CHAPTER 518 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PHARMACY SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 518.2.5	Pharmacy Change of Ownership	September 15, 2010	November 1, 2010
Section 518.3.1.1	Mountain Health Choices	September 15, 2010	November 1, 2010
Section 518.3.1.7	Incarcerated Members	September 15, 2010	November 1, 2010
Section 518.5	Service Limitations	September 15, 2010	November 1, 2010
Section 518.10.2	Prescriptions Returned to Stock	September 15, 2010	November 1, 2010
Section 518.11	Billing Procedure	September 15, 2010	November 1, 2010
Section 518.11.14	False Claims	September 15, 2010	November 1, 2010
Appendix 1	In-Home Parenteral Therapy	September 15, 2010	November 1, 2010
Section 518.4	Description of Covered Services	September 15, 2010	October 1, 2010
Section 518.7	Non-Covered Services	September 15, 2010	October 1, 2010
Section 518.12.3	Co-Payments	September 15, 2010	October 1, 2010
Section 518.5.1	Coverage of Brand Name versus Generic Drugs	March 31, 2010	June 1, 2010
Section 518.6	Non-covered services	March 31, 2010	June 1, 2010
Section 518.7	Prior Authorization (PA)	March 31, 2010	June 1, 2010
Section 518.7.2	Prior Authorization Appeal Process	March 31, 2010	June 1, 2010
Section 518.8.3	Reporting of Cash Payments	March 31, 2010	June 1, 2010
Section 518.9.1	Tamper-Resistant Prescription Pad Requirement	March 31, 2010	June 1, 2010

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Section 518.9.4	Shipping/Receiving	March 31, 2010	June 1, 2010
Section 518.10.10	Compounded Prescription	March 31, 2010	June 1, 2010
Section 518.10.11	Abuse and Inappropriate Utilization	March 31, 2010	June 1, 2010
Section 518.11.3	Co-payments	March 31, 2010	June 1, 2010
Section 518.11.4	Third-Party Liability (TPL) or Coordination of Benefits (COB)	March 31, 2010	June 1, 2010
Entire Manual	Entire Manual	November 10, 2009	January 1, 2010
Entire Manual	Entire Manual	March 13, 2006	April 17, 2006

November 1, 2010

Introduction: Section 518.2.5, Pharmacy Change of Ownership

Old Policy: N/A

New Policy: Change of ownership policy is addressed in *Common Chapter 300, Provider Participation Requirements,* and additional information may be found on the fiscal agent's website, see *Common Chapter 100, General Information,* for information on the fiscal agent. Although a pharmacy provider's NPI may be legally transferred from one owner to the next, BMS recommends that a new owner obtain a new NPI to facilitate a seamless transition.

Introduction: Section 518.3.1.1, Mountain Health Choices

Old Policy: Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained for a 34-day period. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Basic Benefit Package or Plan will be limited to 4 prescriptions per 34 day period.

Certain categories of drugs will not be included in the 4 prescription limit for members who choose the Basic Benefit Package. Drugs in the following therapeutic classes will not count toward the prescription limit for **children** with the Basic Benefit Package, which will be indicated by "BC" on their Medicaid Identification Card:

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a. Diabetes supplies and all insulins
b. Medications used for the treatment of seizures
c. Certain antibiotics-cephalosporins, macrolides, penicillins, and sulfonamides
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

The following therapeutic classes will not count toward the 4-prescription limit for **adults** with the Basic Benefit Package, which will be indicated by "BA" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member's medication profile.

New Policy: Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained per calendar month. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Adult Basic Benefit Package or Plan will be limited to 4 prescriptions per calendar month period. Children under the age of 21 years are not limited in the number of prescriptions they may receive.

The following therapeutic classes will not count toward the 4-prescription limit for adults with the Basic Benefit Package, which will be indicated by "BA" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member's medication profile.

Introduction: Section 518.3.1.7, Incarcerated Members

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Old Policy: N/A

New Policy: Medicaid members who are incarcerated are restricted from coverage of pharmacy benefits until they are released from the correctional system. Claims submitted with dates of service during a period of incarceration will deny. If the member has been released before the restriction is updated, positive identification is required. A call to the Rational Drug Therapy Program help desk must be made to request an override.

Introduction: Section 518.5, SERVICE LIMITATIONS

Old Policy:

• Members enrolled in the Mountain Health Choice's (MHC) basic plans are limited to coverage of four prescriptions per calendar month, with the exception of the following therapeutic classes for children:

- Diabetic supplies and all insulins,
- Medications used in the treatment of seizures,
- Certain antibiotics—cephalosporins, macrolides, penicillins, and sulfonamides
- Drugs used for the treatment of HIV/AIDS
- All contraceptives.

And for adults enrolled in the MHC basic plan, the following exceptions of therapeutic classes to the four prescription limit are:

- Diabetic supplies and all insulins,
- Atypical antipsychotics,
- Antidepressants (all therapeutic classes),
- Drugs used for the treatment of HIV/AIDS,
- All contraceptives.

New Policy:

- Members enrolled in the Mountain Health Choice's (MHC) Adult basic plan are limited to coverage of four prescriptions per calendar month.

  The following therapeutic classes will not count toward the 4-prescription limit:

  - Diabetic supplies and all insulins,
  - Atypical antipsychotics,
  - Antidepressants(all therapeutic classes),
  - Drugs used for the treatment of HIV/AIDS,
  - All contraceptives.

Introduction: Section 518.10.2, Prescriptions Returned to Stock

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Old Policy: Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

New Policy: Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis, within 15 days. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

Introduction: Section 518.11, BILLING PROCEDURE

Old Policy: N/A

New Policy: Claims must accurately report the NDC dispensed, the number of units dispensed, days' supply, and other required data for claims processing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause BMS to report false data to drug manufacturers when billed for drug rebates. BMS will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers or during claim reviews. Pharmacies are required to submit documentation for purchases of drugs reimbursed by BMS upon request.

Introduction: Section 518.11.14, False Claims

Old Policy: N/A

New Policy: Pharmacies are prohibited from submitting false claims to test for drug coverage, member eligibility, or for other purposes. Claims of this type result in false member drug history records and may result in the member or prescriber being included in lawsuits or reviews in error. All claims submitted for reimbursement must be the result of actual prescription requests.

Introduction: Appendix 1, In-Home Parenteral Therapy

Old Policy: Prior authorization form included

New Policy: See the BMS web site at www.wvdhhr.org/bms for the approved prior authorization form.

October 1, 2010

Introduction: Section 518.4, Description Of Covered Services

Old Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions

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• Drugs that require prior authorization, when approved by BMS
• Family planning supplies, including over-the-counter supplies
• Certain diabetic supplies.

New Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions
- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including over-the-counter supplies
- Certain diabetic supplies
- Influenza and pneumonia vaccines for adults over 21 years of age administered by a pharmacist.

Introduction: Section, 518.7, Non-Covered Services

Old Policy: The following list of drugs, drug products, and related services are not reimbursable. Noncovered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

• Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
• Agents used for weight loss or weight gain
• Agents used for cosmetic purposes or hair growth
• Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
• Agents used for fertility
• Drugs used to treat erectile dysfunction
• Drugs that are investigational or approved drugs used for investigational purposes
• Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
• Drugs dispensed after their expiration date
• The cost of shipping or delivering a drug
• Herbal or homeopathic products
• Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
• Drugs which are not medically necessary
• Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
• Nutritional supplements
• Free pharmaceutical samples
• Diagnostic agents

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• Vacation supplies
• Allergenic extracts
• Excipients except when used in compounded prescriptions containing a covered legend drug
• Vaccines via the pharmacy POS
• Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services,* for additional information regarding hemophilia services.

New Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 21 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.

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Introduction: Section 518.12.3, Co-Payments

Old Policy: A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

• If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription
• If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
• If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
• If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

• Prescriptions for family planning services and supplies
• Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
• Prescriptions for pregnant women
• Prescriptions for members under 18 years of age
• 3-day emergency supplies
• Diabetic testing supplies and syringes/needles
• BMS approved home infusion supply

New Policy: A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

- If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription
- If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
- If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
- If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

- Prescriptions for family planning services and supplies
- Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
- Prescriptions for pregnant women
- Prescriptions for members under 18 years of age

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- 3-day emergency supplies
- Diabetic testing supplies and syringes/needles
- BMS approved home infusion supply
- POS-approved vaccines

May 15, 2010
Section 518.5.1

Introduction: Section 518.5.1, Coverage of Brand Name versus Generic Drugs

Old Policy: DAW 1 - Prescriber states that the brand name drug is "medically necessary". This information must be supplied in writing by the **physician** via written prescriptions and by the **physician** on verbal prescriptions. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.
New Policy: Prescriber states that the brand name drug is "medically necessary". This information must be supplied in writing by the **prescriber** via written prescriptions in their own handwriting, and must write on the prescription "Brand Medically Necessary". A check-box or other methods to indicate that the brand should be dispensed shall not be accepted. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.

Introduction: Section 518.6, Non-covered services
Old Policy:
- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which require prior authorization and for which prior authorization criteria have not been met
- Drugs which are not medically necessary

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- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Inappropriate therapeutic/ingredient duplications, early refills, and other Drug Utilization Review events.
- Vaccines via the pharmacy POS
- Factors to treat hemophilia via the pharmacy POS
  (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.)

New Policy:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug

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- Vaccines via the pharmacy POS
- Factors to treat hemophilia via the pharmacy POS
  (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.)

Introduction: Section 518.7, Prior Authorization (PA)
Old Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms.
New Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable until appealed by the prescribing practitioner on behalf of the member.

Old Policy: N/A
New Policy: The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Introduction: Section 518.7.2, Prior Authorization Appeal Process
Old Policy: Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787. All appeals denied by RDTP will be sent to BMS for physician review.
If the outcome of the physician review upholds the denial, the Medicaid member is notified of this denial and of their right to request a fair hearing.
New Policy: Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787.
All appeals denied by RDTP will be sent to BMS for physician review. Any denial resulting from physician review is final. The Medicaid member is notified of this denial and of their right to request a fair hearing.

Introduction: Section 518.8.3, Reporting of Cash Payments
Old Policy: N/A

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New Policy: Pharmacies are encouraged to report to BMS when a member pays cash for prescriptions that would otherwise be covered by Medicaid or considered for reimbursement upon a call to the RDTP, or when the pharmacy provider suspects overutilization by the member. A form used for this reporting can be found on the BMS website, www.wvdhhr.org/bms. The form should be faxed to BMS at 304-558-1542. Information collected through this process may be used for member lock-in consideration and continued eligibility.

Introduction: Section 518.8.4, Member Counseling
Old Policy: N/A
New Policy: Renumber entire section due to addition of section 518.8.3, Reporting of Cash Payments

Introduction: Section 518.9.1, Tamper-Resistant Prescription Pad Requirement
Old Policy: As of October 1, 2008, all prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meets all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS).
New Policy: All prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meet all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS). The three characteristics to meet the tamper-resistant prescription requirement:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription, and;
3. Prevent the use of counterfeit prescription forms.

Old Policy: N/A
New Policy: Computer-generated prescriptions, EMR, or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance, provided they contain the features listed in the table below. Prescribers are urged to contact their software companies to ensure that computer generated prescriptions have all requirements necessary for tamper resistance.

Computer-generated prescriptions must contain the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax. *This requires the purchase of special paper.*
OR	
Micro print signature line	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.

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2. <u>One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.</u>

Feature	Description
UNIFORM NON-WHITE BACKGROUND COLOR – *PREFERABLY GREEN* OR "Toner-lock" paper for laser printed prescriptions, or plain bond paper for inkjet printed prescriptions	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If someone tries to erase copy – the consistent background color will look altered. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from the inkjet printers is absorbed into normal "bond" paper.
QUANTITY WRITTEN AND QUANTITY WITH BORDER CHARACTERISTICS FOR COMPUTER GENERATED PRINTED PRESCRIPTIONS	Quantity written and Quantity surrounded by special characters such as asterisks to prevent modification, e.g. *QTY Fifty ***50****.*
Refill written and refill with border characteristic for computer generated printed prescriptions	Refills written and Refill surrounded by special characters such as asterisks to prevent modification, e.g. *Five refills ****5 refills*****.*

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
SECURITY FEATURES AND DESCRIPTIONS LISTED ON THE PRESCRIPTION	A complete list of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the paper.

Prescriptions for West Virginia Medicaid members written by prescribers that reside outside of West Virginia may meet the federal tamper-resistant prescription requirement if the prescription addresses the three distinct characteristics outlined above, and may contain the same or other features than those adopted by BMS.

Introduction: Section 518.9.4, Shipping/Receiving
Old Policy: N/A
New Policy: Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process, as Medicaid will not reimburse for medications not received by the member.

Introduction: Section 518.10.10, Compounded Prescription
Old Policy: N/A

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New Policy: Products such as suppository molds and other items identified as supplies included in a compounded prescription will not be reimbursed by West Virginia Medicaid.

Introduction: Section 518.10.11, Abuse and Inappropriate Utilization
Old Policy: N/A
New Policy: Automatic filling of prescriptions or automatic shipping of medications to the member is prohibited unless members request the filling or shipping of these medications each time.

Introduction: Section 518.11.3, Co-payments
Old Policy: N/A
New Policy: Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility.

Introduction: Section 518.11.4, Third-Party Liability (TPL) or Coordination of Benefits (COB)
Old Policy: N/A
New Policy: Medicaid covered drugs which currently require a prior authorization (PA) from BMS will continue to require a PA if a primary insurer approves that service, and Medicaid reimburses any part of the cost.

Medicaid co-payment is still required, if applicable, for claims considered by third party payers and reimbursed by BMS.

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CHAPTER 518–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PHARMACY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandated major changes in coverage and reimbursement for Medicaid-covered outpatient drugs. West Virginia Medicaid reimbursement is limited to drugs whose manufacturers have entered into and have in effect a rebate agreement with the Secretary, Department of Health and Human Services.

West Virginia Medicaid offers a comprehensive scope of Pharmacy services to Medicaid members as an optional program, subject to medical necessity, appropriateness criteria, and prior authorization requirements. The West Virginia Medicaid Pharmacy Program is funded by both West Virginia State and Federal funds. All covered drugs, whether legend or non-legend, prescribed by a physician or other authorized practitioner, are addressed within the program. Applicable state and federal laws governing dispensing of drugs and biologicals must be followed.

This manual identifies and explains covered services, their limits, eligibility requirements, and polices that are required to be followed by providers of outpatient prescription drugs in order to obtain reimbursement from federal and state funds.

518.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to the Provider Manual, *Chapter 200, Definitions*. In addition, the following definitions apply and/or relate to Pharmacy Services.

340b Program: a federal program administered by Health Resources and Services Administration (HRSA) whereby certain designated facilities purchase prescription medications at

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deep discounts, allowing these facilities to offer some medications to their patients at greatly reduced prices.

Dispensed As Written (**DAW):** a numerical value used by providers to explain the dispensing of a brand-name product instead of a generic one.

Drug Efficacy Study and Implementation Program (**DESI):** Drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.

End Stage Renal Disease (ESRD): the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

First Data Bank (**FDB):** a database company for drug pricing and drug utilization review (DUR) edits.

Federal Drug Rebates: a payment made by pharmaceutical manufacturers to the states for drugs dispensed to Medicaid members.

Federal Upper Limit (**FUL):** maximum allowable cost (MAC) established by the Centers for Medicare and Medicaid Services for certain prescribed drugs.

Home IV: Intravenous medications administered in the home, provided by specialized pharmacies, that require the services of a nurse or trained caregiver.

Lock-In: Program administered through the retrospective drug utilization review process to limit members to the use of one pharmacy provider.

Medicaid AWP: Average wholesale prices established by the Federal Office of the Inspector General.

Mountain Health Choices: The name of West Virginia Medicaid's program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

Multi-Source Drugs: Drugs that are marketed or sold by two or more manufacturers or labelers.

National Provider Identifier (NPI): A standard unique healthcare provider identification number mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Orange Book: Publication by the Food and Drug Administration which establishes therapeutic equivalency ratings for drugs.

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Pharmaceutical and Therapeutics Committee (**P & T Committee):** an advisory body that recommends drugs to Medicaid for inclusion or exclusion relating to the Preferred Drug List.

Rational Drug Therapy Program (**RDTP):** agency designated by the Bureau for Medical Services for prior authorizing prescription drugs.

Retrospective Drug Utilization Review (**RETRO DUR):** review of member drug history records against predetermined standards to improve quality of healthcare and to educate physicians and pharmacists on common drug therapy issues.

Single-Source Drug: A drug that is available from only one manufacturer.

State MAC (SMAC): Maximum allowable cost for drug products established by the state Medicaid agency.

Supplemental Drug Rebate: A payment from a pharmaceutical manufacturer, negotiated by the state, in addition to the federal rebate.

518.2 PROVIDER PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, pharmacy providers must:

- Meet and maintain all applicable licensing, accreditation, and certification requirements;
- Meet and maintain all BMS enrollment requirements;
- Have a valid trading partner agreement on file that is signed by the provider and BMS upon application for enrollment into the West Virginia Medicaid Program; and
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services and all applicable State and Federal Laws governing the provision of their services

Provider enrollment requirements in general are detailed in *Common Chapter 300, Provider Participation Requirements*.

518.2.1 Certification

A pharmacy eligible to participate in Medicaid must hold a current permit from the West Virginia State Board of Pharmacy and adhere to all state and federal regulations. Pharmacies located out-of-state and filling prescriptions for West Virginia Medicaid members must be licensed by the state in which they are located. Pharmacies located out-of-state and shipping or mailing prescriptions into West Virginia must be licensed by the state in which they are located **and** hold a permit from the West Virginia Board of Pharmacy. Pharmacies are required to file a copy of their current permits with BMS annually. Failure to do so may result in the withholding of payments and/or enrollment termination.

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When the current license and/or permit is not on file, the provider shall not be reimbursed by Medicaid until such time the BMS' Provider Enrollment Unit receives a copy of the current license and/or permit.

Pharmacies completing West Virginia Medicaid enrollment applications must indicate on the form the pharmacy designation, i.e. retail; institutional; hospital outpatient - open to the public; hospital outpatient - closed to the public; mail order; in-home parenteral therapy (home infusion pharmacy).

518.2.2 Dispensing Physicians

Reimbursement for self-administered prescription drugs is limited to licensed and participating pharmacies. BMS does not enroll dispensing physicians for reimbursement as a pharmacy provider type.

518.2.3 In-Home Parenteral Therapy Pharmacy Requirements

Pharmacies requesting reimbursement for in-home parenteral therapy compounding services must meet all state and federal licensure and certification requirements. See Appendix 1 for information pertaining to this program.

518.2.4 Pharmacies Participating in the 340B Program

Pharmacies participating in the program established by Section 340B of the Public Health Services Act of 1992 must notify BMS of their participation in the 340B program by completing the required certification form and supplying 3 recent comprehensive invoices annually. This form is available on the BMS website, www.wvdhhr.org/bms. Drugs with discounts generated from participation in this program are not eligible for federal drug rebates and drug claims from these pharmacies must be exempted from drug rebate invoices that Medicaid sends to the drug manufacturers. Pharmacies participating in this program must submit their actual acquisition costs when billing the Medicaid program. Submission of additional invoices may be required for audit purposes.

518.2.5 Pharmacy Change of Ownership

Change of ownership policy is addressed in *Common Chapter 300, Provider Participation Requirements,* and additional information may be found on the fiscal agent's website, see *Common Chapter 100, General Information* for information on the fiscal agent. Although a pharmacy provider's NPI may be legally transferred from one owner to the next, BMS recommends that a new owner obtain a new NPI to facilitate a seamless transition.

518.3 MEMBER ELIGIBILITY

Medicaid covers pharmacy services for all individuals who meet Medicaid eligibility guidelines. Drug coverage may also be available to other eligibility groups as described below. Refer to Common *Chapter 400, Member Eligibility*, for more information regarding eligibility requirements.

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518.3.1 Medicaid Members Eligible for Pharmacy Services

Medicaid members eligible for pharmacy services have access to legend and over-the-counter drugs as defined in the State Plan filed with CMS. An eligibility card is issued to these individuals. This card must be presented to assure eligibility of the member. Any person requesting services without a Medicaid identification card shall be advised that he/she is responsible for furnishing his or her identification card to the provider prior to services being rendered. If the card is unavailable, eligibility may be verified through the Medicaid Voice Response System at 1-888-483-0793 or by sending an electronic NCPDP E-1 transaction through the pharmacy Point-of-Sale (POS) billing system.

518.3.1.1 Mountain Health Choices

Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained per calendar month. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Adult Basic Benefit Package or Plan will be limited to 4 prescriptions per calendar month period. Children under the age of 21 years are not limited in the number of prescriptions they may receive.

The following therapeutic classes will not count toward the 4-prescription limit for adults with the Basic Benefit Package, which will be indicated by “BA” on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member’s medication profile.

518.3.1.2 Dual Eligible Members

Members eligible for both Medicare and Medicaid are called dual eligible members. Medicare is the primary payer for dual eligible members. Medicare, a federal health insurance program for the aged and disabled, covers certain hospital (Part A), outpatient medical benefits and physicians’ services (Part B) and prescription benefits (Part D) for participating individuals. Some dual

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eligible members may participate in Medicare Managed Care plans (Advantage or Part C plans) which include pharmacy services.

Dual eligible members have prescription drug coverage through Medicare Part D, or Part C if enrolled in a Medicare Managed Care plan. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Medicaid does not reimburse for Medicare Part D or Part C co-payments. Medicaid does not pay as the secondary payer on Medicare Part D or Part C covered drugs.

518.3.1.3 Medicaid Members Enrolled in Medicaid Managed Care Plans

With the exception of drugs used for in-home parenteral therapy and physician/outpatient facility-administered drugs, West Virginia Medicaid members enrolled in a Managed Care Organization (MCO) receive fee-for-service pharmacy benefits. These members will have two identification cards – the managed care identification card for medical services, i.e. physician, hospital, etc, and the Medicaid identification card for pharmacy and other carved-out services. In-home parenteral therapy and physician/outpatient facility- administered drug services are covered by the MCO and are subject to the plans' requirements.

518.3.1.4 Medicaid Members with End Stage Renal Disease (ESRD)

Members diagnosed with End Stage Renal Disease (ESRD) may require additional over-the-counter drug treatments not usually covered by the pharmacy program. In order to accommodate these members, a letter signed and dated by the treating physician is required to verify the diagnosis of ESRD and must include the date dialysis began. This letter shall be directed to:

Bureau for Medical Services
Member Eligibility
350 Capitol Street, Room 251
Charleston, West Virginia 25301-2675

Refer to the BMS website, www.wvdhhr.org/bms, for a list of additional over-the-counter drugs covered for ESRD patients.

518.3.1.5 Qualified Medicare Beneficiary (QMB)

QMB members do not receive pharmacy coverage benefits through the Medicaid program. Medicaid does provide coverage of deductibles and co-insurance amounts for Medicare Part B covered drugs and other Medicare covered services with the exception of those covered under Part D. These members receive a medical identification card, but coverage, as noted on the card, is limited to Medicare co-insurance and deductibles only.

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518.3.1.6 Children in Foster and Adoptive Placement

Children in state custody and entered into foster, residential or adoptive placements may be Medicaid eligible. They receive a medical identification card. The eligibility number begins with "039". Drug claims may be submitted online through the pharmacy Point-of-Sale system or on the approved paper claim form. Medicaid coverage rules apply.

518.3.1.7 Incarcerated Members

Medicaid members who are incarcerated are restricted from coverage of pharmacy benefits until they are released from the correctional system. Claims submitted with dates of service during a period of incarceration will deny. If the member has been released before the restriction is updated, positive identification is required. A call to the Rational Drug Therapy Program help desk must be made to request an override.

518.3.2 Non-Medicaid Individuals Eligible for Pharmacy Services

Individuals who do not qualify for the Medicaid Program may have pharmacy coverage under other federal or state-funded programs. These individuals do not receive medical identification cards, but may receive a letter or other form of eligibility authorization.

518.3.2.1 AIDS Drug Assistance Program (ADAP) or Ryan White Program

The AIDS Drug Assistance Program (ADAP) is funded by the Ryan White Title II CARE Act in West Virginia, and claims are processed through the BMS claims processing system. The program assists eligible persons with HIV infection in obtaining drugs covered by the ADAP formulary. To be eligible for the ADAP, a person must meet the following:

- be an HIV infected resident of West Virginia;
- with a family income less than 325% of the federal poverty level (FPL), and;
- not be eligible for other forms of reimbursement such as Medicaid or full insurance coverage, and;
- have completed the ADAP and Medicaid application at their Department of Health and Human Resources county office.

ADAP participants do not receive a medical identification card, but do receive a letter that verifies eligibility and includes their identification number with a prefix of "69". All claims except those for vaccines may be submitted online through the pharmacy Point-of-Sale system or by using the approved paper claim form. Covered drugs are limited to a 30-day supply. Claims must be submitted within 60 days from the date of service. Formulary drugs must be dispensed in generic form if available. Brand-name drugs that have generic equivalents require prior authorization. There are no co-payment requirements for this program. ADAP may cover co-pays for eligible residents who are covered by insurance or Medicare Part D. Claims for vaccines must be submitted on the approved pharmacy paper claim form and mailed to HIVCC, P. O. Box 6360, Wheeling, West Virginia 26003. Certain drugs may require prior authorization and emergency supplies of these drug may not be dispensed. Please refer to the BMS website,

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www.wvdhhr.org/bms, for the ADAP formulary. More information regarding ADAP can be found at the Bureau for Public Health's website at www.wvdhhr.org/bph.

518.3.2.2 Children with Special Health Care Needs (CSHCN)

Pharmacy services are available for certain children under 21 years of age receiving medical care under the Children with Special Health Care Needs Program. Services are not limited to children of families receiving public assistance grants. Coverage is limited to the formulary established under the program's policy administration. These members do not receive a medical identification card. An identification number with a prefix of "99" is assigned. Claims may be submitted online using the pharmacy Point-of-Sale system or by using the approved paper claim form. Policy questions regarding this program shall be directed to the CSHCN unit at 1-800-642-9704.

518.3.2.3 Individuals Eligible for Immunosuppressant or Antipsychotic Medications

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of immunosuppressant or antipsychotic medications using all state funds. Eligibility for these services is determined at the individual's local county Department of Health and Human Resources office. A six-month eligibility period is established and it is the member's responsibility to reapply for these services. No identification card will be issued. Medicaid receives a written communication from the Division of Family Assistance defining the drug(s) that will be covered for a particular individual. A letter including the services to be covered and the individual's identification number, prefix "39", will be forwarded to the pharmacy provider and the individual. Claims for these services may be submitted online through the pharmacy Point-of-Sale system or on the approved paper claim form. Medicaid coverage rules apply to these claims. (Please note: Some individuals may also be eligible for coverage of immunosuppressant drugs by Medicare Part B. Medicare must be billed first. This state program will pay co-insurance and deductible amounts on Medicare Part B crossover claims only. All other Medicare eligible individuals must pursue coverage of immunosuppressant drugs and antipsychotic medications through their Part D plans.)

518.3.2.4 Tiger Morton Fund

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of selected medications using state funds through the Tiger Morton Fund. These individuals will not have an identification card and coverage will be communicated to the pharmacy provider on a case-by-case basis. Claims for these services must be submitted using the approved paper claim form.

518.3.2.5 Emergency Medical Assistance or Other State Programs

Certain individuals who are not eligible for Medicaid services may be eligible for emergency medical assistance or other pharmacy services using state funds. These individuals will present a letter to the pharmacy provider listing particular drug(s) to be covered. A prefix of "15" or "38" along with the respective county code will be noted on the authorization letter to identify the

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eligible individual. Claims for these services must be submitted using the approved paper claim form with a copy of the eligibility letter attached.

518.3.2.6 Juvenile Services

Certain individuals have pharmacy services coverage through Juvenile Services. A letter of eligibility will be presented to the pharmacy which includes the individual's identification number beginning with prefix "17". Claims for these services may be submitted through the online Point-of-Sale system or by using the approved paper claim form. Medicaid coverage rules apply.

518.3.2.7 Adult Family Care and Protective Services

Children and adults receiving Protective Services as a result of abuse and/or neglect or other individuals in need of assistance may be provided limited eligibility for state-funded services. A Special Medical Authorization Letter is issued as needed by the field staff. This letter specifies the individual, the medical provider authorized to provide services, the services authorized and the coverage period. An identification number for use in billing the services is also provided. Pharmacy claims for these individuals may be submitted online or on the approved paper claim form. Medicaid coverage rules apply.

518.3.3 Denials Due to Eligibility

If an online denial occurs due to eligibility problems, and the member presents a valid Medicaid card or other proof of eligibility, take the following steps:

- Dispense the prescription for valid and covered services.
- Obtain a copy of a valid Medicaid card or other proof of eligibility.
- Choose one of two options:
  (1) Resubmit the claim online at a later date, using the original date of service; or
  (2) Submit the claim on the approved paper claim form and attach a copy of the valid Medicaid card or other proof of eligibility. Mail these claims to:

Molina Corporation
Pharmacy Claims
Post Office Box 3765
Charleston, West Virginia 25327-3709

518.4 DESCRIPTION OF COVERED SERVICES

Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions
- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including over-the-counter supplies

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- Certain diabetic supplies
- Influenza and pneumonia vaccines for adults over 21 years of age administered by a pharmacist.

Drugs covered under the Medicaid outpatient pharmacy program are those that have been approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, when used for medically accepted indications.

Medically accepted indication means any use that is supported by one or more of the following official compendia:

(a) The American Hospital Formulary Service Drug Information;
(b) The United States Pharmacopoeia Drug Information or it's approved replacement;
(c) The DRUGDEX Information System;

All covered drugs, whether legend or over-the-counter, must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and federal requirements.

The West Virginia Medicaid program follows the Office of Inspector General's (OIG) guidelines in excluding prescribers from participating with West Virginia Medicaid who are barred from participating in federal health programs. Reimbursement of prescriptions issued by these excluded prescribers is denied.

West Virginia Medicaid also excludes from reimbursement any prescription ordered by:

a. prescribers not enrolled as providers with West Virginia Medicaid, nor enrolled with a participating West Virginia Medicaid MCO; or,
b. prescribers not employed by or contracted with a facility or group practice that is enrolled as a Medicaid provider.

518.4.1 Preferred Drug List (PDL)

The West Virginia Preferred Drug List (PDL) is a list of medications recommended to BMS by the West Virginia Medicaid Pharmaceutical and Therapeutics (P & T) Committee and approved by the Secretary of the Department of Health and Human Resources. The P & T Committee is composed of actively practicing physicians, pharmacists, a nurse practitioner, and a physician's assistant. Meetings of the P & T Committee are held 3 times per year and are open to the public.

The drugs that are designated as "preferred" have been selected for their clinical significance and overall cost efficiencies. All Medicaid-covered drugs noted as "non-preferred" continue to be available through the prior authorization process.

The PDL only addresses certain drug classes. Some classes of drugs will not be reviewed for preferential agents because there are no or limited cost savings associated with these classes.

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Drugs that meet the criteria for coverage and have no preferred status are considered covered drugs.

The PDL is updated at minimum annually and as needed. Newly released drugs in classes which are included in the PDL will be considered non-preferred until the drug itself has been reviewed.

The complete PDL, criteria for coverage of non-preferred drugs, minutes of P & T Committee meetings, and other pertinent information may be accessed on the Bureau for Medical Services' website at www.wvdhhr.org/bms.

518.4.2 Over-the-Counter Drugs

Certain over-the-counter (OTC) drugs are reimbursed for eligible Medicaid members when prescribed by a qualified practitioner. OTC drugs must be manufactured by companies participating in the federal drug rebate program and are limited to generic products when available. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in the original packaging. These products must be billed at the shelf price of the pharmacy. If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the product will be reimbursed at the same rate as legend drugs.

Over-the-counter drugs are not covered for residents of skilled nursing homes or ICF/MR facilities except for insulin. These drugs are included in the rates paid to these facilities.

For a current list of covered OTC drugs, see the BMS website, www.wvdhhr.org/bms.

518.4.3 Diabetic Testing Supplies and Syringes/Needles

Certain supplies used by eligible diabetic Medicaid members are covered through the outpatient pharmacy program. A prescription issued by a licensed prescriber within the scope of his/her practice is required for coverage of these items. Verbal prescriptions that meet federal and state regulations are permitted. Prescriptions must define the number of tests to be performed per day. Co-payments are not required on prescriptions for these items. Covered supplies include:

- Blood glucose testing strips
- Urine testing tablets and strips
- Lancets
- Insulin syringe and needle combinations for the administration of insulin
- Needles for insulin pen systems

Needle and syringe combinations and disposable pen needles for insulin pens are reimbursed through the pharmacy POS program only for the administration of insulin.

Diabetic testing supplies and syringes/needles are not covered pharmacy services for members residing in skilled nursing or ICF/MR facilities.

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The following limits apply for those members who have insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	150 per 30 days
Lancets	200 per 30 days
Insulin syringe and needle combinations	100 per 30 days
Pen needles	100 per 30 days

The following limits apply for those members who have non-insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	100 per 30 days
Lancets	100 per 30 days

Prescriptions for quantities greater than the above referenced amounts require prior authorization through the Rational Drug Therapy Program (RDTP). The prior authorization criteria shall follow the Medicare regional carrier guidelines in effect at the time. Pharmacies should access the CMS website for the carrier servicing West Virginia on the date of service.

Coverage of blood glucose testing monitors, other types of diabetic testing supplies, insulin pumps and supplies, and/or syringes and needles for other purposes may be available to members through the Durable Medical Equipment (DME) benefit. See *Chapter 506*, *DME/Medical Supplies Manual* for more detailed information.

Dual eligible members have coverage of diabetic supplies through Medicare. Medicaid will not cover these supplies for dual eligible individuals, except for amounts that may be reimbursed on Medicare Part B crossover.

518.4.4 Medical Supplies

Pharmacies may also be enrolled with West Virginia Medicaid to provide other DME supplies. See *Chapter 506, DME/Medical Supplies Manual* for more information regarding these services.

518.4.5 In-Home Parenteral Therapy (IHPT) Pharmacy Services

Drugs used for in-home parenteral therapy services are covered under the Medicaid Pharmacy Program. These drugs require prior authorization and must be justified by the ordering practitioner, including why oral therapy is unsuitable for the patient. **Members enrolled in Medicaid managed care plans have coverage of IHPT pharmacy services through their managed care plan. Dual eligible members have coverage of IHPT pharmacy services through their Medicare Part D plans.**

See *Appendix 1* for detailed information regarding IHPT pharmacy services.

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518.4.6 Tobacco Cessation Program

West Virginia Medicaid makes tobacco cessation services available to members enrolled in the Traditional Benefits Package and those enrolled with a participating West Virginia Medicaid MCO. For a member not enrolled with a participating West Virginia Medicaid MCO to participate in the program, members are required to enroll through the WV YNOTQUIT Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the quit line program. Additional information regarding the YNOTQUIT Line can be accessed through the beBetter Network at www.ynotquit.com.

For members enrolled in Medicaid managed care plans, West Virginia Medicaid covers tobacco cessation for members in the Enhanced Benefit Package and all children's' benefit packages. Medicaid does not cover tobacco cessation programs for those enrolled in the Basic Adult Benefit Package. The West Virginia Division of Tobacco Prevention, administered through the West Virginia Department for Health and Human Resources' Bureau for Public Health, may also assist in providing services for those who are uninsured or under-insured.

West Virginia Medicaid operates a tobacco cessation program to assist members to discontinue use of tobacco products. In order for members to have access to drugs and other tobacco cessation services, the member is required to see their primary care provider and enroll in the program their managed care plan uses. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are also available through the program. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com.

If a Medicaid member is enrolled in a MCO, please contact the member's MCO for service limitations and all other requirements related to this benefit.

Drugs to treat tobacco cessation are limited to members who register with Medicaid's quit line program. Dual eligible members have coverage of legend drugs through their Medicare Part D plans and coverage of the over-the-counter drugs and quit line services through Medicaid. Drug products are limited to a maximum of:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 168 inhalers per 30 days
- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for those who

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have failed other forms of nicotine replacement therapy.)
- Bupropion – 300 mg. daily

518.5 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid pharmacy services will apply for eligible members as follows:

- Covered drugs are limited to their Food and Drug Administration (FDA) approved or medically accepted indications and dosing limits.
- When appropriate, PDL-preferred drugs must be tried before non-preferred drugs are approved.
- All covered outpatient drugs must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and federal requirements.
- Prescriptions may be written or verbal, and must meet all the federal and state guidelines for legal prescriptions.
- Covered outpatient drugs are reimbursed up to a 34-day supply and may be refilled according to state and federal laws. Certain exceptions apply, for example, most oral systemic antibiotics are covered for a 14-day supply with one refill. Exceptions to this policy may apply if the only available package size of the product is one that exceeds the 34-day supply limit.
- Only those legend drugs for the symptomatic relief of cough and colds that appear on the approved BMS list are covered for this therapeutic indication. Certain over-the-counter cough and cold medications are also covered. The list is available on the BMS website, www.wvdhhr.org/bms. Dual eligible members have coverage of cough and cold medications through Medicaid if these products are not covered by their Medicare Part D or Part C plans.
- Barbiturates are not covered except for phenobarbital and mephobarbital, unless the barbiturate is in combination with another active ingredient. Dual eligible members have coverage of phenobarbital; mephobarbital; and butalbital, acetaminophen, and caffeine combination products through Medicaid if these products are not covered by their Medicare Part D plans. (Note: Combination products of butalbital, acetaminophen, caffeine and *codeine* will be covered by Medicare Part D or Part C plans for dual eligible members.)
- Vitamins and minerals are limited to:
    - Legend vitamins A, D, K, folic acid, B-12 for injection, and niacin
    - Minerals including calcium, iron, magnesium, fluoride and additional mineral requirements for the treatment of End Stage Renal Disease
    - Multivitamins for children through age 20
    - Prenatal vitamins for women through age 45
    - Legend fluoride preparations
- Drugs to treat tobacco cessation are limited to members who register with the YNOTQUIT Program. Dual eligible members have coverage of over-the-counter tobacco cessation products through Medicaid if these products are not covered by their Medicare Part D

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plans; legend tobacco cessation agents are not covered for dual eligible members, as these are covered by the Medicare Part D plans.

- Other drugs may be limited in quantity, duration, or based on gender. See the BMS website, www.wvdhhr.org/bms, for information regarding these drug products and their limitations. Exceptions are considered on a case-by-case basis through the Rational Drug Therapy Program.
- Additional drugs may have quantity limits to assure accurate billing of units.
- Limitations apply to diabetic testing supplies and insulin syringes/needles depending on the member's diagnosis, i.e. insulin dependent or non-insulin dependent diabetes. Medicaid does not cover diabetic supplies for dual eligible members, except for coverage of Part B deductibles and coinsurance amounts. These individuals have coverage for diabetic supplies either through Medicare Part B or Part D.
- Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:
    - Benzodiazepines
    - Barbiturates
    - Over-the-counter medications
    - Agents for the symptomatic relief of cough and cold symptoms
    - Prescription vitamins and minerals
- Members enrolled in the Mountain Health Choice's (MHC) Adult basic plan are limited to coverage of four prescriptions per calendar month.

  The following therapeutic classes will not count toward the 4-prescription limit:

    - Diabetic supplies and all insulins,
    - Atypical antipsychotics,
    - Antidepressants(all therapeutic classes),
    - Drugs used for the treatment of HIV/AIDS,
    - All contraceptives.

518.6 COVERAGE OF BRAND NAME VERSUS GENERIC DRUGS

Brand name multi-source legend drugs that have therapeutic equivalents available will be denied for payment. Generic drugs must be substituted, if available. In certain instances, pharmacies may indicate brand name drug usage on submitted electronic and paper pharmacy claims by using Dispensed as Written (DAW) codes. The DAW codes that are recognized by West Virginia Medicaid and can be used by providers to explain the dispensing of a brand name product instead of a generic one are as follows:

DAW 1 - Prescriber states that the brand name drug is "medically necessary". This information must be supplied in writing by the **prescriber** via written prescriptions in their own handwriting, and must write on the prescription "Brand Medically Necessary". A check-box or other methods to indicate that the brand should be dispensed shall not be accepted. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.

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DAW 4 - A generic equivalent is not available or not stocked at the time of dispensing. This code shall only be used when a generic drug is sold out or a generic drug is unavailable on a wide-spread basis. *It shall not be used routinely to circumvent the mandatory generic program for reasons other than these.*

DAW 5 - Pharmacy uses this brand as a generic and realizes it will be paid at the generic rate.

DAW 6 - Pharmacy is dispensing a generic drug that has been identified by the drug database as a brand name drug due to pricing issues. These generic drugs have high Average Wholesale Prices (AWP) in relation to other generic drugs that are available. An effort shall be made to obtain lower-priced alternatives.

- For auditing purposes, documentation shall be made on the prescription to justify use of the DAW codes.
- All other DAW codes that are recognized by NCPDP are not active in the West Virginia Medicaid Program and will not affect the processing of claims if submitted.
- The use of DAW codes is not permitted for non-preferred drugs included in the Preferred Drug List program. Completion of an FDA MedWatch form is required for the failure of a generic product to produce the same outcome as the equivalent brand name drug. The MedWatch form shall be sent by mail or fax to the Rational Drug Therapy Program. The MedWatch form may be accessed from the FDA website at www.fda.gov/medwatch/SAFETY/3500.pdf
- Please note that some generic drugs may be classified as non-preferred by West Virginia Medicaid and require prior authorization. This occurs when brand name drugs are less expensive to Medicaid due to supplemental rebate negotiations. In this case, the pharmacy will be required to dispense the brand name drug instead of the generic equivalent.

518.7 NON-COVERED SERVICES

The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose

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- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 21 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.

518.8 PRIOR AUTHORIZATION (PA)

Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable until appealed by the prescribing practitioner on behalf of the member.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Federal regulations state that Medicaid-covered drugs that require PA must have a 24-hour turnaround for responses. In emergent situations, a 72-hour supply of medication must be made available to members until the PA process can be completed. No more than a 72-hour supply shall be dispensed. Submitting a quantity greater than a 72-hour supply constitutes an improper claim unless it is for a package that cannot be broken. If a product package cannot be broken, then the whole package may be dispensed, if necessary, to meet the member's needs. Documentation of this action shall be made on the prescription for auditing purposes. Repeated

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submissions of 72-hour supplies for the same patient and same drug to circumvent the prior authorization process constitute an improper billing method. This practice is subject to audit.

518.8.1 Process of Requesting Prior Authorization

The Rational Drug Therapy Program (RDTP) is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy Program. RDTP is a non-profit organization affiliated with the West Virginia University School of Pharmacy.

Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied, except in cases of back-dated eligibility. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that he/she will be responsible for the bill.

There is a maximum approval limit of one year.

Prior authorization requests shall include the following:

- Member name and address
- Member Medicaid identification number
- Name of drug, strength, dosage, and duration of treatment
- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug
- Return fax number
- Signature of prescriber or pharmacist

Rational Drug Therapy Program's operating hours are:
Monday through Saturday – 8:30 AM until 9:00 PM
Sunday – 12 noon until 6:00 PM

Prior authorization forms can be downloaded from the Rational Drug Therapy Program's website at www.hsc.wvu.edu/sop/rdtp/. These forms may be duplicated.

518.8.2 Prior Authorization Appeals Process

If a prior authorization request is not approved, the prescriber may appeal the decision to the Rational Drug Therapy Program Appeals Department in writing (first level appeal). Requests must include the following information:

- Member name and address
- Member Medicaid identification number

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- Name of drug, strength, dosage, and duration of treatment
- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug, including any other treatments that have been tried
- Supporting literature
- Return fax number
- Signature of prescriber

Office and/or hospital notes, including signed ones, are not acceptable and do not constitute an appeal.

Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787.

All appeals denied by RDTP will be sent to BMS for physician review. Any denial resulting from physician review is final. The Medicaid member is notified of this denial and of their right to request a fair hearing.

518.9 DRUG UTILIZATION REVIEW (DUR)

The Omnibus Budget Reconciliation Act (OBRA ’90) required that states establish a Drug Utilization Review (DUR) program. The DUR program must consist of prospective and retrospective components as well as components to educate physicians and pharmacists on common drug therapy problems and assessments of whether usage complies with predetermined standards. In order to meet the requirements of the statute, the DUR program must assure that prescriptions are appropriate, are medically necessary, and are not likely to result in adverse medical results. The two primary objectives of DUR systems are (1) to improve quality of care; and (2) to assist in containing health care costs.

The establishment of a DUR Board was required by OBRA ’90. This Board, consisting of local pharmacists, physicians, and other healthcare providers from around the state, is charged with making recommendations for educational interventions to prescribers and pharmacists to identify and reduce, for both providers and patients, the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care. Specific drugs or classes of drugs may be targeted in regard to:

- Therapeutic appropriateness
- Over utilization
- Under utilization
- Appropriate use of generic products
- Therapeutic duplication(same or different prescriber)
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage
- Incorrect duration of drug treatment

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- Drug-allergy interactions
- Clinical abuse/misuse

The West Virginia Medicaid DUR Board meets quarterly to discuss methods of achieving the goals of assuring the appropriate use of drugs in the Medicaid program. These meetings are open to the public. The DUR Board also assists BMS in defining criteria for coverage of drugs that require prior authorization. Meeting agendas, minutes, and other DUR information are available on the Bureau for Medical Services' website, www.wvdhhr.org/bms.

Detailed DUR Event parameters can also be found on the BMS website at www.wvdhhr.org/bms.

518.9.1 Prospective Drug Utilization Review (DUR)

Prospective DUR is conducted at the pharmacy Point-of-Sale (POS) before delivery of a medication by the pharmacist to the Medicaid member or caregiver. Prescription claims are screened to identify potential drug therapy problems of the following types:

- Therapeutic duplication
- Ingredient duplication
- Adverse drug-drug interactions
- Early refill
- Late refill
- High dosage
- Low dosage
- Incorrect duration of drug treatment
- Age/gender precaution
- Pregnancy precaution
- Breast feeding precaution

Dispensing pharmacists use the information provided by the pharmacy POS and their professional judgment to determine if the prescription shall be filled. The pharmacist determines the appropriateness of the prescribed therapy and intervenes with the prescribing physician and/or member in the event of a suspected problem.

Pharmacists may continue to process claims that contain prospective DUR messages by using DUR outcome and intervention codes. A call to the RDTP help desk may be required in certain instances as determined by BMS. More detailed information regarding DUR procedures is found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, found on BMS' link to the fiscal agent website, www.wvdhhr.org/bms.

518.9.2 Retrospective Drug Utilization Review

Retrospective Drug Utilization Review is required in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid members, or associated with specific drugs or groups of drugs. West Virginia

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Medicaid conducts retrospective DUR with the assistance of a vendor. They provide patient profiles addressing drug use that may be inappropriate based on predetermined standards. A Retrospective DUR Committee, consisting of healthcare professionals, meets monthly to review these patient profiles that are used to generate letters to physicians and pharmacists relating to these issues.

518.9.2.1 Pharmacy Lock-in Program

Members who use pharmacy services excessively or inappropriately may be assigned to a single pharmacy provider where they receive their Medicaid-covered medications. The purpose of this program is to assist beneficiaries in using pharmacy services appropriately.

As part of this program, the Retrospective DUR Committee reviews Medicaid member utilization profiles to determine if controlled substances are being used at a frequency or amount that results in a level that may be harmful or not medically necessary. Inappropriate utilization can include frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, overlapping prescription drugs within the same drug class and drug seeking behavior, i.e., doctor shopping.

A series of letters is sent to prescribers and/or the member to seek information regarding his/her drug utilization or to warn that continued over utilization may result in restricting the member to a single pharmacy provider. If the pharmacy lock-in criteria are met, the member is given the opportunity to select a pharmacy, but pharmacy participation is voluntary. Pharmacists serving these members are requested to use their professional judgment in regard to filling prescriptions for controlled substances.

518.9.3 Reporting of Cash Payments

Pharmacies are encouraged to report to BMS when a member pays cash for prescriptions that would otherwise be covered by Medicaid or considered for reimbursement upon a call to the RDTP, or when the pharmacy provider suspects overutilization by the member. A form used for this reporting can be found on the BMS website, www.wvdhhr.org/bms. The form should be faxed to BMS at 304-558-1542. Information collected through this process may be used for member lock-in consideration and continued eligibility.

518.9.4 Member Counseling

OBRA ’90 requires that pharmacists offer counseling to Medicaid patients and must include the following:

- Name and description of the medication;
- The route of administration, dosage form, dosage, and duration of therapy;
- Special directions and precautions for preparation, administration and use by the patient;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- Techniques for self-monitoring prescription therapy;

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- Proper storage;
- Prescription refill information; and
- Action to be taken in the event of a missed dose.

The West Virginia Medicaid program relies on the West Virginia Board of Pharmacy to monitor these activities, but BMS may audit these requirements through routine or special reviews.

518.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, General Provider Participation Requirements*, and *Chapter 800, General Administration*, of the Provider Manual.

Prescriptions must comply with the regulations of the West Virginia State Board of Pharmacy as to content requirements and must be kept for a period of five years. Prescription records must be made available to BMS upon request.

518.10.1 Tamper-resistant prescription pad requirement

All prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meet all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS). The three characteristics to meet the tamper-resistant prescription requirement:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription, and;
3. Prevent the use of counterfeit prescription forms.

Written prescriptions must contain **ALL** of the following:

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax.

Feature	Description
Uniform non-white background color – *preferably green*	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If an attempt is made to erase copy – the consistent background color will look altered.
Quantity check off boxes	In addition to the written quantity on the prescription, quantities are indicated in ranges of 25's (or some other, similar range). Box MUST be checked for this feature to be valid.
Refill indicator	Refill indicator (circle or check number of refills or "NR"). Refill indicator must be used to be a valid feature.

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Feature	Description
Security features and descriptions listed on the front of the prescription	Listing of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the pads/paper.

Computer-generated prescriptions, EMR, or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance, provided they contain the features listed in the table below. Prescribers are urged to contact their software companies to ensure that computer generated prescriptions have all requirements necessary for tamper resistance.

Computer-generated prescriptions must contain the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax. *This requires the purchase of special paper.*
OR	
Micro print signature line	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

Feature	Description
UNIFORM NON-WHITE BACKGROUND COLOR – *PREFERABLY GREEN* OR "Toner-lock" paper for laser printed prescriptions, or plain bond paper for inkjet printed prescriptions	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If someone tries to erase copy – the consistent background color will look altered. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from the inkjet printers is absorbed into normal "bond" paper.
QUANTITY WRITTEN AND QUANTITY WITH BORDER CHARACTERISTICS FOR COMPUTER GENERATED PRINTED PRESCRIPTIONS	Quantity written and Quantity surrounded by special characters such as asterisks to prevent modification, e.g. *QTY Fifty ***50****.*
Refill written and refill with border characteristic for computer	Refills written and Refill surrounded by special characters such as asterisks to prevent modification, e.g. *Five refills ****5 refills*****.*

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generated printed prescriptions	

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
SECURITY FEATURES AND DESCRIPTIONS LISTED ON THE PRESCRIPTION	A complete list of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the paper.

Prescriptions for West Virginia Medicaid members written by prescribers that reside outside of West Virginia may meet the federal tamper-resistant prescription requirement if the prescription addresses the three distinct characteristics outlined above, and may contain the same or other features than those adopted by BMS.

518.10.2 Prescriptions Returned to Stock

Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis, within 15 days. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

518.10.3 Nursing Home Returns

Drugs dispensed to nursing home residents that are not used by the member must be either returned to the dispensing pharmacy or destroyed according to applicable rules and regulations. Drugs that are returned unused by the Medicaid member and are available for re-dispensing, per West Virginia State Board of Pharmacy rules and regulations, must be credited to Medicaid.

Claims for these returned medications must be reversed and resubmitted for the quantity used by the member.

518.10.4 Shipping/Receiving

Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process, as Medicaid will not reimburse for medications not received by the member.

518.11 BILLING PROCEDURES

Claims for prescribed drugs dispensed to Medicaid members may be submitted electronically using the Point-of-Sale system or on paper claim forms. Claims must be filed within 12 months from the date of service.

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Submitting claims via electronic media offers the advantage of speed and accuracy in processing. All claims, regardless of method of submission, are subject to drug utilization review edits, prior authorization, and other Medicaid requirements.

Medications for West Virginia Medicaid members must be dispensed at the facility from which the drug products are prepared and the services rendered.

Claims must accurately report the NDC dispensed, the number of units dispensed, days' supply, and other required data for claims processing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause BMS to report false data to drug manufacturers when billed for drug rebates. BMS will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers or during claim reviews. Pharmacies are required to submit documentation for purchases of drugs reimbursed by BMS upon request.

518.11.1 Point-of-Sale System

Currently, online processing for Medicaid pharmacy claims is available for all pharmacies using NCPDP Version 5.1. The provider must complete and submit the provider trading partner agreement prior to use of Point-of-Sale submission for claims.

See the Molina Health PAS-Rx Pharmacy Point-of-Sale (POS) User Guide for complete billing instructions for the Point-of-Sale system. See the Pharmacy Point-of-Sale (POS) NCPDP Version 5.1 Vendor Specification Document, for specifications and information for switch vendors. These documents and other information are located on the BMS' link to the fiscal agent website.

518.11.2 National Council on Prescription Drug Programs (NCPDP) Payer Sheet

West Virginia Medicaid accepts pharmacy Point-of-Sale claims submitted using NCPDP Version 5.1 or Batch Version 1.1. According to the NCPDP accepted standards, some fields are required, optional, or conditional. See the Pharmacy Point-of-Sale (POS) NCPDP Version 5.1 Vendor Specification Document, located on BMS' link to the fiscal agent website, for the West Virginia Medicaid payer sheet.

518.11.3 Paper Claim Submission for Pharmacy Services

Pharmacies have the alternative of submitting a manual claim using a paper claim form, when necessary. The Universal Claim Form (UCF) provides a standard format for paper submission of drug claims to Medicaid. The UCF adheres to the data elements found in the Telecommunication Standard and Data Dictionary. The new UCF that supports the Telecommunication Standard Version 5.1 is "DAH 2 PT". **Medicaid will not supply these forms to providers**. NCPDP has an agreement with R.R. Donnelley to distribute the UCF. Their telephone number is 1-800-635-9500. The order number for the UCF is Laser UCF form, number UCFL 1. Forms are also available from pharmaceutical wholesalers. An example of the UCF and completion instructions can be found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, located on BMS'

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link to the fiscal agent website, www.wvdhhr.org/bms.

518.11.4 Claim Reversals

Pharmacy claims submitted by Point-of-Sale cannot be adjusted. To correct information submitted on a Point-of-Sale claim, the claim shall be reversed online and then resubmitted using the corrected information. There is currently no paper reversal claim form. If a paper claim submission requires corrections, the pharmacy Help Desk shall be contacted.

518.11.5 Pharmacy Identification Number

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the use of the National Provider Identifier (NPI) as the standard for identifying covered healthcare providers, including pharmacies. Pharmacies must use their NPI number on electronic submissions for reimbursement of pharmacy claims. NCPDP numbers will no longer be accepted on electronic claims. The NPI or NCPDP number will continue to be used on the approved paper claim form. For additional NPI information or to complete an NPI application, visit the CMS website, https://nppes.cms.hhs.gov.

518.11.6 Prescriber Identification Number

The National Provider Identifier (NPI) is required for the prescriber identification information on electronic POS claims. Either the DEA number or the NPI is allowed on the manual claim form (UCF).

Only prescribing NPI entities are permissible. Claims submitted with non-prescribing NPI entities will be denied, including but not limited to pharmacies, laboratories, hospitals, and dialysis centers.

518.11.7 National Drug Codes (NDC)

All pharmacy claims submitted to West Virginia Medicaid must identify the 11-digit NDC printed on the stock container in which the drug was purchased. **Using the correct NDC is extremely important in order to avoid disputes with manufacturers for rebate payments**. For example, if a drug is purchased in a 5000-count bottle and repackaged in 100-count bottles prior to dispensing, submitting the NDC for a 100-count bottle is not permitted. Most drugs distributed by repackagers are not covered by Medicaid because the repackager has not signed a rebate agreement with CMS. A pharmacy may not dispense a repackager's drug and then bill Medicaid using the original manufacturer's NDC.

518.11.8 Decimal Units

The Medicaid pharmacy system is capable of accepting quantity amounts which contain decimal units. Pharmacy claims must be submitted using the standard units, including any decimal increments. Units must not be rounded up or down. Rounding results in over or under payments and creates inaccurate invoicing to manufacturers for the drug rebates owed to the state.

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518.11.9 Days Supply

Each Medicaid-covered prescription is limited to a maximum supply of 34-days, with some exceptions. These exceptions are to accommodate packaging that cannot be broken. The following are examples of drugs that may be submitted as specified below:

Seasonal	91-day supply
Depo-Provera 150mg/ml	90-day supply

The pharmacist is responsible for submitting prescription claims up to this limit. Should a prescription be written for a quantity that is greater than the allowed limit, the pharmacist is responsible for notifying the prescriber of this limit and asking permission to reduce the number of units to be dispensed.

If the prescriber does not allow the prescription quantity to be reduced, the member shall be told that the cost of the prescription is his/her responsibility. Filling a prescription for a 34-days supply when the prescription is intended to last longer constitutes a false claim and is subject to recovery of the paid amounts.

518.11.10 Compounded Prescriptions

A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a covered legend drug. The covered legend drug must be the first NDC submitted on a compounded prescription claim. DESI drugs or non-covered drugs **not appearing as the first NDC** in a compounded product will not cause the claim to deny, but those ingredients will not be included in the reimbursement. Over-the-counter (OTC) ancillary products will be reimbursed provided the drug is manufactured by a company which participates in the federal drug rebate program. A compound may contain up to 25 ingredients.

Products such as suppository molds and other items identified as supplies included in a compounded prescription will not be reimbursed by West Virginia Medicaid.

Billing compounded prescriptions follows NCPDP Version 5.1 guidelines. More information can be found in the User Guide, located on BMS' link to the Fiscal agent website, www.wvdhhr.org/bms.

518.11.11 Abuse and Inappropriate Utilization

The following practices constitute abuse and inappropriate utilization, and are subject to audit:

- Excessive fees (commonly known as prescription splitting or incorrect or excessive dispensing fees): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:

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- Supplying medication in amounts less than necessary to cover the period of the prescription; and/or
- Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.

- Excessive filling: Billing for an amount of a drug or supply greater than the prescribed quantity.
- Prescription shorting: Billing for 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.
- Automatic filling of prescriptions or automatic shipping of medications to the member is prohibited unless members request the filling or shipping of these medications each time.

518.11.12 Lost/Stolen Medications

For members who report to the pharmacy that their medications have either been lost or stolen, the following procedure applies:

- The member must supply the pharmacy with a police report for stolen controlled substances; the pharmacy must retain a copy for audit purposes.
- The prescribing practitioner must agree that the lost or stolen medication shall be replaced.
- Lost/stolen medication approvals are limited to one occurrence per drug per year.

518.11.13 Wasted Medication

Members who have wasted medication due to improper use or storage may have their medication replaced. This will be determined on a case-by-case basis. Members shall be properly instructed on the storage and use of their medications and any special delivery device used to administer their medications. Requests for replacement of wasted medications due to improper storage or delivery by the pharmacy will be denied.

518.11.14 False Claims

Pharmacies are prohibited from submitting false claims to test for drug coverage, member eligibility, or for other purposes. Claims of this type result in false member drug history records and may result in the member or prescriber being included in lawsuits or reviews in error. All claims submitted for reimbursement must be the result of actual prescription requests.

518.12 REIMBURSEMENT

Federal Medicaid regulations governing pharmacy services establish upper limits for payment; i.e., the payment shall be based on the lower of the allowable cost of the drug, plus a dispensing fee or the provider's usual and customary charge to the general public.

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Reimbursement for outpatient drugs is limited to products manufactured by companies participating in the Federal Drug Rebate Program.

518.12.1 Ingredient Cost

Maximum reimbursement for each drug claim processed will be based on the lowest of:

(1) The usual and customary charge to the general public;

(2) The Maximum Allowable Cost (MAC) plus a reasonable dispensing fee. The MAC for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal Register, plus a dispensing fee. A listing of Federal Multiple Source Drug Limits is available on the CMS' website, www.CMS.hhs.gov/Reimbursement.

> **EXCEPTION**: The MAC shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by BMS.

(3) The State Maximum Allowable Cost (SMAC), plus a dispensing fee;

State Maximum Allowable Cost (SMAC) rates are established with the assistance of a vendor. Rates are determined by using 130% of the lowest Wholesale Acquisition Cost (WAC) as provided by national drug information suppliers for 3 manufacturers of the same drug product or, based upon a mean average of pharmacy provider costs obtained through a survey of a percentage of pharmacy providers that are representative of the overall geographical distribution, service volume, and business structures of all pharmacies serving the West Virginia Medicaid Program. This mean average methodology is used to adjust the pricing in accordance with drug market competition and to establish SMAC pricing in those instances where less than 3 manufacturers are supplying products in a specific drug market.

The SMAC rate is applied to all brand and generic drug products in each drug group. Non-AB rated drugs recognized by national drug information suppliers as comparable to a particular brand drug is subjected to the same SMAC rate applicable to the brand and "AB" rated generic drugs of the same chemical composition, package size, dose, and drug group.

The determination of which drugs will be part of the SMAC list will be designated by BMS. Drugs no longer available at the SMAC price are removed. New drugs will be added to the SMAC as they are identified. The vendor on behalf of BMS will continually monitor

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pharmacies and industry information and make changes to the SMAC to reflect current pharmaceutical market conditions.

The SMAC list is available on the BMS website at www.wvdhhr.org/bms. Comments and questions regarding the SMAC list can be made to the vendor.

(4) The Medicaid AWP (MAWP) established by the Federal Office of the Inspector General, plus a dispensing fee;

(5) Estimated Acquisition Cost (EAC), plus a dispensing fee. The EAC is defined as Average Wholesale Price (AWP) minus 15% for brand name drugs and AWP minus 30% for generic drugs.

518.12.2 Application of Dispensing Fee

- For covered legend and over-the-counter drugs, a professional dispensing fee of $2.50 per prescription for brand name drugs or a professional dispensing fee of $5.30 per prescription for generic drugs will be added to the federally established MAC, state established MAC, Medicaid AWP, or state established EAC of each prescribed drug.

- Pharmacies participating in the 340b program, upon completion of the Certification form and submission of the required documentation, are paid a dispensing fee of $8.25 for each paid prescription for drug items dispensed to Medicaid members. These pharmacies are required to submit their actual acquisition costs to Medicaid. This policy is limited to those pharmacies located within Federally Qualified Health Centers (FQHC).

- For a compounded prescription, an additional $1.00 will be added to the dispensing fee. A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a legend drug.

- The dispensing fee may only be paid once every 30 days per drug entity for members residing in ICF/MR or nursing facilities.

- Claims paid on the basis of the usual and customary charge to the general public do not include an additional dispensing fee.

518.12.3 Co-Payments

A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

- If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription

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- If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
- If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
- If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

- Prescriptions for family planning services and supplies
- Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
- Prescriptions for pregnant women
- Prescriptions for members under 18 years of age
- 3-day emergency supplies
- Diabetic testing supplies and syringes/needles
- BMS approved home infusion supply
- POS-approved vaccines

Members have been informed of co-payment requirements and the exclusions from co-payment. Federal regulations stipulate that no provider may deny services to an eligible individual in situations when the member is unable to pay co-payment charges. However, this does not extinguish the liability of the member receiving the services for payment of the co-payment charge to the provider.

Providers may bill the member or refer the member to a collection agency, etc., in the same manner that the provider initiates collections from private pay customers. If it is the routine business practice of the provider to refuse service to any individual, regardless of payer source, for uncollected debt, the provider may refuse future services to Medicaid members if adequate prior notice is provided.

Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility.

518.12.4 Third-Party Liability (TPL) or Coordination of Benefits (COB)

Medicaid is payer of last resort. TPL ensures that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Before submitting claims to Medicaid, providers must pursue all requirements of the primary insurer including, but not limited to prior authorization, brand name justifications, and Drug Utilization Review events.

Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The "third party" may be an individual, institution, corporation, or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits,

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CHAMPUS, Medicare, Hospice, etc. Additionally, no Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan.

Medicaid covered drugs which currently require a prior authorization (PA) from BMS will continue to require a PA if a primary insurer approves that service, and Medicaid reimburses any part of the cost.

Medicaid co-payment is still required, if applicable, for claims considered by third party payers and reimbursed by BMS.

Chapter 600, Reimbursement Methodologies, of the Common Chapters of the Medicaid Manual provides more detailed information regarding Third Party Liability.

See the User Guide for billing instructions for NCPDP Version 5.1 in regard to Coordination of Benefits.

518.12.4.1 Medicare-Covered Drugs & Supplies, Part B

Pharmacies are required to verify and pursue members' Medicare coverage and to submit pharmacy claims to Medicare for those pharmacy services covered by Medicare. Pharmacies can submit claims to Medicare Part B either on the acceptable paper claim form (CMS 1500) or electronically. Once the Medicare claim has been approved and processed, Medicare will automatically submit the balance of the claim as a "crossover" to Medicaid electronically, if the provider's Medicare number is on file with Medicaid. These claims should not be submitted to Medicaid separately if the claim crossed over from Medicare.

For Dually Eligible Beneficiaries and Qualified Medicare Beneficiaries (QMB), if the service is covered by Medicare and Medicaid, Medicaid will pay the lesser of:

- The full coinsurance and deductible amounts due, based upon the Medicare allowed amount, or
- Medicaid's maximum allowable fee for that service minus the amount paid by Medicare.

For Qualified Medicare Beneficiaries (QMB), if the service is not covered or is denied by Medicare, Medicaid will not reimburse.

Drugs that are not covered by Medicare Part B may be covered by Medicare Part D. Medicaid does not reimburse for Part D co-payments.

518.12.4.2 Medicare Covered Drugs, Part D

Dual eligible members have prescription drug coverage through Medicare Part D. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

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- Benzodiazepines
- Barbiturates
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Medicaid does not reimburse for Medicare Part D co-payments. Medicaid does not pay as the secondary payer on Medicare Part D covered drugs.

518.13 HOW TO OBTAIN INFORMATION

An effective medical assistance program is dependent upon the support and cooperation of the providers of medical care and services. The fiscal agent is responsible for establishing and maintaining communication with providers participating in the program. Appropriate staff is available to respond to inquiries regarding program issues.

518.13.1 Policy/Reimbursement

For assistance with issues of program policy or reimbursement, contact Provider Relations, P. O. Box 2002, Charleston, West Virginia 25327-2002; telephone 1-888-483-0793, (West Virginia and border providers); all other providers, (304) 348-3360.

518.13.2 Point-of-Sale (POS)

For assistance with POS claims submission, contact the pharmacy POS help desk, Rational Drug Therapy Program. The telephone number is 1-800-847-3859.

518.13.3 Prior Authorization

For obtaining a prior authorization for a prescribed drug, contact the Rational Drug Therapy Program, Robert C. Byrd Health Sciences Center, Post Office Box 9511; Morgantown, West Virginia 26506-9511, telephone 1-800-847-3859, fax 1-800-531-7787.

518.13.4 Additional Information

For obtaining additional information, refer to the following:

SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
Pharmacy Program Director	Bureau for Medical Services	304-558-1700	304-558-1542
Drug Utilization Review	Bureau for Medical Services	304-558-1700	304-558-1542
Drug Rebate	Bureau for Medical Services	304-558-1700	304-558-

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SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
			1542
Point-of-Sale Help Desk	Rational Drug Therapy Program	800-847-3859	800-531-7787
Prior Authorization	Rational Drug Therapy Program	800-847-3859	800-531-7787
Eligibility	Voice Response System	888-483-0793	
Eligibility Assistance	Bureau for Medical Services	304-558-1700	304-558-1776
Technical support	Molina Help Desk	888-483-0801	
AIDS Drug Assistance Program (ADAP)	Program Director	304-232-6822	740-695-3252
Children with Special Health Care Needs	Office of Maternal, Child, and Family Health	800-642-9704	304-558-2866
Member Denials	Molina Client Services	888-483-0797 800-642-8589	
State Maximum Allowable Costs	Goold Health Services (GHS)	800-340-5970	

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal laws and regulations.

CHAPTER 518
PHARMACY SERVICES

APPENDIX 1
WEST VIRGINIA MEDICAID PHARMACY PROGRAM
IN-HOME PARENTERAL THERAPY
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REVISED NOVEMBER 1, 2010

WEST VIRGINIA MEDICAID PHARMACY PROGRAM
IN-HOME PARENTERAL THERAPY (IHPT)

DEFINITIONS

Antineoplastic - an agent that prevents the development, growth or proliferation of malignant cells.

Chemotherapy - the administration of chemical agents designed to have a specific effect upon disease causing cells or organisms.

In-Home Parenteral Therapy or IHPT - the parenteral administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting.

Parenteral - all routes of administration of substances other than via the gastrointestinal canal. This includes intravenous, subcutaneous, intramuscularly, intrathecal, or epidural and less commonly, mucosal (as in intravaginal).

Total Parenteral Nutrition (TPN) - the administration of nutritional substances by intravenous infusion to nourish members who are not candidates for enteral support.

INTRODUCTION

In-home parenteral therapy (IHPT) is a Medicaid covered service. Medicaid coverage for this service will include drugs and services that are:

- Medically necessary
- Prescribed by a licensed physician
- Administered via central line, peripheral line, infusion port, epidural, intrathecal or subcutaneous site
- Provided by a licensed pharmacy enrolled with the State of West Virginia Department of Health and Human Services, Bureau for Medical Services (BMS)
- Billed via electronic transmission according to standard guidelines or on the approved pharmacy paper claim form
- Prior authorized as directed by BMS

PROVIDER REQUIREMENTS AND RESPONSIBILITIES

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, IHPT providers must:

- Submit an IHPT Medicaid Provider Enrollment Form to the Bureau for Medical Services.
- Submit a copy of the provider's West Virginia Board of Pharmacy (WV BOP) Sterile Compounding Permit or respective state Board of Pharmacy Sterile Compounding Permit.

Participating pharmacies that bill services for West Virginia Medicaid members shall be subject to the laws and regulations set forth by the WV BOP that govern the requirements to hold a Sterile Compounding Permit.

MEMBER REQUIREMENTS

Members receiving In-Home Parenteral Therapy must meet the following requirements:

- The member must reside in either a private home or domiciliary care facility, such as an adult care residence. Members who are residents or patients of a hospital, nursing home (including ICF/MR group homes), rehabilitation centers, and other institutional settings are not eligible for this service.
- The member must be under the care of a physician who prescribes the in-home infusion therapy and monitors the progress of the therapy.
- The member must have sites available for intravenous catheters or needle placement or have central venous access.
- The member must be capable of self administering or have a nurse or a caregiver who can be adequately trained, capable and is willing to administer/monitor home infusion therapy safely and efficiently following appropriate teaching and adequate monitoring.

PRIOR AUTHORIZATION

All IHPT services require prior authorization. Requests must be made through the Rational Drug Therapy Program (RDTP).

See the BMS web site at www.wvdhhr.org/bms for the approved prior authorization form.

- **Pre-mixed Solutions or products requiring no compounding**

  Pre-mixed solutions or products include those injectable items that do not require compounding by the pharmacist because a) the items are marketed as pre-mixed, thus requiring no dilution and/or compounding, or b) compounding is performed by the patient, the nurse or the caregiver. Commercially prepared products are mandated to be dispensed if available. Compounded products and related professional services shall not be reimbursed when the commercially prepared product is available.

  The request for prior authorization must include the diagnosis, duration of therapy, prescribing physician information, and appropriate documentation. The prior approval will be effective from the date of physician's original order and continue for the specified length of therapy unless there is a change in prescription or level of care. Changes in therapy require new prior authorizations. Written requests for prior authorization must be submitted via fax or mail to the RDTP on form IV-1. This form can be found at the BMS website at www.wvdhhr.org/bms.

- **Products requiring compounding**

  Certain injectable products require compounding in order to meet the needs of the member, and are not available commercially.

  The request for prior authorization must include the diagnosis, duration of therapy, prescribing physician information, and appropriate documentation. The prior approval will be effective from the date of physician's original order and continue for the specified length of therapy unless there is a change in prescription or level of care. Changes in therapy require new prior authorizations. Written requests for prior authorization must be submitted via fax or mail to the RDTP on form IV-1. This form can be found at the BMS

website at www.wvdhhr.org/bms. Signed physicians orders for compounded IHPT medications must be provided to RDTP if reimbursement for compounding activities is requested.

Refer to *Chapter 506, DME/Medical Supplies Manual*, for the policy governing parenteral nutrition.

BILLING AND REIMBURSEMENT VIA POINT-OF-SALE

Billing for IHPT claims is accomplished through NCPDP Version 5.1 electronic or 1.1 batch (paper claim) system. Instructions for the processing of claims are found in the general pharmacy manual information.

The active ingredient(s) for each prescription is/are to be billed using the National Drug Code (NDC) and its respective unit of use. The drug portion of IHPT will be reimbursed online according to the current reimbursement policy. The codes used for the reimbursement of compounding services are inclusive of but not limited to diluents for reconstitution, IV fluids, and other supplies used in the compounding process.

Billing shall correspond to those items and fees reflecting therapy for a duration of a maximum of 34 days as prior authorized by RDTP. If the order is discontinued, any therapy that has been billed but not delivered to the member, must be reversed.

- **Pre-mixed Solutions or products requiring no compounding**
  After receiving prior authorization, prescriptions for items which are dispensed with no compounding requirements shall be submitted for payment via Point-of-Sale or approved paper claim form using the NDC number of the product and the quantity dispensed. Reimbursement will be made using the established retail reimbursement policy. (Do not use the NCPDP compound indicator).

- **IV Drugs Requiring Compounding**
  Products for IHPT requiring compounding involve billing in multiple parts. Drug components shall be submitted online or on the approved paper claim form using the actual NDC's that were used and quantity of each drug component, as approved by the Rational Drug Therapy Program. Use the NCPDP compound indicator when the product includes multiple agents. Please note: reimbursement for the diluting agent is included in the compounding fee and shall not be billed as a component of the compounded IHPT product if reimbursement for a compounding fee is requested.

- **Compounding Fee**
  The compounding fee which includes all components of the prescription compounding, such as sterile water, alcohol swabs, IV fluids, needles/syringes, etc., and professional services shall be submitted online or on the approved paper claim form. The authorization for reimbursement of the compounding fee will be issued from RDTP upon receipt of a copy of the signed order from the prescribing physician. (Do not use the NCPDP compound indicator).

- **Units Dispensed**
  Units are defined by First DataBank product classification. In general, if a drug requires reconstitution, the units submitted will be the number of vials. For example, a 2 gm vial of cephazolin is submitted as a quantity of "1" for each vial. If the drug or component is available in solution, the units are submitted in milliliters. For example, a 2ml vial of

gentamicin injection (80mg/vial) is submitted as “2” for each vial. The actual amount used in compounding shall be submitted. Wastage shall be kept to a minimum. The units dispensed must match the amount prior authorized by RDTP.

The RDTP Help Desk is available to assist providers with questions regarding proper unit billing. In all cases, the amount and duration of therapy for which BMS is billed must match those ordered by the physician and delivered to the member.

- **Brand Name Justification**

  If a drug being dispensed is a product for which a generic equivalent exists, the generic must be dispensed. The use of brand name products must be justified, as referenced in the general pharmacy instructions.

- **Supplies**

  Refer to *Chapter 506, DME/Medical Supplies Manual* for coverage policy and billing instructions for supplies associated with IHPT.

ASSIGNED NDC CODES FOR IHPT COMPOUNDING

CODES AND DESCRIPTIONS:

TABLE OF PROGRAM-ASSIGNED NDC NUMBERS FOR THE SUPPLY/COMPOUNDING PORTION OF THE ANTIBIOTIC/CHEMO/HYDRATION/PAIN MANAGEMENT HOME IV THERAPY CLAIM

ANTIBIOTIC THERAPY

	Every 24 hrs	Every 18 hrs	Every 12 hrs	Every 8 hrs	Every 6 hrs	Every 4 hrs	Every 3 hrs
Bag	**$15.92** **99999-2124-00**	**$14.04** **99999-2118-00**	**$12.23** **99999-2112-00**	**$11.02** **99999-2108-00**	**$10.42** **99999-2106-00**	**$9.81** **99999-2104-00**	**$9.50** **99999-2103-00**
Syringe	**$11.54** **99999-2224-00**	**$9.73** **99999-2218-00**	**$7.92** **99999-2212-00**	**$6.71** **99999-2208-00**	**$6.11** **99999-2206-00**	**$5.50** **99999-2204-00**	**$5.19** **99999-2203-00**
Cassettes	**$33.60** **99999-2424-00**		**$29.98** **99999-2412-00**				

CHEMOTHERAPY

	Every 24 hrs	Every 18 hrs	Every 12 hrs	Every 8 hrs	Every 6 hrs	Every 4 hrs	Every 3 hrs
Bag/Syr.	**$17.02** **99999-3424-00**	**$15.21** **99999-3118-00**	**$32.71** **99999-3412-00**	**$12.19** **99999-3108-00**	**$11.59** **99999-3106-00**	**$10.98** **99999-3104-00**	**$10.67** **99999-3103-00**
Cassettes	**$36.33** **99999-3424-00**		**$32.71** **99999-3412-00**				

PAIN MANAGEMENT/CHEMOTHERAPY/ANTIBIOTICS

Cassette – reimbursement per cassette: $36.11

99999-4400-00

Intrathecal Pain Pump Refills – reimbursement per refill: $130.00

99999-5500-00

NOTE: THE ABOVE – REFERENCED COMPOUNDING FEES ARE CALCULATED PER UNIT. EACH BAG, CASSETTE, OR SYRINGE IS CONSIDERED ONE UNIT, REGARDLESS OF VOLUME.

Dispensing fees and co-payment requirements do not apply to the above referenced compounding fees.