Washington State Health Care Authority

Medicaid Provider Guide

A Guide to Prescription Drug Program

[Refer to Chapter 182-530 WAC]

Washington State Health Care Authority

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A Billing Instruction

About this publication

This publication supersedes all previous Agency *Prescription Drug Program Medicaid Provider Guide* published by the Agency.

Note: The Agency now reissues the entire billing guide when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

Reason for Change	Effective Date	Page No.	Subject	Change
Provider Notice 12-92	December 19, 2012	Page 21.	Billing for Compliance Packaging.	Added information regarding NPI of the ordering practitioner.
		Page 28	Clozaril/Clozapine and Related Services	Added procedure codes 99605 and 99606 with modifier HE related to case coordination.
		Page 35.	Billing for Vaccine Administration.	Clarified information regarding use of NPI on the CMS-1500 – claim form.
		Page 43.	Buprenorphine for Pregnant Women.	Added criteria for covering buprenorphine for pregnant women.
		Page 44.	Mental Health Polypharmacy.	Clarified authorization for mental health drugs for clients 17 years of age and younger.
		Page 45.	Step Therapy for Inhaled Long-Acting Beta Agonist/Corticosteroid Combination Drugs.	Clarified documentation for authorization of inhaled long-acting beta agonist/corticosteroid combination drugs.

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		Page 46.	Client eligibility for Synagis ®.	Added hyperlink to the EPSDT program for screening components and client eligibility.
		Page 46.	Requirements for Vivitrol ® (naltrexone IM).	Added process for requesting authorization for Vivitrol.

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How Can I Get Agency Provider Documents?

To download and print Agency Provider Notices and Medicaid Provider Guides, go to the Agency's Provider Publications website.

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Important Contacts

Note: This section contains important contact information relevant to the Prescription Drug Program. For more contact information, see the Agency *Resources Available web page.*

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency *Resources Available* web page
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., Mediciad provider guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Authorization	
Website for pharmacy information	Agency Pharmacy Web Site
Backup documentation	Backup documentation ONLY must be mailed or faxed to: Pharmacy Authorization Section Drug Use and Review PO Box 45506 Olympia WA 98504-5506 Fax: 1-866-668-1214
Technical questions about switch vendor issues or system availability issues	Please contact your switch vendor.
Where can I find Pharmacy Document Submission Cover Sheets?	Document Submission Cover Sheets

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Troubleshooting

If your situation is:	Then you must:
Claim rejection stating "Prior Authorization required" or "Call 1-800-562-3022"	Use Pharmacy Information Authorization, form 13-835a. To download this form, go to Medicaid Forms webpage. Fax form to 1-866-668-1214 **or** Call 1-800-562-3022
Claim rejection starting with "Pref" or "Preferred"	Use Pharmacy Information Authorization, form 13-835a. To download this form, go to Medicaid Forms webpage. Fax form to 1-866-668-1214 **or** Call 1-800-562-3022
Refill too soon or Early Refill	Call the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022. **When you call, you must know:** • When was the last fill for this client? • Was this a change in dose from the last fill?
Find out which drugs are on the Preferred Drug List (PDL)	To view this list, go to Prescription Drug Program Medicaid Provider Guide.
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, form 13-835a. To download this form, go to Medicaid Forms webpage. For information on the following, go to our Provider Publications website: • Medicaid Provider Guides • Expedited criteria • Drug limits Fax form to 1-866-668-1214 **or** Call 1-800-562-3022

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If your situation is:	Then you must:
Dispensed an emergency supply to a client with an emergency that could not wait.	Use Pharmacy Information Authorization, form 13-835a. To download this form, go to Medicaid Forms webpage Fax form to 1-866-668-1214 **or** Call 1-800-562-3022
Dispense as Written (DAW) Reimbursement less than cost for a DAW prescription.	Use Pharmacy Information Authorization, form 13-835a. To download this form, go to Medicaid Forms webpage Fax form to 1-866-668-1214 **or** Call 1-800-562-3022
Reimbursement less than cost Reimbursement less than cost for a prescription that is substitution permitted.	Use Pharmacy Information Authorization, form 13-835a. To download this form, go to Medicaid Forms webpage. Fax form to 1-866-668-1214 **or** Call 1-800-562-3022
Claim rejection stating "Client is restricted to one pharmacy" What pharmacy or doctor is this client restricted to?	Call MACSC at 1-800-562-3022 (option 2).
Claim rejection stating "Client is restricted to one pharmacy" • 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.	Call MACSC at 1-800-562-3022 (extension 51780).
Lost or stolen medications Has the client reported a lost or stolen prescription in the last 6 months?	Call MACSC at 1-800-562-3022.
Expedited Authorization criteria	View the expedited list at the Pharmacy Information web page.
Other claim- or pharmacy-	Call MACSC at 1-800-562-3022 or go to Pharmacy

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If your situation is:	Then you must:
related questions or situations • Appropriate use of NCPDP fields in response to claim edits. • Is this client eligible? • What program is this client on? • Where can clients or doctor's offices call for questions about authorizations or drugs? • What drugs are covered? • What is the TIP program? • How to become an endorsing prescriber. • Where to find a list of over the counter family planning products.	Information.

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Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in this guide. The definitions are presented for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgment.
(refer to WAC 182-530-1050).
Please refer to the Medical Assistance Glossary
for a more complete list of definitions.

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

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

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

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

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

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

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

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

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

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

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. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list. [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 (e.g., Mediset, bingo cards, blister packs).

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, which is used for a medically accepted indication.

DESI (Drug Efficacy Study Implementation) – See "Less Than Effective Drug."

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

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

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

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

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

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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) and has enrolled (see www.rx.wa.gov) with the Health Care Authority (HCA), agreeing to allow therapeutic interchange (substitution) of a preferred drug for any non-preferred drug in a given therapeutic class on the Washington PDL.

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

Evidence-Based Practice Center – A research organization that has been designated by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. government to conduct systematic reviews of all the evidence to produce evidence tables and technology assessments to guide health care decisions.

Expedited Authorization (EA) - The process for authorizing selected drugs in which providers use a set of numeric codes to indicate to the Agency the acceptable indications, conditions, diagnoses, and criteria that are applicable to a particular request for drug authorization.

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

Federally approved hemophilia treatment center - A hemophilia treatment center (HTC) which:
(1) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;
(2) Is qualified to participate in 340B discount purchasing as an HTC;
(3) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC web site;
(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and
(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

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

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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) – Those drugs that lack substantial evidence of effectiveness as determined by the Food and Drug Administration (FDA).
[Refer to WAC 182-530-1050]

Managed Care Organization (MCO) - An organization having a certificate of authority or certificate of registration from the Office of the Insurance Commissioner, that contracts with the Agency under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance clients under the Agency's managed care programs.

Maximum Allowable - The maximum dollar amount the Agency will reimburse a provider for a specific service, supply, or piece of equipment.

Maximum Allowable Cost (MAC) - The maximum amount that the Agency reimburses for a specific dosage form and strength of a multiple-source drug product.

Medical Identification Card(s) – See *Services Card*.

Medically Accepted Indication – Any use for a covered outpatient drug:

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

(2) The use of which is supported by one or more citations included or approved for inclusion in any of the following compendia of drug information.

   (a) The American Hospital Formulary Service Drug Information
   (b) The United States Pharmacopoeia Drug Information
   (c) DRUGDEX Information System

Medically Necessary – See WAC 182-500-0005)

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

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

Multiple-Source Drug - A drug marketed or sold by:

- Two or more manufacturers or labelers; or
- The same manufacturer or labeler:
  - ✓ Under two or more different proprietary names; or
  - ✓ Under a proprietary name and a generic name.

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

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

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

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

Non-Preferred Drug – A drug that has not been selected as a preferred drug within the therapeutic class (es) of drugs on the preferred drug list.

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

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

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

Patient Identification Code (PIC) – See ProviderOne Client ID.

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

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

Point-of-Sale (POS) - A pharmacy claims processing system capable of receiving and adjudicating claims on-line.

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

Practitioner – An individual 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.

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

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

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

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

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

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

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

Remittance Advice (RA) - A report produced by ProviderOne, the Agency's claims processing system, which provides detailed information concerning submitted claims and other financial transactions.

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

Revised Code of Washington (RCW) - Washington State law.

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 individuals who, because of their mental or physical conditions, 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.)

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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 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 written by an endorsing practitioner who has indicated that substitution is permitted. 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 a 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 an individual, as determined by:

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

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

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.

Usual and Customary Charge - The fee that the provider typically charges the general public for the product or service.

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 purchase of drugs in state-operated health care programs.

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About the Program

What Is the Goal of the Prescription Drug Program?

The operational goal of the Prescription Drug Program is to pay providers for outpatient drugs, devices, and drug-related supplies according to Agency rules and subject to limitations and requirements specified in these billing instructions.

The Agency programs are governed by federal and state regulations. This guide is intended to help providers comply with the rules and requirements of the program.

Basic things to know:

The Agency reimburses for medically necessary drugs, devices, and supplies according to rules in Washington Administration Code (WAC) and the Reimbursement Section of this guide.

The Agency covers outpatient drugs, including over-the-counter drugs listed on the Agency's Covered Over-the-Counter Drug list, when:

- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). (Exceptions to this rule are described in the *Compounded Prescriptions* Section.);
- Approved by the Food and Drug Administration (FDA);
- Prescribed by a provider within the scope of their prescribing authority, andhas not had his/her core provider agreement terminated or denied;
- Prescribed for a medically accepted indication;
- Prescribed for an eligible client; and
- Not excluded from coverage under WAC 182-501-0050, 182-530-2100, and Program Restricions Section of this guide. ("What drugs, devices, and supplies are not reimbursed?").

The Agency does not cover:

- Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927(d)(2)(K) of the Social Security Act, unless such drugs are used to treat a condition other than sexual or erectile dysfunction and these uses have been approved by the FDA;

- A drug that is not approved by the FDA;

- A drug prescribed for a non-medically accepted indication or dosing level;

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- A drug from a manufacturer without a federal rebate agreement; or

- Drugs and indications excluded from coverage by Washington Administrative Code (WAC) such as drugs prescribed for:

  - ✓ Weight loss or gain;
  - ✓ Infertility, frigidity, or impotence;
  - ✓ Sexual or erectile dysfunction; or
  - ✓ Cosmetic purposes or hair growth.

Provider Requirements

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

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

The Agency may require a pharmacy to:

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

Important Notes

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

- **Prescription splitting:** Billing inappropriately to obtain additional dispensing fees. For example:

  - ✓ Supplying medication in amounts less than necessary to cover the days prescribed; and/or

  - ✓ Supplying medications in strengths less than those prescribed to gain more than one dispensing fee.

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- **Excessive Filling:** Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity (except when the Agency specifies a mandatory minimum of an OTC drug).
- **Prescription Shorting:** Billing for a drug or supply greater than the quantity actually dispensed.

- **Substitution to Achieve a Higher Price:** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug was available (except when the Agency identifies a higher-priced drug as preferred).

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Client Eligibility

Types of Identification That Prove Eligibility

Valid types of eligibility identification:

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

Note: Providers enrolled with ProviderOne can check eligibility by accessing the New Provider Enrollment page.

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

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

Check the identification for the following information:

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

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

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

- **FAX** a copy of the client's Benefit Inquiry Screen in ProviderOne to 1-360-586-1403; or
- Mail in a **completed** paper claim with a photocopy of the client's Benefit Inquiry Screen in ProviderOne attached.

The Agency will update eligibility information from the copies of client's Benefit Inquiry Screen in ProviderOne within two working days so claims may be resubmitted.

Who Is Eligible?

Please see the Agency *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Categories of Healthcare Services Table* for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in an Agency Managed Care Plan Eligible for Pharmacy Services?

Yes! Clients who are enrolled in an Agency managed care plan **are eligible** for pharmacy services **under their designated plan**. Managed care enrollment will be displayed on the Client Benefit Inquiry screen in ProviderOne.

See the *Billing* Section for information regarding clients enrolled in an Agency managed care plan.

Newborns of clients enrolled in an Agency managed care plan are the responsibility of the mother's plan for the first 60 days of life. If the mother changes plans, the baby follows the mother's plan.

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

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Program Restrictions

How Does the Agency Determine Which Drugs to Cover?

[Refer to WAC 182-530-2000 (2)]

Coverage determinations for the Agency are decided by:

- The Agency in consultation with federal guidelines; or
- The Drug Use Review (DUR) Board; and
- The Agency's medical consultants and pharmacist(s).

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

> The Agency evaluates a request for a drug that is listed as non-covered under the provisions of WAC 182-501-0160 that relates to non-covered services. The request for a noncovered drug is called a "request for an exception to rule." See WAC 182-501-0160 for information about exceptions to rule.

What Drugs, Devices, and Supplies Are Covered?

[Refer to WAC 182-530-2000 (1)]

The Agency covers:

- Outpatient drugs, including over-the-counter drugs listed on the Agency's Covered Over-the-Counter Drug list, as defined in WAC 182-530-1050, subject to the limitations and requirements in this chapter, 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?"; and
  - ✓ The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate

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requirement are described in WAC 182-530-7500 which describes the drug rebate program.

- Family planning drugs, devices, and drug-related supplies per chapter 182-532 WAC and as follows:
  - ✓ Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies without a prescription when the Agency determines it necessary for client access and safety.
  - ✓ Family planning drugs that do not meet the federal drug rebate requirement in WAC 182-530-7500 on a case-by-case basis; and
  - ✓ Contraceptive patches, contraceptive rings, and oral contraceptives, only when dispensed in at least a three-month supply, unless otherwise directed by the prescriber. There is no required minimum for how many cycles of emergency contraception may be dispensed.
- Prescription vitamins and mineral products, only as follows:
  - ✓ When prescribed for clinically documented deficiencies;
  - ✓ Prenatal vitamins, when prescribed and dispensed to pregnant women; or
  - ✓ Fluoride varnish for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.
- Drug-related devices and drug-related supplies as an outpatient pharmacy benefit when:
  - ✓ Prescribed by a provider with prescribing authority;
  - ✓ Essential for the administration of a covered drug;
  - ✓ Not excluded from coverage under WAC 182-530-2100; and
  - ✓ Determined by the Agency, that a product covered under chapter 182-543 WAC Durable medical equipment and supplies should be available at retail pharmacies.

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

- Preservatives, flavoring and/or coloring agents, only when used as a suspending agent in a compound.
- Over-the-counter drugs to promote smoking cessation, without a prescription, only when the client meets the following requirements:

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- ✓ 18 years of age or older; and
- ✓ Participating in an Agency-approved smoking cessation program.

- Prescription drugs to promote smoking cessation, only when the client meets the following requirements:

  - ✓ 18 years of age or older; and
  - ✓ Participating in an Agency-approved smoking cessation program.

What Drugs, Devices, and Supplies Are Not Covered?

[Refer to WAC 182-530-2100 and 182-530-7500]

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

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

- Nutritional supplements such as shakes, bars, puddings, powders, medical foods, etc. These products may be reimbursable under the conditions of the Nondurable Medical Supplies and Equipment (MSE) and/or Enteral Nutrition programs.

- Drugs when the manufacturer has **not signed a rebate agreement** with the federal Department of Health and Human Services.

- Drugs listed in the federal register as "**less than effective" (DESI drugs**) or which are identical, similar, or related to such drugs. (Refer to: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp for a list of DESI drugs.)

- Free pharmaceutical samples.

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- Drugs [prescription or over-the-counter(OTC)] and drug-related supplies:
  - ✓ Which have not been prescribed by a provider with prescriptive authority (with the exception of OTC family planning products and OTC smoking cessation products);
  - ✓ Which 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; or
  - ✓ Cosmetic purposes or hair growth.
- OTC drugs which are not listed on the Agency's Covered Over-the-Counter Drug list.
- Drugs and drug-related supplies for multiple patient use.
- Any drug regularly supplied as an integral part of program activity by other public agencies (such as drugs, vaccines, or biological products available without charge to the client from the Department of Health).
- Products or items that do not have an 11-digit national drug code (NDC).
- Drugs with NDCs which have been designated as obsolete for more than two years.
- Drugs whose shelf life has expired prior to being dispensed.
- Drugs which have been terminated or removed from the market.
- More than a 34-day supply of any product except:
  - ✓ Drugs when the smallest package size exceeds a 34-day supply;
  - ✓ Drugs with special packaging instructions which would require dispense of a quantity that exceeds a 34-day supply;
  - ✓ Contraceptive patches, contraceptive rings, and oral contraceptives not used for emergency contraception. These products must be dispensed at a minimum of a three-month supply, unless otherwise directed by the prescriber;
  - ✓ When the drug is specifically identified as exempt from the 34-day limit.

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- Any vitamin product other than:
  - ✓ Prenatal vitamins prescribed to pregnant women;
  - ✓ Vitamins determined by the Agency to be the least costly therapeutic alternative for the treatment of a client's diagnosed condition; or
  - ✓ When the Agency agrees that the vitamin product is the least costly alternative in treating documented vitamin deficiency which has been confirmed by laboratory testing.
- Fluoride preparations other than as prescribed for children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Non-preferred drugs in drug classes on the Washington Preferred Drug List (PDL), except as detailed in PDL Section within this guide.
- Drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:
  - ✓ Diagnosis-related group (DRG);
  - ✓ Ratio of costs-to-charges (RCC);
  - ✓ OTC products supplied to Skilled Nursing Facility (SNF) residents (unless included in the Washington PDL);
  - ✓ Managed care capitation rates;
  - ✓ Block grants; or
  - ✓ Drugs prescribed for clients who are in the Agency's Hospice program when the drugs are related to the client's terminal condition.

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- Drugs prescribed for an indication that is not evidence-based as determined by:
  - ✓ The Agency in consultation with federal guidelines; or
  - ✓ The Drug Use Review (DUR) Board; and
  - ✓ Agency medical consultants and pharmacist(s).
- Drugs that are:
  - ✓ Not approved by the Food and Drug Administration (FDA); or
  - ✓ 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, and/or coloring agents.
- Prescriptions written on pre-signed prescription blanks completed by SNF operators or pharmacists. The Agency may terminate the CPA of pharmacies involved in this practice.
- Drugs used to replace those taken from SNF emergency kits.
- The cost differential between the least costly dosage form of a drug and a more expensive dosage form within the same route of administration, unless the prescriber designated the costlier dosage form as medically necessary.
- Over-the-counter or prescription drugs to promote smoking cessation unless the client is 18 years old or older and participating in an Agency-approved smoking cessation program.

Exceptions to the Prescription Requirement

[Refer to WAC 182-530-2000(4)]

Over-the-Counter Family Planning Products

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

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

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

Point-of-Sale billers must:

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

Hardcopy billers must:

Enter 5123456787 in the Prescriber NPI field.

Over-the Counter Nicotine Replacement Therapy (NRT)

The Agency reimburses for specific OTC NRT products without a prescription (See Smoking Cessation.) when distributed by an Agency-approved smoking cessation program.

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Compliance Packaging

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

What Is Included in Compliance Packaging?

[Refer to WAC 182-530-7400(2)]

Compliance packaging includes:

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

How Do I Determine if a Client Is Eligible for Compliance Packaging?

[Refer to WAC 182-530-7400(1)]

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

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

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

- 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; or
  - ✓ Tuberculosis.

-AND-

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- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day; or
- Have demonstrated 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.

Billing for Compliance Packaging

To bill for compliance packaging:

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

Procedure Description	Procedure Code	Modifier	Maximum Allowable Fee
Reusable compliance device or container	T1999*	UE	$6.00 maximum per device (limit of 4 per client, per year).
Reusable compliance device or container, extra large capacity	T1999*	SC	$16.91 maximum per device (limit of 4 per client, per year).
Filling fee for reusable compliance device or container	A9901	SC	$2.50 per fill (limit of 4 fills per client, per month).
Non-reusable compliance device or container	T1999	NU	$3.00 (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.

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

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* May be billed in combination but not to exceed a total of 4 per year.

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Compounded Prescriptions

What Is Compounding?

[Refer to WAC 182-530-7150(1)(3)]

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

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

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

Which Ingredients Are Not Reimbursed in Compounds?

[Refer to WAC 182-530-7150(2)]

- Coloring agents, preservatives, and flavoring agents used in compounded prescriptions **except** when they are necessary as a complete vehicle for compounding (e.g., simple syrup).

- Any product which would not be reimbursable when used outside of a compound, except as detailed in the following section.

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What Additional Ingredients Are Reimbursable in Compounds?

- Bulk chemicals which are active ingredients and are considered non-drug items when used outside of a compound.

- Vehicles or suspending agents necessary for the completion of the compound.

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

Labeler Code	Company
00395	Humco Labs
00802	Emerson Labs
10106	J T Baker
17317	Amend
49452	A-A Spectrum

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

Is Authorization Required to Compound Prescriptions?

[Refer to WAC 182-530-7150(5)(b and c)]

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

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

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

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Billing for Compounded Prescriptions

[Refer to WAC 182-530-7150(4) and (5)]

- Pharmacies must bill each ingredient used in compounded prescriptions using the 11-digit NDC for each ingredient.

- Bill the **appropriate** quantity used for each ingredient on one claim. **Do not bill the combined total quantity.**

- The Agency pays a dispensing fee for each payable ingredient. The Agency does not pay separate fees for compounding time or preparation fees.

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

BILLING

Hard copy billers must:

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

Point-of-Sale billers must:

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

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Special Programs/Services

Smoking Cessation

Client Eligibility

The Agency's Smoking Cessation program includes **all** eligible Agency clients who meet the coverage requirements. Smoking cessation is not a covered benefit for clients eligible under the Family Planning Only, TAKE CHARGE, or Alien Emergency Medical programs.

Coverage Requirements

The Agency covers:

- **Over-the-counter drugs**, *without a prescription*, to promote smoking cessation only when the client meets the following requirements:

  - ✓ 18 years of age or older; and
  - ✓ Participating in an Agency-approved smoking cessation program; and
  - ✓ The product is distributed by the Agency-approved smoking cessation program.

- **Prescription drugs** to promote smoking cessation, only when the client meets the following requirements:

  - ✓ 18 years of age or older; and
  - ✓ Participating in an Agency-approved smoking cessation program.

The Agency covers the following smoking cessation drugs:

- Nicotine gum;
- Nicotine Transdermal Patches;
- Bupropion SR (Zyban®); and
- Chantix® (varenicline tartrate).

The Agency does not allow combinations within or across smoking cessation drug types.

Note: The only smoking cessation drug that the Agency will cover for pregnant women is bupropion SR (Zyban®). The Agency will cover this drug for up to 11 months per client.

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Coverage Limitations and Restrictions

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

- The required use of Free & Clear Inc. behavior modification for all smoking cessation drug therapy. You may contact Free & Clear Inc. toll-free at: 1-800-QUIT NOW (1-800-784-8669).

- Limiting all smoking cessation drugs to 12 weeks per year, per client, except bupropion SR (Zyban®) for pregnant women.

- The Agency will authorize bupropion SR (Zyban®) only if a client does not have a history of seizures or Bipolar Disorder.

- The Agency will authorize Chantix® (varenicline tartrate) only if the client does not have a history of neuropsychiatric symptoms and dosage reductions are based on renal clearance.

Nicotine Replacement Therapy (NRT)

The Agency contracts with Free & Clear Inc. to provide the nicotine replacement therapy (NRT) only as follows:

- No pregnant women are allowed on NRT;
- No combination within NRT delivery systems or in combination with prescription smoking cessation drugs is allowed;
- NRT coverage includes only transdermal patches and gum;
- NRT must be in conjunction with behavioral modification; and
- NRT is limited to 12 weeks per year, per client.

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Smoking Cessation for Pregnant Women

[Refer to WAC 182-533-0400 (20)]

The Agency pays eligible providers for including tobacco cessation counseling as part of an ante partum care visit or a post pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

A provider may prescribe pharmacotherapy for tobacco cessation for a client when the provider considers the treatment appropriate for the client. Bupropion SR (Zyban®) is the only drug that the Agency reimburses for tobacco cessation of pregnant women, and only under the following conditions:

- Must be prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant (PA);
- The client must be 18 years of age or older;
- The pharmacy provider must obtain authorization from the Agency when filling the prescription for pharmacotherapy; and
- The prescribing provider must include both of the following on the client's prescription:
  - ✓ The client's estimated or actual delivery date; and
  - ✓ Indicate that the client is participating in tobacco cessation counseling.

  To obtain authorization for bupropion SR (Zyban®), pharmacy providers must:

  - ✓ Fax a request for authorization to 1-866-668-1214; or
  - ✓ Call 1-800-562-3022.

Clozaril/Clozapine and Related Services

The Agency reimburses pharmacies for Clozaril/Clozapine plus pays a dispensing fee. Bill Clozaril/Clozapine using the appropriate national drug code (NDC) on either the Point-of-Sale (POS) system or the Pharmacy Statement form, 13-714. This form is available for electronic download at Medicaid Forms.

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

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

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

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

Procedure Code	Modifier	Description	Reimbursement
36415		Routine Venipuncture	Per the Resource-Based Relative Value Scale (RBRVS) fee schedule
~~90862~~		~~Case Coordination~~	~~$10 per week, per client~~
99605	HE	Case coordination for new clients	$10 per week, per client
99606	HE	Case coordination for returning clients	$10 per week, per client
85022[1]		Complete Blood Count (CBC)	Per RBRVS fee schedule

Note: Due to close monitoring requirements, the Agency allows up to five (5) fills per month.

[1] **Can be billed by CLIA certified laboratories only.**

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Emergency Contraceptive Pills (ECP)

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

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

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

Emergency Contraception (EC) Counseling

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

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

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

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BILLING ON A 1500 Claim Form

- Enter the diagnosis code V25.09 (contraceptive management) in field 24E.
- Use the following procedure code and modifier to bill for EC counseling:

Procedure Code	Modifier	Description	Maximum Allowable Fee
99605	FP	EC Counseling	$13.50

Anti-emetics

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

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

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Patient Review and Coordination (PRC) Program

[Refer to WAC 182-501-0135]

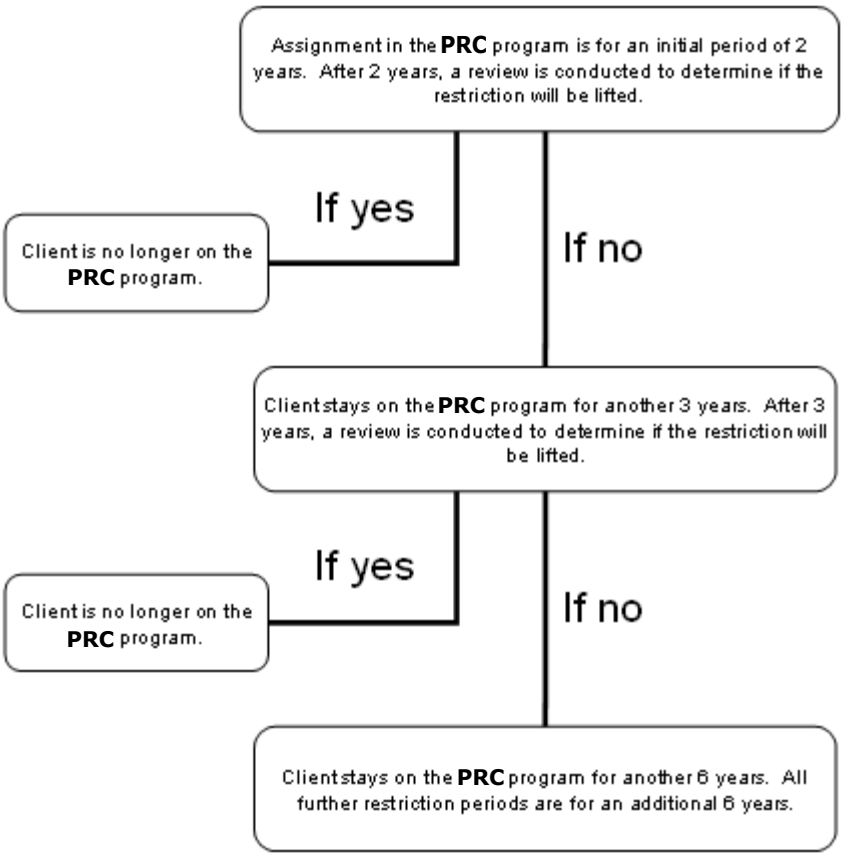
PRC is a health and safety program for FFS and managed care clients needing help in the appropriate use of medical services.

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

A client in the PRC program may be restricted to any of the following:

- Primary care provider (PCP);
- Narcotic prescriber;
- Pharmacy;
- Hospital (for non-emergency medical services); or
- Another qualified provider type, as determined by the Agency or managed care organization (MCO) staff on a case-by-case basis.

Below is a flow chart explaining how PRC assignment works:



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PRC criteria:

- Any two or more of the following conditions occurred in a period of 90 calendar days. The client or enrollee:
  - ✓ Received services from four or more different providers, including physicians, ARNPs, and PAs;
  - ✓ Had prescriptions filled by four or more different pharmacies;
  - ✓ Received 10 or more prescriptions;
  - ✓ Had prescriptions written by four or more different prescribers;
  - ✓ Received similar services from two or more providers in the same day; or
  - ✓ Had 10 or more office visits.

-OR-

- Any one of the following occurred within a period of 90 calendar days. The client or enrollee has:
  - ✓ Made two or more emergency Agency visits;
  - ✓ A medical history that indicates "at-risk" utilization patterns;
  - ✓ Made repeated and documented efforts to seek health services that are not medically necessary; or
  - ✓ Been counseled at least once by a health care provider or an Agency or MCO staff member, with clinical oversight, about the appropriate use of health care services.

-OR-

- The client or enrollee received prescriptions for scheduled drugs from two or more different prescribers in any month.

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

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

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

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

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

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

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

Washington State has the "prudent layman's" law, in which clients can go to the emergency room *if they think* they have a problem and must be seen by the emergency room staff. However, emergency room prescriptions cannot be overridden in the POS system by a non-assigned PRC pharmacy. In this situation, the pharmacist may:

Call the PRC referral line during regular business hours (Monday-Friday, 8 a.m. – 5 p.m.) at (360) 725-1780 to request an override.

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

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

Patient Review and Coordination
PO Box 45532
Olympia, Washington 98504-5532
Phone: 1-800-794-4360, ext. 51780 or 1-360-725-1780
FAX: 1-360-725-1969

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Vaccines and Vaccine Administration Fees

- The Agency reimburses qualified pharmacists for the administration of all Agency-covered vaccines for clients on eligible programs.
- The Agency does not reimburse for any vaccine available free from the Department of Health (DOH).
- Pneumonia and influenza vaccines for adults (19 years of age and older) are reimbursed through the POS system only.

Note: Flu vaccine will be reimbursed only when administered during the flu season, as established by DOH.

- All covered vaccines other than pneumonia and influenza must be billed on the CMS-1500 Claim Form.
- Administration fees must be billed on the CMS-1500 Claim Form (including pneumonia and influenza for clients age 18 and under). The POS does not have the capability to reimburse for professional services other than dispensing fees.

Clients Age 18 and Younger

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

How to Check Which Vaccines are Covered and if They are Available Free From DOH

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

Billing for the Administration of a Vaccine Available Free From DOH

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

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Billing for Vaccines That are NOT Free From DOH

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

Reimbursement for Influenza and Pneumonia Vaccine

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

Billing for Vaccine Administration

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

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

HCPCS Code	Description	Maximum Allowable Fee
G0008	Administration of influenza virus vaccine	$11.47
G0009	Administration of pneumococcal vaccine	$11.47

The Agency pays for HCPCS codes G0008 and G0009 (administration codes) only when billed with place of service 01 (pharmacy).

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

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

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Human Papillomavirus (HPV) Vaccine

GARDASIL®

The Agency reimburses for GARDASIL® (HPV [Types 6,11,16,18] Recombinant Vaccine) See the Immunizations Section in *Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide*.

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Pre-filling Syringes

Fees for pre-filling syringes may be billed on an approved professional services claim form (e.g., paper CMS-1500 Claim Form; electronic CMS-1500 Claim Form; or electronic 837-P claim form). **These fees are not billable on POS.**

- Each unit billed must be for a two-week supply;
- The maximum number of units allowed per month is three; and
- Use the following procedure code:

Description	Procedure Code	Maximum Allowable
Pharmacy compounding and dispensing services (to be used for pre-filling syringes)	S9430	$10.00 per unit

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

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

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

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Special Drug Initiatives, Projects, and Services

The Agency has developed targeted drug initiatives to:

- Guide appropriate drug therapy;
- Improve therapeutic outcomes; and
- Improve the quality of life for Agency clients.

The Agency has specific services that:

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

Examples of these services are described below:

ADHD (Attention Deficit Hyperactivity Disorder) Drug Initiatives

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

- The clients are five years of age and younger; or

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

Safety Edit – AGE

Five Years Age and Younger

ADHD medications prescribed for children 5 years of age and younger require authorization and an Agency-approved second opinion. When the patient is already taking the ADHD drug, the Agency will authorize continuation for 90 days while the second opinion is taking place. Prescribers of new ADHD prescriptions for children 5 years of age and younger are required to obtain the Agency-approved second opinion prior to submitting an authorization request to the Agency. The Second Opinion Network Provider List is available at the Pharmacy Information page.

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Safety Edit - DOSAGE

Dosing limits for clients 5 years of age and older:

- Adult and child dosing greater than the following requires review:

Drug Class	Form	Dosage	Limitation
Methylphenidates:	Daytrana® transdermal patch	30mg per day for clients unable to take oral medications	See Dosage
	Long acting forms All other forms	120mg per day as a single daily dose 120 mg per day	Total of 120mg per day across long and short acting forms
Dexmethylphenidate:	Long acting forms All other forms	60 mg per day as a single daily dose 60mg per day	Total of 60mg per day across long and short acting forms
Amphetamines:	Vyvanse®	70 mg per day as a single daily dose	See Dosage
	Long acting forms All other forms	60mg per day as a single daily dose 60mg per day	Total of 60mg per day across long and short acting forms
Atomoxetine:	All forms	120mg per day as a single or twice daily divided dose	See Dosage

- Children younger than 18 years of age require an Agency-approved second opinion and Agency authorization. Adult doses exceeding the limits require authorization by the Medical Director, or his designee, who will review clinical chart notes that must show:

  - ✓ Less risk than usual care;
  - ✓ Less cost to the state; and
  - ✓ The next step in reasonable care, including tried and failed FDA dosing.

- Refills above dose limits are authorized until the review is completed.

- Initiation of therapy above these dose limits requires review prior to payment.

When the patient is already taking the medication and the authorization request is denied, the Agency will allow one additional refill (up to a 34-day supply) of medication for the purpose of tapering the dose to fall within the accepted limits stated above. New prescriptions exceeding the recommended doses for children 18 years of age and younger require the recommendations of an Agency-designated Mental Health specialist from the Second Opinion Network Provider List. This list is available at the Pharmacy Information page

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Safety Edit – ADHD DRUG COMBINATIONS

- Combinations across drug types (e.g., methylphenidate with amphetamine) require authorization.
- Combinations of Strattera with stimulant ADHD drugs require authorization.
- Continuation of a combination is authorized for a maximum of 30 days while tapering a client off of a drug.

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

Combinations of Medications in Two or More ADHD Categories				
	Methylphenidate	Dexmethylphendidate	Amphetamines	Strattera®
Methylphenidate		X	X	X
Dexmethylphendidate	X		X	X
Amphetamines	X	X		X
Strattera®	X	X	X	

The Agency reimburses combinations of short-acting and long-acting forms of the same ADHD drug without authorization. The Agency requires the pharmacy to request authorization for a combination of ADHD medications across drug categories. When the pharmacy requests authorization, the Agency will contact the prescriber to obtain medical justification for the combination therapy. For children 17 years of age and younger, medical justification must include the recommendations of an Agency-designated Mental Health specialist from the Second Opinion Network Provider List. This list is available at the Pharmacy Information page.

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Alcohol and Substance Abuse Pilot Project

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

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

Anticonvulsants, Off-label Use Initiative

The Agency requires authorization for off-label use of certain anticonvulsants (Neurontin® or gabapentin, Topamax®, Keppra®, and Gabitril®). "Off label" guidelines can be reviewed at the Pharmacy Information page. The anticonvulsants are all used for treatment of seizures, and the Agency has established Expedited Authorization (EA) codes to allow immediate authorization for this use. Any other use outside of the FDA labeling requires the pharmacy to call the Agency's Authorization toll-free telephone number 1-800-562-3022.

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

EA codes and criteria:

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

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Antidepressants, Therapeutic Duplication

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

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

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

SSRI – Celexa® (citalopram), Lexapro® (escitalopram), Luvox® (fluvoxamine), Paxil® (paroxetine HCl), Pexeva® (paroxetine mesylate), Prozac® (fluoxetine), and Zoloft® (sertraline)
NaSSA – Remeron® (mirtazapine)
NDRI – Wellbutrin® (bupropion)
SARI – Serzone® (nefazodone)
SNRI – Cymbalta (duloxetine), Effexor (venlafaxine), Pristiq (desvenlafaxine)

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

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Buprenorphine for Pregnant Women

The Agency covers buprenorphine for pregnant women when the client meets the following criteria:

- Is 16 years of age or older;
- Is pregnant with a verifiable estimated due date (EDD);
- Has a DSM-IV-TR diagnosis of opioid dependence;
- Is psychiatrically stable, or is under the supervision of a mental health specialist;
- Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics;
- Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses;
- Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and
- Is enrolled in a state-certified chemical dependency treatment program. See WAC 388-805- 610.

Limitations:

- No more than a 7-day supply may be prescribed at a time;
- Urine drug screens for benzodiazepines, amphetamine/ methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. The prescriber must ensure that the drug screen has been completed prior to prescribing the next 7-day supply;
- Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and
- Payment for the medication is limited to the duration of pregnancy.

A Buprenorphine Authorization for Pregnancy form, DSHS 13-901, must be completed and sent to the Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) before prior authorization can be considered. To download form, go to: http://www.dshs.wa.gov/forms/eforms.shtml

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Mental Health Polypharmacy

Mental health experts participated in the Agency's Mental Health Drug Initiative Stakeholder Workgroup to determine the threshold for clinical review and select which drugs are recognized as mental health drugs. The Agency's list of recognized mental health drugs can be viewed at the Pharmacy Information page.

The Agency requires authorization for concurrent therapy with 5 or more mental health drugs for clients who are 17 years of age and younger.

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

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

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

Narcotic Review Project

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

Pharmacy Authorization staff fax the patient's recent narcotic profile (12 months of all narcotic prescriptions and prescriber names) to the prescriber who wrote the latest prescription. After the prescriber reviews the profile and makes a decision whether to continue with the prescription or not, the prescriber faxes the form back to Pharmacy Authorization, and the prescription is authorized or not authorized, depending on the prescriber's response.
If the prescriber believes that the patient's pattern of narcotic utilization is medically necessary and does not show abuse/misuse, the patient's case is reviewed by the Agency's Drug Use Review Team, and a decision is made whether to remove the patient from the authorization requirement.

For more information about drug abuse prevention or treatment, please contact the 24-Hour Alcohol/Drug Helpline at 1-800-562-1240, or call the state Division of Alcohol and Substance Abuse at 1-877-301-4557 and ask for the regional administrator for your county to help you access public care. If you believe a patient may need help for drug abuse, please refer them to the Helpline.

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Opioid Dosing Guidelines

Opioid Dosing Guidelines are available the Pharmacy Information page. These guidelines were developed by the Interagency Workgroup on Practice Guidelines (the Department of Corrections, Department of Health, Department of Labor and Industries, Department of Social and Health Services, and the Health Care Authority) in collaboration with actively practicing physicians who specialize in pain management. The guidelines are to assist the practitioner in prescribing opioids in a safe and effective manner. The guidelines do not apply to the treatment of cancer pain or end-of-life (hospice) care.

Sedative/Hypnotic Restrictions for Children

Sedatives and hypnotics in children less than 18 years of age are limited to a one-time authorization of less than 5 doses in a 30-day period.

Step Therapy for Inhaled Long-Acting Beta Agonist/Corticosteroid Combination Drugs

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

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

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

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

- Whose disease is not adequately controlled on other asthma-controller medications (e.g.,low- to medium- dose inhaled corticosteroids); or
- Whose disease severity clearly warrants initiation of treatment with two maintenancetherapies, as found in the Agency for Healthcare Research and Quality (AHRQ) report "Diagnosis and Management of Asthma" located at:

http://www.guideline.gov/summary/summary.aspx?doc_id=11676&nbr=006025 .

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Synagis ®

See EPSDT Screening Components Section and the Client Eligibility Section in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Medicaid Provider Guide for information on Synagis.

Requirements for Vivitrol ® (naltrexone IM)

To request prior authorization for Vivitrol®, complete a Vivitrol IM Physician Prior Authorization form, DSHS 13-791. To download or print a copy of the form, go to Medicaid Forms webpage.

Note: Upon completion of the **DSHS 13-791** form, you must be fax the form to the Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) at 360-586-0343 for review.

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Emergency Fills

The Agency guarantees claim payment for any good faith effort on the part of a pharmacist to meet a client's immediate needs in an emergency after the Agency's regular business hours.

> "After hours" means outside of normal business hours for the Agency's 1-800 Customer Service lines, including Coordination of Benefits, Pharmacy Authorizations, and the Medical Assistance Customer Service Center.
>
> "Immediate Needs" means the pharmacist uses their professional judgment in determining the quantity to dispense to best meet the client's needs in an emergency.

If, in your professional judgment, the client has a genuine emergency need, and your electronic claim submissions are rejected by the Agency without payment, please meet the client's immediate needs and contact the Agency within 72 hours.

- Coordination of benefits can be established the next business day, ensuring payment by either the primary insurer or the Agency.
- Authorization requirements can be overridden the following day as well. The Agency will authorize payment for any prescription filled in an emergency. Medical necessity requirements will be applied to any future fills of the same medication, but will be waived to ensure payment of Emergency Fills.

To receive reimbursement, justification for the emergency fill must be provided to the Agency no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

Hemophilia- and von Willebrand-Related Products for Home Administration

[Refer to WAC 182-531-1625]

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

Note: If a client has not yet established a care relationship with a qualified hemophilia COE, but an initial appoint has been scheduled, specialty pharmacy providers may contact the Agency to request an authorization to continue to dispense product to the client. The pharmacy must call HCA's Pharmacy Authorization Section at 1-800-562-3022, extension 15486.

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Criteria for Qualified Hemophilia Center of Excellence (COE)

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

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

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

- Receive written approval from the Agency including conditions of payment and billing procedures.

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Annual Documentation Requirement

To remain a qualified hemophilia COE, the hemophilia COE must annually submit the following to the Agency:

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

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

To view the list of qualified Centers of Excellence (COE) for hemophilia treatment, see the Physicians Related Services Medicaid Provider Guide.

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Authorization

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

When Does the Agency Require Authorization?

[Refer to WAC 182-530-3000(2)]

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

- Early refills;
- Therapeutic duplications;
- Client's whose utilization patterns are under review;

- More than four prescriptions or prescription refills per calendar month for the same product in any of the following categories:

  - ✓ Antibiotics;
  - ✓ Anti-asthmatics;
  - ✓ Schedule II & III drugs;
  - ✓ Anti-neoplastic agents;
  - ✓ Topical preparations; or
  - ✓ Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations; and

- More than two prescriptions or prescription refills per calendar month for any other product.

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

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

Note: To receive reimbursement, justification for the emergency fill must be provided to the Agency no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

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How do I Obtain Authorization?

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

- Fax a Prescription Drug Authorization Fax Request form, 13-835A, to the Agency at 1-866-668-1214. To download this form go to the Medicaid Forms webpage
- Call the Agency at 1-800-562-3022.

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

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

- Previous authorization number, if available;
- Pharmacy NCPDP #;
- Pharmacy NPI#
- Rx #;
- Quantity and days supply;
- Tried and failed;
- Client's ProviderOne Client ID;
- National Drug Code (NDC) being dispensed;
- Prescriber's name and specialty (if known);
- Prescriber's phone and fax number;
- Date(s) of dispense; and
- Justification for the requested service:

  - ✓ The medical need for the drug and/or dosing (sig);
  - ✓ The diagnosis or condition of the client; and
  - ✓ Other therapies that have been tried and failed in treatment of the same condition.

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

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Who Determines Authorization Status for Drugs in the Agency's Drug File?

[Refer to WAC 182-530-3100(1)]

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

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

How Is Authorization Status Determined for Drugs in the Agency's Drug File?

[Refer to WAC 182-530-3200(2) and (3)]

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the the Agency pharmacist(s) a written request and 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; and
- Any additional information the manufacturer considers appropriate.

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

Whether the manufacturer has signed a federal drug rebate contract agreement.	Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage.
Whether the drug is a less-than-effective drug.	The drug's potential for abuse.
The drug's risk/benefit ratio.	Whether outcome data demonstrate that the drug is cost effective.
Whether like drugs are on the Agency's drug file and there are less costly therapeutic alternative drugs.	

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What Authorization Status May Be Assigned to a Drug?

The Agency may determine that a covered drug is:

- Covered without restriction;
- Requires authorization; or
- Requires authorization when the Agency-determined limitations have been exceeded.

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

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

To view the Agency's current List of Limitations on Certain Drugs go to the Pharmacy Information page.

Physicians and pharmacists should monitor the use of these drugs and counsel patients when the limits are exceeded. Authorization is required in order to exceed these limits.

How Are Drugs Added to the Agency's Drug File?

[Refer to WAC 182-530-3000(2) and (3)]

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

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Drugs That do Not Require Authorization

To view the Agency's current List of Limitations on Certain Drugs go to the Pharmacy Information page.

IMPORTANT: Products on this list are **subject to all other coverage rules**.

What Are the Criteria for Early Refills?

[Refer to WAC 182-530-3000(5)(b)]

The following circumstances are justification for early refills:

- If a client's prescription is lost, stolen, or destroyed (only once every six months, per medication).
- If a client needs a refill sooner than originally scheduled due to a prescriber dosage change. (The pharmacist must document the dosage change.)
- If a client is suicidal, at-risk for potential drug abuse, or being monitored by the prescriber.
- If a client needs a take-home supply of medication for school or camp, or for skilled nursing facility clients.

For any other circumstance, the provider must contact the Agency's Pharmacy Authorization Section to request approval and an authorization number (see *Important Contacts* Section).

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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 experience difficulties in managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

BILLING

Hard copy billers must enter one of the following justification descriptions in the *Justification/ Comments* field on the Pharmacy Statement [13-714].

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

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

Can Clients Receive Early Refills or Extended Days Supply for Travel?

[Refer to WAC 182-530-3000(5)(b)]

The Agency will not approve early refills or prescriptions filled for over a 34-day supply for clients who will be out of the area. Early refills for the purpose of travel are considered to be services rendered for a future date. Clients may elect to self-pay for an early refill or a larger days’ supply, as they are not considered Medicaid eligible for the future service at the time of fill.

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

- If clients will not be out of state, they may have their prescription filled at any Agency-contracted pharmacy throughout Washington or border areas of Idaho and Oregon.
- Clients may arrange with you to refill their prescription at the appropriate time, and have a relative or other designee pick up the prescription for them. The client’s designee may then ship the medication to the client at their own expense.

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- You can make arrangements with the client to ship the medication from your pharmacy. The cost of shipping is not billable to the Agency and will not be covered. Shipping is at your expense or the client's expense if you retain a signed consent on file.

- Some chain stores have the ability to "transfer stock", billing the prescription from a local Washington pharmacy, while having the medication dispensed from a store in another part of the country.

Brand Name Drugs

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

Substitute generic drugs for listed brand name drugs when:

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

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

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Expedited Authorization (EA)

[Refer to WAC 182-530-3200(4)]

What is the EA process?

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

How is an EA number created?

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

BILLING

Hardcopy billers must enter the EA Number in the *Authorization Number* field on the Pharmacy Statement [13-714].

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

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

Pharmacists are reminded that EA numbers are only for those drugs listed *on the following pages*. They are not valid for:

- Other drugs requiring authorization through the Prescription Drug Program;
- Waiving the S-MAC or A-MAC price; or
- 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.

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EA Guidelines:

- **Diagnoses -** Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet 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:

  ✓ Calling 1-800-562-3022; or
  ✓ Faxing 1-866-668-1214.

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

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

EA Code and Criteria List

The Expedited Authorization code lists.

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Reimbursement

General Information on Reimbursement

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

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

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

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

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

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

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Reimbursement Rates

[WAC 182-530-7000]

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

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

Note:

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

Estimated Acquisition Cost (EAC)

[Refer to WAC 182-530-8000]

The Agency uses Estimated Acquisition Cost (EAC) for drugs not otherwise covered by FUL, S-MAC, or A-MAC rates. The Agency selects the source for reference pricing and determines the calculation to be used for estimated acquisition (EAC) cost.

Currently, the EAC is calculated as a discount off AWP:

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

- For multiple source drugs with five or more manufacturers/labelers, the discount from AWP is 50%.

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Federal Upper Limits (FUL)

[WAC 182-530-8050]

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

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

To view the CMS Federal Upper Limits, go to:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits.html**.**

Drugs subject to FUL may also be subject to other Agency pricing methodologies. The Agency reimburses the lower of EAC, S-MAC, A-MAC, FUL, or usual and customary charges.

Automated Maximum Allowable Cost (A-MAC) Program

[WAC 182-530-8150]

The Agency's POS payment system calculates an A-MAC price for all multiple source drugs not currently on the State Maximum Allowable Cost (S-MAC) list.

A-MAC reimbursement for all products with the same ingredient, form and strength is at the A-MAC determined for the second lowest priced product, or the A-MAC of the lowest priced drug from a manufacturer with a current, signed federal rebate agreement.

For drugs with five or more manufacturers or labelers the A-MAC price is AWP minus 50%.

State Maximum Allowable Cost (S-MAC) Program

[WAC 182-530-8100]

An S-MAC may be applied to specific, equivalent multiple-source drugs. If applied, the Agency reimburses both the brand name and generic drugs at the S-MAC price.

The S-MAC may be waived for:

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

For the most up-to-date S-MAC list

Tax

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

Dispensing Fees

[Refer to WAC 182-530-7050]

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

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

Listed below are the Agency's dispensing fee allowances for pharmacies:

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

A provider's dispensing fee is determined by the:

- Total volume of prescriptions;
- Pharmacy fills for Agency clients; *and*
- General public.

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

Return the annual prescription count survey to:

Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562

Drug Rebate Program

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

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

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

To download the Agency's version of the Federal List of Drug Manufacturers Participating in the Centers for Medicare and Medicaid's (CMS) Drug Rebate Program, go to the Pharmacy Information page.

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Billing

General Instructions for Billing

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

Important Notes:

When another insurer or an Agency managed care plan requires authorization for a drug, perform all steps necessary to obtain the authorization.

Requiring authorization is not the same as a denial of coverage.

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Tamper-Resistant Prescription Pad Requirement

All written prescriptions for Medicaid clients in fee-for-service (FFS) programs, including over-the-counter medications, must be on tamper-resistant pads or paper, in compliance with federal regulations. This requirement for tamper resistant pads or paper applies whether Medicaid is the primary or secondary payer.

What is the requirement?

42 United States Code (USC) Section 1936b(i)(23) requires that the tamper-resistant paper must prevent the prescription from being changed by having at **least one** of the following characteristics:

- **No copying:** For example, pantographs that reveal the word "VOID" when copied.
- **No altering:** For example, chemical stains or an altered background reveal attempts at ink or toner removal.
- **No counterfeiting:** For example, pads have a watermark and can't be reproduced.

The prescription pads must have **all three** characteristics to be considered tamper-resistant.

Information about vendors who provide prescription pads that meet the federal requirement can be found at the Washington Medicaid web site. The Health Care Authority (the Agency) does not endorse any specific vendor. The Agency does not reimburse prescribers' costs for tamper-resistant paper.

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

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How are clients enrolled in managed care affected?

- This requirement for tamper-resistant paperdoes not apply to prescriptions paid for by a managed care plan for enrollees in one of the following:

  - ✓ Healthy Options (HO) Managed Care;
  - ✓ Basic Health Plus (BHP+);
  - ✓ General Assistance Unemployable-Managed Care (GAU-MC);
  - ✓ Washington Medicaid Integration Partnership (WMIP); or
  - ✓ Medicare/Medicaid Implementation Program (MMIP).

- This requirement does apply when a managed care contract excludes a drug if the drug is otherwise reimbursable under fee-for-service.
- If a client has third-party liability (TPL) with a managed care plan for non-contracted Medicaid services, then the requirement **does** apply.

What about emergency dispensing?

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

What about Medicaid clients with retroactive certification?

To submit a claim for a Medicaid client retroactively certified for Medicaid, the following applies:

- The prescription must meet the tamper-resistant paper requirement.

- Refills that occur after the date on which the client is determined to be eligible require a new, tamper-resistant prescription.

- If the original order is not compliant with the tamper-resistant paper requirement, the pharmacy may either obtain a verbal, faxed, or email confirmation of the prescription from the prescriber.

- The pharmacy must reimburse the client in accordance with WAC 182-502-0160.

What are the documentation and records retention requirements?

The pharmacist must document that the prescriber was contacted by telephone, fax, or email to verify that the legitimacy of the prescription written on non-compliant paper **before** it was dispensed.

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Prescription records, including documentation for non-compliant prescriptions, must be kept for six years according to WAC 182-502-0020.

Prescription Transfers Between Pharmacies

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

What Is the Time Limit for Billing?

[Refer to WAC 182-502-0150]

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

- **Medicare Part B Crossover Claims:** If Medicare Part B allows the claim, it is no longer billable as a Prescription Drug Program claim through the Point-of-Sale (POS) system. A claim allowed by Medicare Part B is billable as a crossover claim on a CMS-1500 Claim Form within six months of the date that Medicare processes the claim. If Medicare prints remark code MA07 or the phrase "claim information forwarded to Medicaid" on the EOMB, the Agency will extend the billing period for these claims to 12 months from the date of service. If Medicare denies payment of the claim, the Agency requires the provider to meet the Agency's initial 365-day requirement for the initial claim. If you have billed Medicare but have not received a response, you must still bill the Agency within 365 days of the date of service to establish timeliness.

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- ## Resubmitted Claims and Adjustments

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

- ## Reversals

The Agency allows pharmacies to reverse any prescription drug claim with a timely ICN within 15 months of the date the service was provided to the client. Hardcopy paper adjustment forms must be submitted if a pharmacy wishes to reverse a transaction that can no longer be reversed electronically from their own system. This includes:

- ✓ Reversals between 12 and 15 months from the date of dispense;
- ✓ "Lost" transactions (paid claim not found in the pharmacy's own system); and
- ✓ Claims older than the pharmacy's own system will allow them to reverse.

- ## Overpayments That Must Be Refunded to the Agency

The 15-month period allowed for resubmission of claims above **does not apply** to overpayments that a prescription drug provider must refund to the Agency. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. **Do not submit a claim adjustment.** Questions regarding overpayments may be directed to the MPA Cash Control at 1-360-725-1279.

- ## Client Responsibility

The Agency does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements in this Section, resulting in the claim not being paid by the Agency. See "Billing a Client" in the Billing Section within this guide.

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National Provider Identifier (NPI) Requirements

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

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

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

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

- An emergency room practitioner must report his or her individual NPI (Type 1), not the supervising practitioner's NPI with a prescription order.
- Each practitioner at a teaching hospital must report his or her individual NPI (Type 1) with a prescription order that is submitted to the dispensing pharmacy.

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

Point-of-Sale billers:

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

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Billing for a Baby Using His or Her Mom's ProviderOne Client ID

BILLING

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

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

Billing a Client

[Refer to WAC 182-502-0160]

A pharmacy may bill a fee-for-service client for a noncovered prescription if the client and provider complete and sign an Agreement to Pay for Healthcare Services form, 13-879 regarding payment for service. Form 13-879 can be found on the Agency's Medicaid Forms webpage.

To download and print form 13-879, go to the Medicaid Forms webpage..

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

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

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

Eligibility

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

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- **FAX** a copy of the client's Benefit Inquiry Screen from ProviderOne to Claims Entry at 1-866-668-1214; or

- Mail in a **completed** paper claim with a photocopy of the Benefit Inquiry Screen from ProviderOne attached.

The Benefit Inquiry Screen in ProviderOne will be updated within two working days in order for claims to be resubmitted. Please do not fax **claims** to this number.

For the complete Billing the Client WAC, go to:
http://apps.leg.wa.gov/WAC/default.aspx?cite=182-502-0160

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

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

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

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

Clients Enrolled in an Agency Managed Care Plan

The Agency reimburses for drugs dispensed to clients enrolled in an Agency managed care plan only when a managed care contract excludes the drug or pharmaceutical supply and the product is otherwise reimbursable under FFS. The following may be billed FFS to the Agency:

- Prescriptions written by **dentists** will be paid FFS.
- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed following abortion procedure are reimbursable on a fee –for-service (FFS) basis for clients enrolled in an Agency managed care plan.
- Over-the-counter contraceptives, including emergency contraception for female clients 18 years of age and older, when billed by a pharmacy that is not contracted with the clients managed care plan.

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Billing for Managed Care clients

Eligible medical assistance clients enrolled in a managed care plan must have their prescriptions filled at a pharmacy contracted with the Managed Care Organization (MCO). If your pharmacy is non-contract, the client must be referred to an MCO-contracted pharmacy.

- Bill the managed care plan first, except for drugs prescribed by a Health Department.
- If the managed care plan denies with a conditional claim rejection, such as Managed care plan limitations or prior authorization required, do what is necessary to be reimbursed by the Managed care plan.
- If the managed care plan denies the claim and the prescriber is a Family Planning Agency or a Community Mental Health Center, bill the Agency with the "2" in the *Prior Authorization Type Code* field for reimbursement if the service is a benefit under the client's program.
- If the managed care plan denies the claim and the prescriber is a dentist, bill the Agency with the prescriber's individual National Provider Identifier in the Prescriber ID field. If the claim is rejected with a dental prescriber identified, bill the Agency with the "2" in the *Prior Authorization Type Code* field. If the claim still rejects, please call Pharmacy Authorizations at 1-800-562-3022, to request assistance.

Clients enrolled in an Agency managed care plan may receive services under separate contracts from the following 3 entities:

- Community Mental Health Centers;
- Family Planning Agencies; and
- Health Departments.

The prescriptions written by the above entities must be related to the therapeutic classifications listed below. Clients may take these prescriptions to any medical assistance-participating pharmacy and are reimbursable FFS by the Agency.

Pharmacists must document the prescribing entity (i.e., community mental health center, family planning agency, or health department) on the original prescription. All other FFS rules apply to claims for the therapeutic classes listed below, including authorization requirements.

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Community Mental Health Centers may prescribe mental health drugs within the following therapeutic drug classes:

- Attention Deficit Hyperactive Disorder (ADHD) drugs;
- Anti-anxiety;
- Anticonvulsants;
- Antidepressants;
- Antipsychotics;
- Central Nervous System (CNS) drugs; and
- Ancillary drugs for the treatment of side-effects.

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

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

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

- Antibiotics;
- Anti-emetics;
- Anti-infectives;
- Contraceptive drugs/devices; and
- Tuberculosis drugs.

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

Prescribed by Family Planning Agency;
Prescribed by Community Mental Health Center; or
Prescribed by Health Department.

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

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Family Planning Only and TAKE CHARGE Clients

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

Contraceptives and Drugs	
Contraceptives, oral, including emergency contraception	Macrolides
Contraceptives, injectables	Antibiotics, misc. other
Contraceptives, transdermal	Quinolones
Contraceptives, intravaginal	Cephalosporins – 1st generation
Contraceptives, intravaginal, systemic	Cephalosporins – 2nd generation
Contraceptives, implantable	Cephalosporins – 3rd generation
Vaginal lubricant preparations	Absorbable Sulfonamides
Condoms	Nitrofuran Derivatives
Diaphragms/cervical caps	Antifungal Antibiotics
Intrauterine devices	Antifungal Agents
Vaginal antifungals	Anaerobic antiprotozoal – antibacterial agents
Vaginal Sulfonamides	
Vaginal Antibiotics	
Tetracyclines	

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

Anti-anxiety Medication – Before Sterilization Procedure

Medication	Maximum Number of Doses
Diazepam	2
Alprazolam	2

Pain Medication – After Sterilization Procedure

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

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BILLING

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

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

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

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Skilled Nursing Facility (SNF) Clients

Over-the-Counter (OTC) Drugs

The Agency does not reimburse for OTC drugs when the client resides in a SNF unless the drugs are on the Washington Preferred Drug List (See Therapeutic Interchange Program (TIP) Section within this guide) or the Agency's Covered Over-the-Counter Drug List. Reimbursement for OTC drugs is included in the SNF per diem.

Medications for SNF clients on leave

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

SNFs should determine which 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; or
- The client may return the prescription medication to the SNF following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

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

BILLING

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

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

Emergency Kits

The *emergency kit* is a set of limited pharmaceuticals furnished to a 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.

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SNF Unit Dose Delivery Systems
[Refer to WAC 182-530-7350]

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

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

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

Refer to the *Reimbursement* Section of this guide for Agency Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?
[Refer to WAC 182-530-5100(1)]

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

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

For information on becoming a unit dose provider, please contact Provider Enrollment (see Important Contacts).

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How do pharmacies bill the Agency under a unit dose delivery system?
[Refer to WAC 182-530-5100(2), (3), and (4)]

Under a unit dose delivery system, a pharmacy must bill the Agency only for the number of drug units actually used by the Agency client in the SNF.

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

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

Exception:

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

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

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

Who is responsible for the cost of repackaging client's bulk medications?
[Refer to WAC 182-530-5100(5)]

The cost of repackaging is the responsibility of the SNF when the repackaging is done:

- To conform with the SNF's delivery system; or
- For the SNF's convenience.

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

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What records do SNF pharmacies need to keep?
[WAC 182-530-5100(6) and (7)]

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

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

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

What needs to be submitted annually to the Agency?
[WAC 182-530-5100(8)]

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

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What Additional Records Do Pharmacies Need to Keep?

[Refer to WAC 182-530-5000]

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

Provision of Prescription Drugs

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

- Authorizing 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; and
- Proof of fill.

Proof of Delivery

- When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the item(s) delivered.

- When a provider mails an item to the client, the provider must be able to furnish proof of delivery, including a mail log.

- When a provider uses a delivery/shipping service to deliver items, the provider must be able to furnish proof of delivery and it must:

  - ✓ Include the delivery service tracking slip with the client's name or a reference to the client's package(s); the delivery service package identification number; and the delivery address.

  - ✓ Include the supplier's shipping invoice, with the client's name; the shipping service package identification number; and a detailed description(s).

- When a client or the client's authorized representative picks up the prescription, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the item(s) delivered.

- Make proof of delivery records available to the Agency, upon request.

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Coordination of Benefits

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

It is the provider's responsibility [See WAC 182-501-0200] to bill the Agency appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated in ProviderOne;
- The Point-of-Sale (POS) system alerts the provider to a client's insurance; or
- The provider believes insurance is available.

The Insurance Carrier List and carrier information is available on the Coordination of Benefits – Information for Medicaid Contracted Providers Agency web site. The information can be downloaded and printed or used as an online reference.

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

For questions related to insurance, refer to the *Important Contacts* Section.

Other Coverage Codes

Why are Other Coverage Codes important?

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

The provider's weekly Remittance and Status Report (RA) shows that the claim is denied with the Explanation of Benefits (EOB) 090. The EOB states "*Please bill your claim to the insurance company as instructed. For questions call 1-800-562-6136."* The insurance carrier information is printed on the RA for the provider's reference.

When may providers use Other Coverage Codes?

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

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

Contact the Coordination of Benefits **(**COB) Hotline number (1-800-562-3022) for any situations that are not listed below. See Point-of-Sale (POS) Section within this guide for values and definitions of the *Other Coverage Codes***.**

A removable summary of the following table is available at the end of the COB Section.

Situations	Explanation/ Solution	Other Coverage Code
The insurance has made payment to the pharmacy. *(An EOB or electronic transmission from insurance identifying the insurance paid amount.)*	Bill balance to the Agency.	**2**
Insurance allowed amount of the prescription is less than or equal to the copay. *(An EOB or electronic transmission from insurance identifying both the insurance allowed and co-pay amounts.)*	Bill the Agency.	**4**

Situations	Explanation/ Solution	Other Coverage Code
The prescription must be filled by mail order. *(Contract verification that the prescription must be filled by mail order; or denial from insurance stating mail order.)*	Bill the Agency.	**3**
Plan only covers a new prescription. *(An EOB or electronic transmission from insurance showing only new prescriptions covered.)*	Bill refills to the Agency.	**3**
The insurance carrier applied the claim charges to the client's deductible. *(An EOB or electronic transmission from insurance identifying the claim amount was applied to the deductible.)*	Bill the Agency.	**4**
The client's insurance plan maximum annual benefit has been met. *(An EOB or electronic transmission from insurance identifying the annual benefit has been met.)*	Bill the Agency.	**4**
The insurance denied the medication as a noncovered drug. Clarify if denial is for noncovered or nonformulary drugs. If nonformulary, third-party payment procedures must be followed. *(An EOB or electronic transmission identifying the drug is **noncovered** or include a copy of the contract drug exclusion list)*	Bill the Agency.	**3**
The client has a discount card. *(Verification of discount card or denial from insurance stating "discount card".)*	Bill the Agency.	**3**
Capitated service agreement with insurance carrier. *(Group Health and Kaiser pharmacies only.)*	Bill the Agency.	**8**
Medicare Part D copay. **Effective for dates of service on and after January 1, 2011**, the Agency will no longer provide coverage for Medicare Part D medication copayments. Medicare Part D copayments will be the responsibility of the client. *For questions, call the Agency Customer Service Center at 1-800-562-3022.)*		
Note: For questions on the use of *Other Coverage Codes* or acceptable documentation, call COB at 1-800-562-3022.		

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

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

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

Clients with Privately Purchased HMO Insurance

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

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

Billing

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

Primary Insurance Billing Exceptions

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

What does the provider do if a third-party liability question arises and it is after COB hours?

Situations may occur when a client is asking to fill a prescription, a question arises and it is outside of COB's regular business hours. After making reasonable attempts to access the primary insurance coverage, proceed with filling what is necessary to meet the client's immediate needs. "Immediate needs" means pharmacists using their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. The pharmacy must contact COB within 72 hours for billing assistance. Examples may include:

- The Agency indicates that the patient has insurance, but the coverage cannot be identified and the patient does not provide it; or
- The patient has HMO private insurance or has a closed pharmacy network.

What does the provider do if the client's coverage is prepay?

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

How do I bill for nonformulary or noncovered drugs?

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

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

Coordination of Benefits (COB)
Frequently Asked Questions (FAQ)

1. How do I find out if a client has retail prescription drug coverage and who processes the prescriptions?

Ask the client if she has insurance coverage, an insurance card, and/or Services Card. 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.

Download the insurance carrier contact information at Coordination of Benefits – Information for Medicaid Contracted Providers.

2. What do I do if a client's insurance states there is no coverage or the insurance coverage has ended?

If there is no coverage or the coverage has ended, notify COB at 1-800-562-3022.

3. What do I do if a client's insurance plan cannot identify the client?

If the insurance carrier cannot identify the client, contact COB at 1-800-562-3022 to verify the cardholder identification and the plan being billed are the same as on file with COB. We will assist you with verifying the client's prescription coverage or update COB records if the client does not have coverage.

4. What is discount only or mail order only coverage?

Discount only or *mail order only* coverage means insurance does not reimburse for any prescriptions filled at retail pharmacies.

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

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

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

5. Why would my claim be paid at zero or denied by insurance?

If you cannot verify the reason the claim was paid at zero, you must contact the insurance carrier and find out why the claim was paid at zero or denied. If you still have questions after contacting the insurance carrier, contact COB.

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

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

7. How do I bill for after hours services?

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

8. 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. Please contact COB within 72 hours for billing assistance. Examples may include:

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

9. 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.

10. What do I do when POS will not accept an *Other Coverage Code*, or I do not know where to enter the *Other Coverage Code*?

Contact your pharmacy software or switch vendor.

11. Why does my claim get rejection code DV (MISSING/INVALID OTHER PAYER AMOUNT PAID) or E8 (MISSING/INVALID OTHER COVERAGE CODE) when I try to bill the balance to the Agency?

If you get 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 you get a rejection code E8, you have entered an insurance payment, but have not entered the 2 in the *Other Coverage Code* field.

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, please contact your software or switch vendor.

12. If I cannot get the claim to 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.

13. When can I use Other Coverage Code 8?

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

14. How do I submit a claim to the Agency when the insurance allowed amount is less than or equal to the copay amount?

Copay is the amount that private insurance has determined the person with the private insurance coverage is expected to pay per prescription.

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

15. What is a closed pharmacy network?

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. [See WAC 182-530-7800(3a)]

The Agency may pay for the prescription without requiring the client to use a participating network pharmacy ONLY in the following situations:

a. When the prescription is not covered by the policy;
b. If the client is out of the service area; or
c. 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.

16. What do I do if I am not contracted with the client's private insurance carrier?

The Agency requires clients to use pharmacy providers contracted with their private insurance carrier. Clients with managed care private insurance will have an HM, HI, or HO identifier on the Client Benefit Inquiry Screen in ProviderOne.

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

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

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

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

17. What do I do if a client's insurance coverage requires paper billing and our pharmacy only bills electronically?

The pharmacy must meet all third-party billing requirements prior to billing the Agency.

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

18. How do I paper bill the Agency after primary insurance has been billed?

While POS billing is preferred, pharmacies who submit their claims to the Agency on paper must enter any amount paid by the primary insurance in the *insurance paid amount* field and the primary insurance processing details in the *justification/comments* section on the Pharmacy Statement (525-106) form, 13-714. To download this form, go to Medicaid Forms webpage.

19. If the client is enrolled in an Agency-contracted managed care organization and private insurance, who do I bill?

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

20. If I bill the insurance carrier and the denial reason is "plan limits exceeded," can I bill the Agency with an Other Coverage Code?

If the client's insurance benefits have been exceeded, it is appropriate to bill the Agency with an *Other Coverage Code* 3.

The pharmacy must meet all third-party billing requirements prior to billing the Agency.

21. How do I bill if the insurance carrier requires authorization?

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

22. The insurance carrier requires authorization. The prescriber will not provide information to the pharmacy or insurance carrier so authorization can be obtained. Can I bill the Agency directly?

No. The insurance carrier requirements must be met. It is not appropriate to bill the Agency with an *Other Coverage Cod*e unless the billing conditions of the insurance carrier have been met.

23. What are the documentation requirements? How long does documentation need to be kept?

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. Documentation is to be made available to the Agency for 6 years from the date of service. [WAC 182-502-0020]

24. The client has insurance coverage through multiple carriers. Am I required to bill all potential payers?

Yes. It is the provider's responsibility to seek timely reimbursement from a third-party when a client has available third-party resources. [See WAC 182-501-0200]

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

Agency *Other Coverage Code* Summary

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

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

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

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

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

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

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

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients covered under the CNP or MNP Benefit Service Package as well as QMB)

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

Part B—Medical Insurance

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and are furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service, it may not be covered by Part B. Medicare Part B also covers a limited number of other types of drugs. (Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to: http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx) .

Medicare Part B Medications (that are not covered through Part D)

After Medicare Part B has processed the claim, and if Medicare has allowed the medication(s), in most cases Medicare will forward the claim to the Agency for any supplemental Medicaid payment. When the words, *"Claim information forwarded to Medicaid*," appear on the Medicare remittance notice, it means that the claim has been forwarded to the Agency or a private insurer.

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

  You must submit the claim to the Agency within 6 months of the Medicare statement date. If Medicare prints remark code MA07 or the phrase "claim information forwarded to Medicaid" on the EOMB, the Agency will extend the billing period for these claims to 12 months from the date of service.

- If **Medicare Part B has denied** a medication, bill the Agency through the POS system using the appropriate DUR outcome code. Claims may also be billed on the Pharmacy Statement form and must have the Medicare denial letter or Explanation of Benefits (EOMB) attached. [**Note:** When Medicare denies a service that requires authorization, the Agency waives the *prior* requirement, but authorization is still required.]

Bill Medicare's coinsurance and deductible using the CMS-1500 Claim Form.

Medicare Part D

Copayments

Effective for dates of service on and after January 1, 2011, the Agency will no longer provide coverage for Medicare Part D medication copayments. Medicare Part D copayments will be the responsibility of the client.

For dates of service February 21, 2006, through December 31, 2006, the maximum basic Medicare Part D copayment is $5.00.

For dates of service January 1, 2007, through December 31, 2007, the maximum basic Medicare Part D copayment is $5.35.

For dates of service January 1, 2008, through December 31, 2008, the maximum basic Medicare Part D copayment is $5.60.

For dates of service on and after January 1, 2009, the maximum basic Medicare Part D copayment is $6.00.

Note: Some dual-eligible clients have elected prescription coverage from Medicare-approved "creditable coverage" plans or from enhanced Medicare prescription drug plans. The Agency pays the maximum copayment amount described above for dual-eligible clients. Copayment amounts above the maximum copayment amount of $5.60 per prescription are the client's responsibility.

How do I bill the copayment?

Enter an *8* in the *Other Coverage Code* (308-C8) field 308-C8 and enter only the copayment amount in the *Other Amount Claimed Submitted* (480-H9) field. **Do not submit the COB/Other Payment Segment.**

Note: The Agency pays only the copayment of a paid Medicare Part D claim, in the amount indicated by the client's plan up to the maximum copayment amount.

Prescription Drug Insurance

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; and
- Drugs that are:
  - ✓ Available only by prescription;
  - ✓ Used and sold in the United States; and
  - ✓ 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. These drugs or classes of drugs are listed at. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads//PartDDrugsPartDExcludedDrugs.pdf.

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.

How do I bill if Medicare denies as nonformulary?

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 nonformulary drugs. Due process under the Medicaid appeal rules such as an administrative hearing and Exception to Rule are not available to the client under this circumstance.

Helpful hyperlinks

- List of medications that the Agency will cover: Medication Coverage Lists.
- Medicare Part D web site.
- The agency's Medicare web site:
- SHIBA web site:
  http://www.insurance.wa.gov/consumers/medicare/medicare-part-d.shtml.
- CMS web site:
  http://www.cms.gov/.

Hardcopy Billing: Pharmacy Statement 13-714

General Instructions

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

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

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

Hardcopy claim submission is required for rebilling a claim between 12 and 15 months beyond the date of dispense and any reversal that the pharmacy cannot submit electronically via Point of Sale.

To **download** Agency forms, the Medicaid Forms and scroll down to form number 13-714.

Provider Name and Address - Enter your name and address as recorded by the Agency.

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

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

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

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

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

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

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

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

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

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

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

SAMPLE NDC NUMBER: 12345-6789-10

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

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

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

Drug Name - Enter the drug name and strength.

Prescriber's NPI - Enter the 10-digit National Prescriber Identifier of the prescriber. If the prescriber does not have an NPI number, enter the prescriber's 9-digit DEA number. Be sure to use the **unique individual provider identification number.** Do not complete with a group billing number. If this field is left blank, the claim will be denied.

Prescription (Directions for Use) - Enter the *Sig.*

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

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

Justification/Comments – Enter values or descriptions per this billing instruction. Enter any other information applicable to this prescription.

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

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

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

Section 3

For Compound claims:

Name – Enter the drug name and strength.

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

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

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

Hardcopy Billing: CMS-1500 Claim Form

Note: Refer to the Agency *ProviderOne Billing and Resource Guide* for instructions on completing the CMS-1500 Claim Form.

Electronic Billing

What Is Point-of-Sale (POS)?

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

POS Rejections

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

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

The chart on the following page outlines categories of potential reasons for claim rejection, rather than specific rejection messages.

Rejection Message Description	Reason	Required Action	Service Denial By the Agency?
Message starts with 'TIP:'	Therapeutic Interchange Program is required under Senate Bill 6088; Chapter 29, Laws of 2003. See Washington Preferred Drug List Section in this guide.	Pharmacist must substitute a preferred drug for the nonpreferred drug prescribed, unless the prescription is ordered Dispense As Written (DAW).	Not a denial of service. If prescription is DAW resubmit claim with Product Selection Code of 1. If not DAW, dispense a preferred therapeutic alternative within the same drug class.
Message starts with "Preferred" or "Pref"	Product prescribed is non-preferred for Agency clients.	See Washington Preferred Drug List Section in this guide. Consult prescriber to determine whether a preferred alternative can be prescribed. If medication cannot be changed to a preferred alternative, contact Pharmacy Authorization.	Not a denial of service, unless authorization is requested and denied in writing by the Agency.

Rejection Message Description	Reason	Required Action	Service Denial By the Agency?
Detail of missing or invalid codes. (Any standard NCPDP D.0 reject code which states "M/I")	A required field has been left blank, or an invalid value has been submitted in a field that could affect claim adjudication.	Correct claim and resubmit.	Not a denial of service. Claim must be re-submitted with valid values to determine coverage.

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

Rejection Message Description	Reason	Required Action	Service Denial By the Agency?
States 'Maximum' or 'Minimum' in relation to quantity, days supplied, client age, fills per month, etc…	The Agency has established therapeutic parameters for the use of the product. Claims may be authorized outside of those conditions. To view the Agency's current List of Limitations on Certain Drugs go to: http://www.medicaid.hca.wa.gov/pharmacy/	Verify accuracy of submitted claim information. If all information is accurate, contact prescriber to consider alternate therapies within FDA indications. If prescriber still feels that the product should be dispensed as prescribed, contact Pharmacy Authorization.	Not a denial of service, unless authorization is requested and denied in writing by the Agency.

Rejection Message Description	Reason	Required Action	Service Denial By the Agency?
States that a product is 'not billable through POS', states 'Bill as a professional service'; or 'Refer to DME/Non-DME billing instruction.	Product is a potentially covered benefit, but not considered part of the client's prescription drug benefit.	Consult appropriate billing instructions and bill as a professional service on a 1500 claim form, or comparable HIPAA compliant electronic claim format.	Not a denial of service. Benefit may be payable as Durable Medical Equipment, Enteral Nutrition, or a professional service.
"Expedited Authorization Code Required"	See *Authorization* Section. Product has an expedited code available for authorization if specific criteria are met.	Consult Expedited Authorization List in the *Authorization* Section. If criteria are met, resubmit claim with appropriate EA code in the Prior Authorization Number Submitted field (462-EV). If criteria are not met, contact Pharmacy Authorization.	Not a denial of service, unless authorization is requested and denied in writing by the Agency.

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

Prospective Drug Use Review (Pro-DUR)

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

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

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

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

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

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. [Refer to WAC 182-530-1050]

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

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

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

NCPDP Version D.0 Claim Format

In order to comply with the Health Insurance and Accountability Act (HIPAA) requirements, **The Agency requires all pharmacy providers to use NCPDP Version D.0 claim format** when submitting Point-of-Sale (POS) claims. **The Payer Specification Sheet** is available online at the Pharmacy Information page..

General Information

The NCPDP Version D.0 Claim Format:

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

What Transaction Segments Are Supported?

Transaction Header Segment

The Transaction Header Segment is mandatory on all transactions and all fields within the segment are mandatory.

The Transaction Header Segment tells the system where to send the claim, what type of submission it is, how many transactions, who is submitting the claim, date of service, and the vendor certification number.

Patient Segment

The Patient Segment is mandatory for all transaction types. The NCPDP standard requires the submission of Date of Birth (304-C4) and Patient Gender Code (305-C5) fields. The Agency requires submission of the Patient Residence (384-4X) field depending on the situation. When appropriate, and necessary for claim adjudication, please 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; or
12 - To indicate an ITA claim.

Insurance Segment

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

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

Claim Segment

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

Prescriber Segment

The Prescriber Segment contains data describing the prescriber and is required on all Authorization (P1, P2, P3, P4) or Billing transactions with the exception of Reversals (B1, B3). The mandatory/required fields are the Segment Identification, Prescriber ID Qualifier, and Prescriber ID. For Authorization transactions, Prescriber Last Name and Phone Number are also required.

COB/Other Payment Segment

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

Use the Other Coverage Code field in the Claim Segment to indicate insurance coverage information. Refer to page J.18.

DUR/PPS Segment

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

Pricing Segment

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

Compound Segment

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

Prior Authorization Segment

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

Therapeutic Interchange Program

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

What Is the Therapeutic Interchange Program?

The Therapeutic Interchange Program (TIP) is a process developed by the Department of Social and Health Services, the Health Care Authority (HCA), and Labor and Industries (L&I) to allow physicians and other prescribers to endorse the Washington Preferred Drug List (PDL). TIP is intended to streamline administrative procedures and make prescription drugs more affordable to Washington residents and state health care programs.

TIP applies only to drugs on the Washington PDL prescribed by an endorsing practitioner and not to other drugs requiring authorization.

What Is an Endorsing Practitioner?

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

What Does This Mean to Pharmacies?

When an endorsing practitioner issues a prescription to a medical assistance client for a nonpreferred drug on the Washington PDL, the filling pharmacist must dispense the preferred drug in that therapeutic class in place of the nonpreferred 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 nonpreferred drug is medically necessary and instruct the dispensing pharmacist to dispense the nonpreferred drug as written (DAW). When an endorsing practitioner indicates "**DAW**" on a prescription for a nonpreferred drug, the Agency will not require authorization, and the dispensing pharmacist will dispense the nonpreferred drug as prescribed.

Exemptions from TIP

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

- Antipsychotic;
- Antidepressant;
- Chemotherapy;
- Antiretroviral;
- Immunosuppressive; or
- Immunomodulator/antiviral drugs used to treat hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks. (RCW 69.41.190).

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

Continuation of Therapy Privilege for Exempted Drug Classes

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

What if a Non-endorsing Practitioner Issues a Prescription for a Nonpreferred Drug?

When a **non-endorsing** practitioner issues a prescription for a nonpreferred drug, the Agency requires authorization, and the dispensing pharmacist must fax a completed form “13-835a” to 1-866-668-1214, or call the Agency at 1-800-562-3022 to request authorization by providing medical justification.

For more information and access to the complete Washington PDL, go to HCA’s website http://www.rx.wa.gov/.

How Does the Pharmacy Bill for a DAW Prescription Written by an Endorsing Practitioner?

- **Hard copy billers** must enter "**DAW**" in the *Justification/Comments* field on the Pharmacy Statement [13-714].

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

Washington Preferred Drug List

What Is the Washington Preferred Drug List?

The Health Care Authority (the Agency) and Labor & Industries (L & I), have developed a list of preferred drugs within a chosen therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness. The drugs within a chosen therapeutic class are studied by an evidence-based practice center (EPC). A written report on the comparative safety, efficacy, and effectiveness from the EPC is evaluated by the Washington State Pharmacy and Therapeutic Committee which makes recommendations to the state agencies regarding the selection of the preferred drugs on the Washington Preferred Drug List (PDL). **[WAC 182-530-4100]**

What Is the Process to Obtain Drugs on the Washington PDL?

1. **Preferred Drugs -** Prescription claims for preferred drugs submitted to the Agency are reimbursed without authorization requirements unless the drug requires authorization for:

    a. Safety criteria;
    b. Special subpopulation criteria; or
    c. Limits based on age, gender, dose, or quantity.

2. **Non-preferred Drugs -** Prescription claims for non-preferred drugs submitted to the Agency are reimbursed without authorization requirements when written by an Endorsing Practitioner who has indicated "DAW" on the prescription unless the drug requires restrictions for safety. See WAC 182-530-4150.

3. Prescription claims for non-preferred drugs submitted to the Agency are reimbursed only after authorizing criteria are met if written by a non-endorsing practitioner.

4. Pharmacies must call the Agency for authorization when required. Call 1-866-668-1214**.**

What Are the Authorization Criteria That Must Be Met to Obtain a Nonpreferred drug?

- For most drug classes on the Washington PDL, the authorization criteria is that the client must have tried and failed, or is intolerant to, at least one preferred drug. Drugs may have criteria that go beyond these basic criteria for the reasons stated in #1 on the previous page.

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

The Agency requires pharmacies to obtain authorization for nonpreferred drugs when a therapeutic equivalent is on the Washington PDL. The following table shows the preferred and nonpreferred drug in each therapeutic drug class on the Washington PDL:

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

Washington Preferred Drug List

The Washington Preferred Drug List is located online at Prescription Drug Program Medicaid Provider Guide. .