guidelines recommend the following for the treatment of GERD:

- Weight loss
- Head of bed elevation
- Avoidance of meals 2-3 hours before bedtime
- PPI for 8 weeks

For the complete Apple Health (Medicaid) PPI policy and sample taper plan, please visit the **Apple Health (Medicaid) Drug Coverage Criteria** webpage.

Does HCA have limits on opioid prescriptions?

Yes. HCA applies the following limits to opioids:

- Short-acting opioids allowed for acute use only
- Limit of 18 dosages per prescription for children (≤20 years of age)
- Limit of 42 dosages per prescription for adults (≥21 years of age)
- A day supply limit of 42 calendar days of opioid use within a rolling 90-day period
- Attestation required to exceed 120MME up to 200MME
- PA required to exceed 200MME

For more information and resources regarding HCA's Apple Health (Medicaid) opioid clinical policy, refer to HCA's **Opioid webpage**.

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

HCA has reviewed and determined that the covered OTC drugs on the **Apple Health Preferred Drug List (PDL)** are the least costly therapeutic alternatives for medically accepted indications. (See WAC **182-530-2000**(1)(d).)

OTC drugs listed on HCA's Apple Health Preferred Drug List as not covered OTC may be billed directly to the client as a non-prescribed OTC.

Respiratory syncytial virus infection (RSV) prevention in children

HCA follows the guidelines and standards as published in The Official Journal of the American Academy of Pediatrics (AAP) for respiratory syncytial virus infection (RSV) prevention.

Beyfortus™ (nirsevimab-alip)

HCA does not reimburse for products that are available free from the Department of Health (DOH) through the Universal Vaccine Distribution Program and the federal Vaccines for Children (VFC) program. Beyfortus™ is available through the VFC program, and HCA pays only the administration fee when billed on a professional claim for clients under two years of age.

Synagis® (palivizumab)

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

Does HCA have an emergency fill policy?

Yes. Emergency fill means that the dispensing pharmacist used their professional judgment to meet a client's urgent medical need and is willing to dispense the medication to the client prior to receiving reimbursement from HCA.

HCA guarantees payment on claims meeting the emergency fill policy. The pharmacist is required to document on the prescription or member record that the emergency fill code was used, the pharmacist's initials, and the date of use. The pharmacy then bills the emergency fill by entering a value of 13 in the NCPDP field (420-DK) and the submission clarification code and the submission clarification code count in field 354-NX.

For more information and guidelines on emergency fills, see HCA's Emergency Fill Policy.

When does HCA pay for hemophilia- and von Willebrand-related products for home administration?

HCA does not pay for hemophilia- and von Willebrand-related products for administration in the home when dispensed by and billed through retail or specialty pharmacies. HCA pays for hemophilia- and von Willebrand-related products shipped to clients 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, retail or specialty pharmacy providers may contact HCA to request an authorization to continue to dispense product to the client. The pharmacy must call HCA's Pharmacy Authorization Section at 800-562-3022, extension 15483.

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

Washington State Health Care Authority

Authorization

Note: Authorization does not guarantee payment. All administrative requirements (client eligibility, claim timeliness, etc.) must be met before HCA can reimburse a claim.

When does HCA require authorization?

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. HCA 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 two prescription fills (of the same drug) per calendar month

HCA 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. For more information see HCA's Emergency Fill Policy.

How do I obtain authorization?

To obtain authorization for pharmacy products, providers may:

- Fax a *Pharmacy Information Authorization* form 13-835A to HCA at: 1-833-991-0704. (See **Where can I download HCA forms**?)
- Call HCA at: 1-800-562-3022.

What information does HCA need when requesting authorization?

When calling or faxing to request authorization, the following information must be provided:

- Previous authorization number, if available
- Pharmacy NPI#
- Rx #

- Quantity and day's supply
- Medications have been tried and failed in the past
- Client's ProviderOne Client ID
- National Drug Code (NDC) on the claim
- Prescriber's name
- Prescriber's phone and fax number
- Date(s) being requested for authorization
- Justification for the requested service addressing the following:
    - The diagnosis or condition of the client
    - The medical need for the dose or to exceed the HCA maximum dose
    - Other therapies that have been tried and failed in the treatment of the same condition

HCA may request additional information on a case-by-case basis.

If the request for authorization is missing any required information, it will be considered invalid, and HCA may not process the request.

Who determines when a drug requires authorization?

HCA pharmacists, medical consultants, and the Drug Use Review Team evaluate drugs to determine authorization status. HCA may consult with an evidence-based practice center, the Drug Use Review (DUR) Board, or participating HCA providers in this evaluation.

How does HCA determine when a drug requires authorization

HCA pharmacists and medical consultants evaluate drugs based on, but not limited to, the following criteria:

- Evidence for efficacy and safety
- If there is an equally effective, less costly therapeutic alternative
- The potential for misuse and abuse
- If a drug has a narrow therapeutic index
- Other safety concerns

For more information on how HCA determines when a drug requires authorization, see WAC 182-530-3100.

Drug manufacturers who wish to facilitate the evaluation process for a drug product may email HCA a written request with all 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

How do I know if a drug requires authorization?

For drugs billed through the pharmacy point-of-sale (POS) system, the Apple Health Preferred Drug List (AHPDL) will have a status of preferred or nonpreferred and a pharmacy authorization status of Y= yes. The AHPDL includes product specific authorization requirements indicating if the following apply:

- Expedited authorization
- A second opinion
- A non-clinical policy
- An applicable clinical policy

Drug coverage criteria and policies can be found on **HCA's Apple health (Medicaid) drug coverage criteria webpage**.

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

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

- The prescription is written for short days-supply because the client's prescriber is monitoring the client's supply

> **Note:** Pharmacies must enter an 8 in the Prior Authorization Type Code (NCPDP 461-EU) field when the prescriber is monitoring the client's supply, and more fills are needed.

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 supply of medication due to travel (up to a 90-day supply once every 6 months, per medication). For more information on early fills for medication travel supplies, see **May clients receive early refills or extended days' supply for travel**?
- A client needs a take-home supply of medication for school, camp, or skilled nursing facility.

For early refills related to reentry from a carceral setting, see the Refill-Too-Soon section in the Reentry Initiative Policy and Operations Guide.

For any other circumstance, the provider must contact HCA's Pharmacy Authorization Section to request approval. (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).

Point-of-Sale billers must enter one of the following codes in the 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

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

HCA will allow an early refill up to a 90-day supply once every six months, per medication. The pharmacy must contact HCA's Pharmacy Authorization Section to request approval. (See Resources Available)

It is also possible to help clients who will be out of the area to receive refills covered by HCA 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 HCA-contracted pharmacy throughout Washington or border areas of Idaho and Oregon.
- A pharmacist or a dispensing medical practitioner may mail medications that are not considered to be controlled substances to clients under their care. (See Title 21, Section 802(6) U.S.C. for the definition of controlled substances and the U.S. Postal Service website for additional restrictions and guidelines for mailing medications.) HCA does not cover the cost of shipping. The pharmacy is responsible for the cost of shipping. Clients must not be billed for shipping or postage costs. (WAC 182-502-0160(9)(c)).

- Some chain stores can "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?

Authorization is required for brand name drugs when indicated on the Apple Health Preferred Drug List (AHPDL). If the AHPDL indicates brand name authorization is required, the prescriber must provide medical justification for the use of the brand name drug. 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.

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

Expedited authorization

What is expedited authorization?

HCA's EA process is designed to eliminate the need to request authorization from HCA. 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 expedited authorization number created?

To bill HCA for drugs that meet the EA criteria, the pharmacist must create an 11-digit EA number. The first eight digits of the EA number must be **85000000**. The last three digits must be the code number of the diagnosis/condition that meets the EA criteria.

> **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 products 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 (MAC)
- 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 1-833-991-0704
- **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

What is an exception to rule?

The process used by HCA 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.

For clients enrolled in fee-for-service, providers may request an exception to rule (ETR) for a noncovered service by contacting HCA and providing the information outlined in WAC 182-501-0160.

Reimbursement

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

- HCA 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.
- HCA 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 HCA 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 **Does HCA participate in the federal drug rebate program?** for more information.
- Bill HCA the usual and customary charge using the complete 11-digit national drug code (NDC) from the dispensing container.
- Include quantity dispensed, using the metric or metric decimal quantity for the product.
- Delivery of a service or product does not guarantee payment. For example, HCA 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 HCA.
    - The client has third party coverage, and the third party pays as much as, or more than, HCA 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.
    - The prescription has been used to meet a client's financial obligation towards spenddown.

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

The actual acquisition cost (AAC) is adjudicated by the payment system based upon the available prices in the drug file. Depending on the status of the drug, POS reimburses at the lowest of the available rates using the following price points:

- National average drug acquisition cost (NADAC)
- Maximum allowable cost (MAC)
- Federal upper limit (FUL)

- Wholesale acquisition cost
- Provider's usual and customary charge to the non-Medicaid population
- Submitted ingredient cost
- 340B MAC for covered outpatient drugs purchased, dispensed, or administered under section 340B of the Public Health Services (PHS) Act and dispensed to medical assistance clients.
- Actual acquisition cost for drugs listed in **What drugs require prior authorization and are reimbursed at AAC**?
- Medical supplies allowable through point-of-sale are reimbursed at the rate established in the **Medical Equipment and Supplies Fee Schedule**.

> **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 HCA for the prescription. (Example: A $5.00 off coupon for purchases elsewhere in the store.)
>
> Any drug or product provided free to the public must also be provided free to the Medicaid customer.

How does HCA determine the actual acquisition cost (AAC)?

HCA uses the following sources to determine actual acquisition cost (AAC) including, but not limited to:

- National average drug acquisition cost (NADAC) published by the Centers for Medicare and Medicaid Services (CMS)
- Acquisition cost data made available to HCA by audits from state or federal agencies, other state health care purchasing organizations, pharmacy benefit managers, individual pharmacy providers, other third-party payers, drug file databases, actuaries, and other consultants.

What drugs require prior authorization and are reimbursed at actual acquisition cost (AAC)?

HCA reimburses providers for drugs on the **Drugs excluded from MCO responsibility (billed to FFS)** list at AAC only. An invoice showing the purchase price of the medication from the billing pharmacy is required when submitting prior authorization. The invoice must be current and include all the following:

- The name of the drug, device, or drug-related supply
- The NDC of the product or products
- The drug strength

- The product description
- The quantity
- The cost, including any discounts or free goods associated with the invoice

(WAC 182-530-7250 [2])

If HCA approves the PA request, providers must submit an invoice to HCA **every** 6 months showing the pharmacy purchase price of the medication for the duration of the authorization. To submit an invoice for an authorization, fax a completed Pharmacy Information Authorization (HCA 13-835A) form as the first page followed by the invoice and supporting documentation. If the invoice was requested by HCA on the Prescription Drug Request Status (HCA 13-358) form, fax the form (HCA 13-358) as the first page followed by the invoice.

How are federal upper limits calculated?

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

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

Drugs subject to FUL may also be subject to other HCA pricing methodologies. HCA reimburses the lower of AAC, MAC, FUL, submitted cost, or usual and customary charges.

When is the maximum allowable cost (MAC) applied?

The maximum allowable cost (MAC) may be applied to specific, equivalent covered outpatient drugs. If applied, HCA reimburses both the brand name and generic drugs at the MAC price.

The MAC may be waived for:

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

For more information, see the up to date SMAC list.

How is tax computed?

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

How do I request a reimbursement change?

To request a reimbursement change to the provider's actual acquisition cost (AAC) for a drug, providers may:

- Complete *Pharmacy Information Authorization* form 13-835A following the instructions on the form. For a reimbursement change request, indicate 522 for Pharmacy Rates in field #1 – Org.
- Provide a copy of the invoice relevant to the drug on the submitted claim. Invoice must show name and strength of drug, NDC, quantity, purchase date, and purchase price.
- Fax a completed *Pharmacy Information Authorization* (HCA 13-835A) form as the first page followed by the invoice and supporting documentation. (See **Where can I download HCA forms**?)

What are HCA's professional dispensing fees?

HCA uses a three-tier professional dispensing fee structure with an adjusted fee allowed for pharmacies that participate in the Unit Dose programs.

HCA's professional dispensing fees for pharmacies **after July 1, 2023, are**:

Pharmacy Type	Amount	Professional Dispensing Fee
High-volume pharmacies	70,000 or more claims per year	$9.80 per claim
Mid-volume pharmacies	30,000 – 69,999 claims per year	$11.91 per claim
Low volume pharmacies	Fewer than 30,000 claims per year	$14.30 per claim
Unit dose systems		$14.30 per claim

A provider's professional 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 volume survey.

Return the annual prescription volume survey by fax to: (360) 725-1982 or by mail to:

Pharmacy Rates Unit
PO Box 45510
Olympia, WA 98504- 5510

Does HCA pay professional dispensing fees for non-drug items?

HCA does not pay a professional dispensing fee for non-drug items, devices, or supplies unless HCA determines that the drug file is not maintaining prices sufficient to cover product cost.

Does HCA Participate in the federal drug rebate program?

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates that states claim federal financial participation (FFP) 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 11-digit NDC for the drug dispensed and the quantity, using the appropriate unit of measure.

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

> **Note**: To download HCA's version of the Federal List of Drug Manufacturers Participating in the Centers for Medicare and Medicaid (CMS), visit HCA's Pharmacy webpage and download the Participating Drug Rebate Manufacturers List.

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

What are the general instructions for billing?

- Providers must follow the billing requirements found in HCA ProviderOne Billing and Resource Guide.
- Bill HCA your usual and customary charge using the 11-digit NDC from the dispensing container.
- Include the actual quantity dispensed using the appropriate metric or metric decimal quantity for the product.
- HCA 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 HCA-contracted managed care organization (MCO) are eligible for pharmacy services under their designated plan.

Note: Requiring authorization is not the same as a denial of coverage. When another insurer or an HCA-contracted MCO requires authorization for a drug, perform all steps necessary to obtain the authorization.

How do I bill electronically for services?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers and Providers webpage, under Webinars.

See HCA's ProviderOne Billing and Resource Guide for general billing instructions.

What is point-of-sale (POS)?

HCA'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 HCA.

What do the POS rejection codes mean?

HCA's POS system uses NCPDP D.0 reject codes. Although these codes have meaning within the NCPDP standard, HCA's POS system returns a message of explanation with the claim rejection. It is important for pharmacies to read these messages. If providers do not know how to access these reject messages, they must contact their software vendor for assistance.

HCA providers must not accept payment from clients for any service potentially covered under the client's HCA benefit. **It is important for providers to understand that a claim rejection through the POS system is not a denial of service**. Some claim rejections indicate when a product is not covered, while others may indicate additional steps are necessary to determine coverage for the product or service.

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

HCA 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 claim may be resubmitted using the NCPDP DUR Reason for Service, Professional Service, and Result of Service codes.

Entering DUR codes will not automatically bypass DUR screening. HCA 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. Entering the DUR codes on a claim is subject to review and recoupment if documentation does not show the action was taken.

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 HCA the provider must use the 11-digit NDC, including zeros, from the dispensing container. (See WAC 182-530-5000(1)(b))

What is the NCPDP Version D.0 claim format?

To comply with the Health Insurance and Accountability Act (HIPAA) requirements, HCA 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. HCA requires submission of the Patient First Name (310-CA) and Patient Last Name (311-CB). HCA uses 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 (302-C2) field, and Patient Relationship Code should be set to 1.

Claim segment

The claim segment is mandatory on all billing (B1, B2, B3), transactions. This segment contains data relating to the dispensing of the actual prescription. 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 billing transactions except for Reversals (B1, B3). The mandatory/required fields are the Segment Identification, Prescriber ID Qualifier, and Prescriber ID.

Clinical segment

The clinical segment is a situational segment and includes diagnosis code count (491-VE), the diagnosis code qualifier (492-WE), and the diagnosis code (424-DO) fields. Entering the diagnosis on the claim transaction may bypass some prior authorization requirements.

COB/other payment segment

This segment is required when HCA 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. 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 Product ID Qualifier, Compound Product ID, Compound Ingredient Quantity, Compound Ingredient Drug Cost, and Compound Ingredient Basis of Cost Determination. HCA will reimburse a professional 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.

What about emergency dispensing?

Pharmacists are allowed to dispense a prescription written on noncompliant paper if 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 are the documentation and records retention requirements?

The pharmacist must document that the prescriber was contacted by telephone, fax, or email to verify 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.

Are automatic refills allowed?

No. Clients must request a prescription refill before the pharmacy may submit a claim and fill the prescription. Automatic refills are only permitted when the client is either:

- Receiving compliance packaging
- Residing in a skilled nursing facility or inpatient facility

What does a pharmacy do if a client becomes retroactively enrolled with Medicaid?

If a client becomes retroactively enrolled with Medicaid, pharmacies must submit the claim to the contracted managed care organization or fee-for-service, whichever the client is enrolled in. If the pharmacy previously accepted cash, and the retroactive enrollment covers the date of fill, the pharmacy must reimburse the client in accordance with WAC 182-502-0160.

What is the time limit for billing?

HCA requires providers to submit initial claims and adjust prior claims in a timely manner. The following are HCA'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 HCA **ProviderOne Billing and Resource Guide**.

Medicare Part B crossover claims

If a client has active Medicare Part B coverage and the drug is covered by Medicare Part B, the claim must be billed within six months of the date that Medicare processes the claim. To bill HCA, use the COB transaction segment, including the applicable COB codes. Providers can rebill or resubmit a crossover claim up to 15 months from Medicare's process date. If Medicare denies payment of the claim, HCA requires the provider to meet HCA'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 HCA within 365 days of the date of service to establish timeliness.

Resubmitted claims and adjustments

HCA allows providers to resubmit, modify, or adjust any prescription drug claim 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 456 days from the date dispensed. After 15-months, HCA does not accept a prescription drug claim for resubmission, modification, or adjustment.

Reversals

HCA allows pharmacies to reverse any prescription drug claim within 15 months of the date the service was provided to the client. Claims may be reversed electronically for 456 days from the date the claim was dispensed. If a pharmacy wishes to reverse a transaction that can no longer be reversed electronically from the pharmacy's own system, a request may be submitted to HCA for reversion only under the following circumstances:

- "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

If one of the above circumstances applies, a pharmacy may request a reversal by submitting a help ticket via email, with a subject line: POS claim reversal. The email must include:

- Client name and ProviderOne ID number
- Drug name and NDC
- Claim number
- Date of fill
- Provider NPI
- Prescription number

If unable to submit a help ticket via email, pharmacies may also fill out a Pharmacy Adjustment Request (HCA 13-715) form and fax it to 360-507-9074. See Where can I download HCA forms?

Overpayments that must be refunded to HCA

The 15-month period allowed for resubmission of claims above **does not apply** to overpayments that a prescription drug provider must refund to HCA. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. For more information regarding overpayments, see the ProviderOne Billing and Resource Guide.

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.

HCA 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.

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.

When is a pharmacy allowed to bill a client?

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* (HCA 13-879) form. See Where can I download HCA forms?

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. See WAC 182-502-0160, Billing the client.

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

May a pharmacy accept cash if ProviderOne shows the client is eligible, but POS rejects the claim as not eligible?

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, **FAX** a copy of the client's benefit screen from ProviderOne to Claims Entry at 866-668-1214. The benefit inquiry screen in ProviderOne will be updated within two working days for claims to be resubmitted. Do not fax **claims** to this number.

See Billing the Client in WAC 182-502-0160.

How do I bill for Avastin (bevacizumab)?

Avastin (bevacizumab) is reimbursed when billed with the National Drug Code (NDC) of the product and one of the following HCPCS and corresponding diagnosis codes. All other diagnoses are noncovered.

HCPCS code	Drug	Limitation
J9035	bevacizumab (Avastin	C00 – D49
Q5107	bevacizumab-awwb (MVASI)	C00 – D49
Q5118	bevacizumab-bvzr (ZIRABEV)	C00 – D49
Q5126	bevadizumab-maly (ALYMSYS)	C00 – D49
Q5129	bevacizumab-adcd (vegzelma)	C00 – D49
J7999	Compounded drug, not otherwise classified	H35.32XX, E08.3XX, E08.32XX, E08.33XX, E08.34XX, E08.35XX, E09.32XX, E09.33XX, E09.34XX, E09.35XX, E10.32XX, E10.33XX, E10.34XX, E10.35XX, E11.32XX, E11.33XX, E11.34XX, E11.35XX

Note: For wet age-related macular degeneration (AMD) or Retinopathy due to diabetes mellitus, claims will be reimbursed only when billed with an NDC for a 4mL vial using an ophthalmology billing taxonomy.

How do I bill for take-home naloxone?

In response to the increase in opioid overdose-related deaths in Washington State, the legislature passed Senate Bill 5195 (chapter 273, Laws of 2021). This law helps to increase access to naloxone for all individuals at risk of an opioid overdose. The law requires distribution of prepackaged (take-home) naloxone to individuals at risk of an opioid overdose at:

- Hospital emergency departments (EDs)
- Pharmacies
- Opioid treatment programs
- Certified or licensed behavioral health agencies (BHAs)

Naloxone distributed to Apple Health fee-for-service (FFS) clients may be billed as a separate line item with one of the following HCPCS codes and the National Drug Code (NDC) of the product distributed:

HCPCS Code	Modifier	Drug	Unit
J2310		Naloxone injection	1mg
J2311		Naloxone injection, Zimhi™	1mg
J3490	HG	Naloxone 4mg nasal spray	1 single-spray device*
J3490	TG	Naloxone 8mg nasal spray	1 single-spray device*

*If dispensing a package/kit that contains more than one single-spray device, bill for the total number of units within the package/kit. For example, if one package/kit contains two individually packaged single-spray devices, bill for 2 units.

Note:

- When provided in the ED, take-home naloxone must be billed as a separate line item. HCA does not package naloxone when provided in the ED.
- When provided by a Behavioral Health Agency, take-home naloxone must be billed as a separate professional claim.
- For rates related to take-home naloxone, please see the Outpatient Hospital (OPPS) or Professional Administered Drug Fee Schedules on HCA's Provider billing guides and fee schedules webpage.

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:

> **Note: Point-of-Sale billers** must enter "**11**" in the **Patient Segment, Patient Residence** (384-4X) field.

Do not use this procedure for dates when the client is not on hospice services.

Does HCA reimburse for a client's prescriptions when enrolled in an HCA-contracted managed care organization?

HCA reimburses for drugs dispensed to clients enrolled in an HCA-contracted MCO only when a managed care contract excludes the drug, and the product is reimbursable fee-for-service (FFS). (See WAC 182-538-095(5).) This includes:

- Drugs excluded from MCO responsibility (billed to FFS)
- Hemophilia and von Willebrand-related products when used for administration in the home.
- Compliance packaging when one or more medications are paid under the fee-for-service benefit. Refer to Compliance Packaging for more information.

What drugs and supplies are covered under the Family Planning Only Programs?

The following drugs and supplies related to family planning and contraceptives are covered for Family Planning Only Program clients:

- Prescription contraceptives
- Over-the counter nonprescribed contraceptive drugs and supplies (for example: emergency contraception, condoms)
- Antibiotics and antifungals for the treatment of sexually transmitted infections (STIs)
- Pain medications used after a sterilization procedure

> **Note:** When billing for postoperative pain medications for Family Planning Only clients:
>
> - **Point-of-sale billers** must enter "**6**" in **Claim Segment, Prior Authorization Type Code** (461-EU) field

See the Family Planning Billing Guide for more information on covered products and services for Family Planning Only clients.

Does HCA pay for prescriptions when a client lives in a skilled nursing facility (SNF)?

HCA reimburses covered prescription drugs for SNF clients. (See What drugs, devices, and supplies are covered?).

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 practices are in accordance with state regulations.

Point-of-sale billers: Enter "**8"** in the **Claim Segment, Prior Authorization Type Code** (461-EU) field to bill for the medication needed to cover SNF leave.

What is a skilled nursing facility (SNF) 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 HCA for SNFs?

HCA 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 professional 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 professional dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to **Reimbursement** for HCA's professional dispensing fee allowances for pharmacies.

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

To be eligible for a unit dose professional dispensing fee from HCA, a pharmacy must:

- Notify HCA in writing of its intent to provide unit dose service
- Specify the type of unit dose service to be provided
- Identify the SNF or facilities to be served
- Indicate the approximate date unit dose service to the facility or facilities will commence
- Sign an agreement to follow HCA requirements for unit dose reimbursement

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

How do pharmacies bill HCA under a unit dose delivery system?

Under a unit dose delivery system, a pharmacy must bill HCA only for the number of drug units used by the HCA 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 HCA client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment or claims reversal of the charge to HCA 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 HCA for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

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

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

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 HCA a fee for repackaging a client's bulk medications in unit dose form.

What records do SNF pharmacies need to keep?

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 HCA. HCA may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to HCA?

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

What additional records do pharmacies need to keep?

In addition to the record keeping requirements found in the **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

What is required as proof of delivery?

- When a pharmacy delivers an item directly to or for pick-up by the client, the client's authorized representative, or the prescriber, the pharmacy must be able to furnish proof of delivery, including **ALL** the following:
  - The signature of either the client, the client's authorized representative, or the prescriber receiving the delivery
  - The client's name
  - 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
- The provider must make proof of delivery records available to HCA upon request.

Washington State Health Care Authority

Coordination of Benefits

How are client resources applied?

HCA is required by federal regulation to determine the liability of third-party resources available to HCA 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, HCA may make reimbursement for the balance if the insurance payment is less than HCA's allowed amount.

It is the provider's responsibility to bill HCA 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 in the **ProviderOne Billing and Resource Guide**. The information can be downloaded and printed or used as a reference.

HCA'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 HCA. The provider should not bill HCA with an Other Coverage Code if the claim was denied by the insurance carrier for late filings.

Washington State Health Care Authority

Other Coverage Codes

Why are Other Coverage Codes important?

HCA POS system alerts a provider when a client has other insurance. When a provider submits a claim through the POS system, and HCA files indicate that a client has insurance and payment has not been collected, HCA will deny the claim. The provider must bill the client's insurance before using the Other Coverage Codes.

The provider's weekly Remittance and Status Report (RA) shows 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 table lists situations in which other insurance is available, gives directions to the provider, and explains which Other Coverage Codes to enter. In all 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.

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 HCA	2
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 HCA	4

Situations	Explanation/Solution	Other Coverage Code
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 HCA	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 HCA	4
The insurance denied the medication as a noncovered drug. If non-formulary, 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 HCA	3
Medicare Part D copay	HCA does not provide coverage for Medicare Part D medication copayments. Medicare Part D copayments are the responsibility of the client	

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.

What if a client has 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 HCA 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.

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.)

Are there 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 HCA must be usual and customary charges, except for capitated copayments.

What does the provider do if a third-party liability question arises after regular business hours?

Situations may occur when a client is asking to fill a prescription, a question arises, and it is outside of regular business hours. After making reasonable attempts to access the primary insurance coverage, the pharmacist may apply the HCA emergency fill policy by submitting the claim using the submission clarification code (420-DK) 13 and meet the client's immediate need. "Immediate needs" means pharmacists using their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency.

Examples may include:

- HCA indicates that the patient has insurance, but the coverage cannot be identified, and the patient is unable to 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 HCA with an Other Coverage Code. Prepay is defined on a case-by-case basis.

What if authorization is required by the primary payer?

Pharmacists are required to obtain prior authorization from the insurance carrier before providing the drugs to the client. 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 until the pharmacy has met all third-party billing requirements for billing HCA.

What if the drug is not covered by the primary payer?

Not covered is different than non-formulary. It is the provider's responsibility to correctly determine if the drug is not covered or non-formulary with the primary insurance carrier. Drugs that are not covered by the primary payer may be billed to HCA using the Other Coverage Code 3.

What if HCA requires authorization?

If the claim is submitted to HCA with an Other Coverage Code 2 and the primary payer has paid more than fifty percent of the claim, HCA will bypass our authorization requirements. If the primary payer does not pay at least fifty percent, HCA authorization requirements will apply.

Washington State Health Care Authority

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, see the ProviderOne Billing and Resource Guide.

What if a client's insurance states there is no coverage, the insurance coverage has ended, or the insurance plan cannot identify the client?

For private insurance updates, submit a Contact Us email to HCA.

What is mail order only coverage?

Mail order only coverage means insurance does not reimburse for any prescriptions filled at retail pharmacies.

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

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 submit a Contact Us email to HCA. Do not bill the insurance, and do not bill HCA with an **Other Coverage Code**.
- Less than copay, benefits are exhausted, or any other paid at zero response. Bill HCA using **Other Coverage Code 4**.

How are after-hours services billed?

After-hours services means prescriptions filled outside of 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. See HCA's emergency fill policy.

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:

- HCA 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.

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.

How is a claim submitted to HCA 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. When the insurance allowed or payable amount is less than or equal to the copay amount and the insurance non-payment reason is less than the copay, bill HCA after you bill the insurance. Use a 4 in the Other Coverage Code field. Eligible Medicaid clients with private insurance are not expected to pay a copay.

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. HCA 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 HCA require clients to use pharmacy providers that are contracted with the client's private insurance carrier?

HCA 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 non-contracted pharmacy providers, contact COB for billing assistance.

If a pharmacy is not contracted and the coverage is not pre-pay, HCA 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 HCA.

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.

If the client is enrolled in an HCA-contracted MCO and private insurance, is the MCO billed for the service or the private insurance?

If a client is enrolled in an HCA-contracted managed care organization (MCO) **and** 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 HCA with an Other Coverage Code?

If the client has exceeded their insurance benefit, it is appropriate to bill HCA with an **Other Coverage Code 3**. The pharmacy must meet all third-party billing requirements prior to billing HCA.

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 HCA 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 HCA be billed directly?

No. The insurance carrier requirements must be met. It is not appropriate to bill HCA 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 HCA 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 182-502-0150)

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.

HCA cannot make direct payments to clients to cover the deductible and coinsurance amount of Medicare Part B. HCA **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.

HCA will pay up to Medicare's allowable, or HCA's allowable, whichever is less.

ProviderOne will indicate whether 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, HCA 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, HCA 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, HCA 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 (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 HCA 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 HCA or a private insurer.

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

  Providers have six months from the Medicare process date to submit their initial crossover claim, and two years from Medicare's process date to re-bill or resubmit a crossover claim.

- If **Medicare Part B has denied** a medication:
  - Retail and specialty pharmacies may bill HCA through the POS system using the appropriate DUR result of service code.
  - For professionally administered drugs, bill HCA electronically through ProviderOne and include the Explanation of Benefits (EOB) or Medicare denial letter as supporting documentation. See HCA's ProviderOne Billing and Resource Guide for general billing instructions.

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

Medicare Part D

Are copayments covered?

No. 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 HCA will cover**
- **Medicare Part D website**
- **SHIBA website**
- **CMS website**

HCA Other Coverage Code Summary

Situations	Explanation/Solution	Other Coverage Code
The insurance has made payment to the pharmacy	Bill balance to HCA	2
Insurance allowed amount of the prescription is less than or equal to the copay	Bill HCA	4
The insurance carrier applied the claim charges to the client's deductible	Bill HCA	4
The client's insurance plan maximum annual benefit has been met	Bill HCA	4
The insurance denied the medication as a noncovered drug. If non-formulary, third-party payment procedures must be followed.	Bill HCA	3
Medicare Part D copay	**Medicare Part D copays are not covered**	

Washington State Health Care Authority

Therapeutic Interchange Program

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 HCA), 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 in drug classes 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 on the Washington PDL.

What does this mean to pharmacies?

When an endorsing practitioner issues a prescription to a medical assistance client for a non-preferred drug in a drug class 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, HCA will not require authorization, and the dispensing pharmacist will dispense the non-preferred drug as prescribed.

Exemptions from TIP

RCW 69.41.190 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 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, HCA requires authorization, and the dispensing pharmacist must fax a completed *Pharmacy Information Authorization* (HCA 13-835A) form (see Where can I download HCA forms?) to 833-991-0704, or call HCA at 800-562-3022 to request authorization by providing medical justification. See HCA's Pharmacy website for further information.

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

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

Washington State Health Care Authority

Apple Health Preferred Drug List

What is the preferred drug list?

HCA has 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 evaluated by the Drug Use Review Board, which makes recommendations to HCA regarding the selection of the preferred drugs.

The Apple Health Preferred Drug List (PDL) is used by Apple Health managed care plans and the Fee-For-Service program. The Therapeutic Interchange Program (TIP) only applies to drug classes that are also included on the Washington Preferred Drug List (PDL).

What is the process to obtain drugs on the preferred drug list?

- Prescription claims for **preferred drugs** submitted to HCA 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 HCA are reimbursed only after all authorizing criteria are met.
- Prescription claims submitted to HCA for **non-preferred drugs** that are subject to the Therapeutic Interchange Program (TIP) are reimbursed without authorization requirements when written by an endorsing practitioner who has indicated "DAW" on the prescription, unless the drug requires other restrictions as listed above. See WAC 182-530-4150.
- **Pharmacies** must call HCA for required authorization. Call 1-800-562-3022.

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

- To obtain a nonpreferred drug, a client must have tried and failed, or is intolerant to, a designated number of preferred drugs within the drug class unless contraindicated or not clinically appropriate. The designated number of preferred drugs is listed on the Apple Health PDL. Pharmaceutical samples given to the client do not apply toward the number of preferred drugs tried. Some drugs have additional criteria that must be met for approval.

HCA requires pharmacies to obtain authorization for non-preferred drugs on the Apple Health Preferred Drug List.

Where is the Apple Health Preferred Drug List?

See HCA's Apple Health Preferred Drug List webpage.