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1.0 Descriptions of the Service

This policy applies to Medicaid-covered legend drugs and covered over-the-counter (OTC) drugs dispensed by outpatient pharmacy providers.

2.0 Eligible Recipients

Outpatient pharmacy services are available to all eligible Medicaid recipients.

2.1 General Provisions

Medicaid-eligible individuals with a need for this specialized treatment confirmed by a licensed physician are eligible as long as they meet individual eligibility requirements. Medicaid recipients may have service restrictions due to their eligibility category, which would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service,

product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 Covered Services

The N.C. Medicaid Outpatient Pharmacy Program covers prescribed drugs when they meet the following guidelines and specific criteria listed in this policy:

- a. The prescribed drug must have Federal Drug Administration (FDA) approved indications.
- b. The prescribed drug must bear the federal legend statement.
- c. A legend drug must be manufactured by a company that has signed a National Medicaid Drug Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS).

Selected OTC medications and insulin products are covered when they meet the criteria listed in General Medical Policy No. A-2.

Refer to **Section 4.0, When the Service Is Not Covered**, for information on prescribed drugs that are not covered by the Medicaid Outpatient Pharmacy program.

3.2 Coverage of Compounded Drugs

Compounded drugs are covered when:

- a. A mixture of two or more ingredients is physically inseparable.
- b. At least one of the components of the compounded drug is a legend drug.

- c. It is expected that the quantity of legend drug is sufficient to have a therapeutic effect.
- d. The legend drug is manufactured by a company that has signed a national Medicaid Drug Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS).

A compounded prescription is expected to contain a quantity of a legend drug sufficient to have a therapeutic effect. It cannot be two different drugs (capsules and/or tablets) separable but dispensed in the same bottle. All Drug Efficacy Study Implementation (DESI) drugs and combinations equivalent to a DESI drug are not reimbursable in compounded prescriptions.

Example: Guaifenesin and Theophylline are equal to Quibron, which is DESI and noncovered.

A compounded prescription, which is equivalent to an OTC drug, is not reimbursable.

Example: Hydrocortisone 1% cream 60 gm and Eucerin Cream 60 gm are equal to Hydrocortisone 0.5% cream 120 gm, which is OTC and noncovered.

Refer to **Attachment A, Compounded Drugs**, for additional information on billing and reimbursement.

3.3 Medicaid Drug Rebate Program

The N.C. Medicaid Outpatient Pharmacy Program can only cover drugs from manufacturers who have signed national Medicaid Drug Rebate Agreements with CMS. Drug companies sign the agreements for specific drug manufacturer codes. Drug coverage is thus determined by the manufacturer code and not by the manufacturer name. The manufacturer code is indicated by the first five digits of the 11-digit National Drug Code (NDC) number. Since rebates are determined by North Carolina's Medicaid utilization data, it is imperative that pharmacies bill Medicaid using the NDC number of the drug actually dispensed. If accurate NDCs are not used for pharmacy claims, there is the potential for denial of claims, sanctions, and termination of provider agreements. The N.C. Medicaid program supplies pharmacy providers with a list of any additions or deletions to the list of covered Medicaid Rebate Manufacturers through Medicaid Pharmacy Newsletters located on the Division of Medical Assistance (DMA) Web site at <http://www.ncdhhs.gov/dma/pharmnews/>.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

In addition to the prescribed drugs listed in **Sections 4.1** and **4.2**, prescribed drugs are not covered when the criteria listed in this policy are not met.

4.2 Noncovered Services under the N.C. Medicaid Outpatient Pharmacy Program

Following is a list of services not covered by Medicaid when billed under the Outpatient Pharmacy Program:

- a. OTC drugs (except Insulin and selected OTC products per General Medical Policy No. A-2).
- b. Federal Legend drugs or their generic equivalents that are on the DESI list established by the FDA.
- c. Any drug manufactured by a company who has not signed a rebate agreement.
- d. Fertility drugs.
- e. Drugs used for cosmetic indications.
- f. Medical supplies and devices are not covered in the Outpatient Pharmacy Program and must be billed under the specific program service using the appropriate procedure code. For example, needles, syringes and suction catheters are covered under durable medical equipment services. Urinary catheters, IV sets and TED hose are covered under home health services, home infusion therapy services and physician services, respectively.
- g. Diaphragms must be billed under the appropriate procedure code as a family planning service
- h. Routine immunizations, flu vaccines and DPT immunizations must be billed under the appropriate procedure code in accordance with guidelines from the Advisory Committee on Immunization Practices (ACIP) when provided in a physician's office. Medicaid does not reimburse for vaccines provided to recipients ages birth to 18 years that are available through the Universal Childhood Vaccine Distribution Program and Vaccines for Children Program.
- i. Oxygen concentrators and wheelchairs must be billed under durable medical equipment services under the appropriate procedure code.
- j. IV fluids (Dextrose 500 ml or greater) and irrigation fluids in an inpatient facility must be billed as ancillary services.
- k. Erectile dysfunction drugs
 - l. Weight loss and weight gain drugs
- m. Drug samples
- n. Drugs obtained from any patient assistance program

4.3 Drug Efficacy Study Implementation Drugs (DESI)

Reimbursement is denied on drugs described by the FDA as DESI. These are products that the FDA has found to be less than effective or not proven to be as effective as indicated. Drug products that are identical, related or similar to DESI drugs are also considered DESI. Updates and corrections are published in the Medicaid Pharmacy Newsletters on DMA's Web site, <http://www.ncdhhs.gov/dma/pharmnews/>.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prescription Limitations

The N.C. Division of Medical Assistance (DMA) has established a prescription limitation of eight prescriptions per recipient per month.

5.1.1 Exemptions from the Monthly Prescription Limitations

A pharmacist may override the monthly prescription limit with three additional prescriptions per recipient per month for recipients aged 21 and older. Overrides are available at the discretion of the pharmacist based on the assessment of the recipient's need for additional medications during the month of service.

Recipients under 21 years of age are exempt from the prescription limitation under guidelines established through Medicaid for Children (Health Check/EPSDT). Recipients who reside in nursing facilities, intermediate care facilities/mental retardation centers, assisted living facilities, and group homes are also exempt from the prescription limitation. Exemption from the monthly prescription limitation for these recipients is incorporated in the recipient eligibility file.

5.1.2 Focused Risk Management (FORM) Program

Some recipients have clinical indications that warrant more prescriptions than are allowed under the monthly prescription limitations. DMA requires that recipients receiving more than 11 unduplicated prescriptions per month be evaluated as part of a Focused Risk Management (FORM) program. The recipient's pharmacist is the facilitator of the FORM process. The pharmacist coordinates, integrates, and communicates medication regimen discussions with the patient's primary care provider. Upon provider consensus, the pharmacist may translate the information to the recipient. This service comprises the following components:

- a. Perform a comprehensive drug regimen review to identify, resolve, and recommend cost-effective, safe, and efficacious drug alternatives, when available, to the recipient's primary care provider, such as by
 1. increasing generic efficiency rates by promoting generic alternatives to branded prescription medications, when available
 2. identifying opportunities for therapeutic interchange within an existing therapeutic drug class
 3. identifying opportunities for therapeutic substitution

4. assisting primary care providers in understanding the complexities of drug therapies
5. identifying opportunities for optimizing therapeutic outcomes
6. establishing routine communication with the primary care provider
- b. Review the appropriateness of dose/strength/schedule, safety, effectiveness, and convenience of drug therapy regimen, such as by
 1. checking for suboptimal dosage
 2. assessing dosing regimen
 3. identifying opportunities for dose optimization
 4. identifying opportunities for dosage consolidation
 5. determining addition/deletion of medications to existing protocol
 6. identifying inappropriate medications
- c. Recognize opportunities to prevent, minimize, and manage adverse drug events, such as by
 1. identifying risk factors for adverse drug events
 2. identifying potentially harmful medications
- d. Improve patient management and adherence/compliance to individualized treatment plan, such as by
 1. identifying recipients who experience a significant gap in their medication therapies, with the priority aim to improve health care outcomes through greater adherence to chronic medication regimens
 2. evaluating/advising on recommended adjustments to drug regimen, if necessary
 3. continuously monitoring and managing drug therapies
 4. establishing routine communication with and education of the patient
 5. discontinuing short-term acute medication, filled on a monthly basis
- e. Communicate and translate information to the recipient

Frequency of Review. The qualified licensed pharmacy provider will conduct the FORM review at least every three months to ensure clinically appropriate, efficacious, and cost-effective use of drug therapy. As needed, the pharmacist should obtain consultation for specific patient therapy questions from clinical pharmacy experts [for example, AHEC pharmacists, Community Care of North Carolina (CCNC) pharmacists, drug information centers, and academic pharmacists]. The first review must be completed within two months of the recipient's identification for the program; subsequent reviews must be performed at least every three months thereafter.

Management Fee and Required Documentation. Pharmacies participating in this program are eligible for a quarterly FORM fee upon completion of the comprehensive review plan required for each Medicaid recipient being managed. Documentation of the review of the recipient's medical profile can use the pharmacy's standard software, as long as it incorporates professional standards of clinical appropriateness. The appropriate signatures by the recipient's primary care physician and pharmacist are required on the FORM review to ensure compliance with the frequency of review and agreement on actions undertaken.

By requesting to allow the recipient to opt-in at their pharmacy, the pharmacy is indicating its acceptance of the responsibility to conduct the FORM review. Program Integrity will perform audits to ensure adherence to this policy. Failure to perform the review as required by this policy, or failure to have documentation of the review on file at the time of audit, will result in the recoupment of the FORM payment as well as of payment for all claims that exceed the limit of 11 unduplicated prescriptions per month. The signed documentation of the reviews must be kept on file in the pharmacy and must be readily retrievable for review by Program Integrity. If the primary care physician refuses to sign the FORM review, then the pharmacist must document this on the review form. The name of the primary care physician who refused to sign and the reason for the refusal must be stated and dated. DMA will allow up to one month from date of initial impartation to the primary care provider for the appropriate documentation for circumstances in which the physician refuses to sign the review form. Recoupment for not documenting quarterly reviews will not affect providers when recipients have been opted in for 2 months or less.

When a recipient elects to change from one opt-in pharmacy provider to another during a calendar quarter, the new pharmacy provider is expected to ask the former provider if a FORM review has been done for that calendar quarter. N.C. Medicaid will pay only one FORM professional service fee per opt-in pharmacy per recipient per calendar quarter.

5.1.3 Recipient Opt-in (Restricted Pharmacy Services) Program

DMA utilizes a Recipient Opt-in (Restricted Pharmacy Services) Program. Recipients identified for the FORM program who require more than 11 unduplicated prescriptions each month are restricted to a single pharmacy. The recipient must elect to participate in the opt-in program to receive more than 11 unduplicated prescriptions; however, written consent is not required. Every six months, recipients will be systematically removed from the opt-in program when fewer than 12 unduplicated prescriptions were dispensed in two out of the last three months or if fewer than 12 unduplicated prescriptions were dispensed in the sixth month. The recipient's primary care physician or pharmacy provider can contact EDS to request changes to the pharmacy opt-in provider. To reach EDS between 8:30 a.m. and 4:30 p.m. on weekdays, dial 919-851-8888 or 1-800-688-6696.

The following recipients are exempt from mandatory pharmacy opt-in:

- a. recipients who are younger than 21 years of age;
- b. recipients residing in nursing facilities or intermediate care facilities/mental retardation centers.
- c. Recipients residing in assisted living facilities and group homes

Refer to **Attachment A** for additional information on exemptions for nursing facilities and intermediate care facilities/mental retardation centers.

5.1.4 Emergency Supplies for the Recipient Opt-in Program

Emergency fills are allowed for recipients who opt-in to a pharmacy for situations in which the recipient may not be able to get to their pharmacy. The

emergency supply is limited to a four-day supply. The provider will be paid for the drug cost only and the recipient will be responsible for the appropriate co-payment.

Records of dispensing of emergency supply medications are subject to review by Program Integrity. Paid quantities for greater than a four-day supply are subject to recoupment.

5.1.5 FORM Process Oversight

CCNC network qualified clinical pharmacists will provide monitoring and consultation services to DMA and to the participating community pharmacists. CCNC will have oversight of the FORM process. However, Program Integrity will conduct audits to ensure compliance with this policy.

5.2 Dispensing and Maximum Days Supply

The maximum days supply for all drugs is a 34-day supply unless the medication meets the criteria described below to obtain a 90-day supply.

5.2.1 Birth Control and Hormone Replacement Therapies

Up to three months of birth control medications and prepackaged hormone replacement therapies are allowed. The days supply for Depo Provera (150 mg/ml) should be accurately indicated as a 90-day supply. There is an audit in the system to ensure that claims are only being submitted every three months.

5.2.2 Generic, Non-Controlled Maintenance Medications

Medicaid recipients can obtain a 90-day supply of other medications if the claim is for a generic, non-controlled, maintenance medication and they have had a previous 30-day fill of the same medication. The claim must also pay at either the Federal or State Maximum Allowable Cost (MAC) rate for a 90-day supply to be allowed. If the product is deleted from the MAC list, then the recipient can only obtain a 34-day supply. This is at the sole discretion of the recipient's health care provider. Only one co-pay is collected and only one dispensing fee is paid for the 90-day supply.

5.2.3 Quantity and Unbreakable Packages

If the drug is packaged in an unbreakable package and will last longer than 34 days, then **the claim should be filed for the full quantity, but a 34-day supply should be indicated** even though it will last longer. For example, with insulin prescriptions, the number of units per day for a 10ml vial may be greater than a 34-day supply. The pharmacist should use his/her best judgment in determining the days supply.

DMA solicits the help of each pharmacist to keep the program free of fraud and abuse. Utilization review procedures have been established for program control through the cooperation of pharmacies and good utilization review procedures in an effort to avoid further system limitations.

5.2.4 Quantity and Episodic Drugs

Some drugs are meant to be used episodically and dispensed in quantities that support less than daily use. DMA may impose quantity limitations for episodic drugs based on advice from the North Carolina Physician Advisory Group

(NCPAG), which will consider FDA labeling, evidence-based guidelines, and/or systematic reviews, and consultation with the CCNC Clinical Directors as to North Carolina community and best practice standards about precise duration of use.

The NCPAG may recommend for each drug that is designated as an episodic drug other restrictions or actions currently available under the Outpatient Pharmacy Program including but not limited to:

- a. Evaluating the applicability of quantity limitations of episodic drugs for patients who normally receive their legend medications packaged in a specialized distribution system;
- b. Prior authorization criteria and requirements;
- c. Listing the drug on the Prescription Advantage List (PAL) and/or
- d. Actions that will minimize the number of dispensing fees for drugs that are prescribed in limited quantities.

The current list of drugs and their limits is in **Attachment O**.

DMA will monitor utilization of designated episodic drugs on an annual basis or more frequently if necessary in order to assess the need for changes in the limits. This data will be shared with the NCPAG.

5.3 Filing Prescriptions

Section C-4 of the Pharmacy Provider Participation Agreement states that as a provider of prescribed drugs, the provider certifies and agrees to file prescriptions numerically and in chronological order, either in normally occurring order with other prescriptions filled by the provider or in a separate file, and to record each authorized refill. Failure to comply is a direct violation of a provider's agreement. There are no exceptions.

5.4 Co-payments

5.4.1 Co-payment Requirements

All eligible Medicaid recipients who receive prescribed drugs are required to make a co-payment of \$3.00 for each prescription received unless they are exempt for one of the reasons listed below. A provider may not deny services to any Medicaid patient because of the individual's inability to pay a deductible, coinsurance or co-payment amount. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. The provider may open an account for the patient and collect the amount owed at a later date.

5.4.2 Co-payment Exemptions

Recipients are exempted from co-payments if:

- a. The recipient is under 21 years of age.
- b. The recipient resides in a nursing home facility, intermediate care facility for individuals with mental retardation (ICF/MR) or a mental health hospital (adult care homes and hospice patients are responsible for co-payment).
- c. The recipient is pregnant. For a pregnant recipient, it is requested that the prescriber note "Pregnancy" on the prescription. A "4" in the Prior Authorization Field on a point-of-sale (POS) claim or a "P" in the Location

Field for a paper claim indicates an exemption from the co-payment deduction for pregnancy. If the patient has a pink card, the exemption will be done automatically by the system.

- d. The drug is classified as family planning (birth control medication). Exemption from the co-pay for family planning drugs is indicated on the drug file and does not require any additional indicators. Do not collect a co-pay for oral contraceptives.
- e. The recipient is classified as a CAP recipient as indicated on the recipient's MID card.

5.5 Returned Medication

Pharmacists must follow the N.C. Board of Pharmacy regulations for returned medications. If a returned medication is returned to stock, **a credit must be issued** for that prescription. Credits should be handled by completing one of the following:

- a. Reversal of a POS claim
- b. Pharmacy Adjustment Request form

Refer to **Attachment A**, Pharmacy Claim Adjustments; Point-of-Sale Reversals; and Resubmission of Rejected or Denied Claims, for additional information.

5.6 Prescription Drugs Requiring Prior Authorization

Refer to www.ncmedicaidpbm.com for a list of prescription drugs that require prior authorization. The Web site lists the medical necessity criteria for coverage for each medication that requires prior approval. Refer to **Attachment C** for instructions on requesting prior authorization.

Additional information on the prior authorization designation process is available in General Medicaid Policy A-3, Prior Authorization for Outpatient Pharmacy Point of Sale Medications, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>.

5.6.1 72-Hour Emergency Supply

A 72-hour emergency supply should be provided to all recipients who are waiting for acknowledgment of the prior authorization request. The pharmacy will be reimbursed for the supply if the prescription is changed to an alternative medication.

Refer to **Attachment C** for information on the processing of 72-Hour Emergency Supply.

5.6.2 Prior Authorization Process for Pharmacists Serving Long-term-care Facilities

Pharmacists serving nursing facilities, adult care homes, and intermediate care facilities for persons with mental retardation are allowed to request prior authorization.

5.7 Generic Substitution

Refer to **Section 5.10** for information on Narrow Therapeutic Index (NTI) drugs.

The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically

orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicates in his/her own handwriting on the prescription order “**medically necessary.**” Current Session Law states

Dispensing of Generic Drugs---Notwithstanding G.S. 90-85.27 through GS 90-85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the SSA), and except as otherwise provided in this subsection for atypical antipsychotic drugs and drugs listed in the narrow therapeutic index, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand name drug is medically necessary and has written on the prescription order the phrase “**medically necessary.**” An initial prescription order for an atypical antipsychotic drug or a drug listed in the narrow therapeutic drug index that does not contain the phrase “**medically necessary**” shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit **oral or written** approval of the prescriber given at the time the order is filled.

The selection of a drug product shall not be more expensive than the brand or trade name originally written by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner. The Division may use a certification form and procedures for “medically necessary” brand-name drugs (42 CFR 447.331). For audit purposes, the brand name and manufacturer must be documented on the prescription.

5.7.1 Generic Substitution for Brand Medically Necessary Medications

A prescription for a drug written under its brand or trade name must be filled with a generic version of the drug when one is available unless the prescriber has indicated that the brand name drug is medically necessary for the recipient to receive. The prescriber indicates this by writing “medically necessary” on the prescription order for the drug. If the pharmacist receives a prescription for a drug written by its brand or trade name with the medical necessity documentation on the face of the prescription even though there is a generic version of the drug available, the pharmacist must dispense the brand name drug. If the prescription is written by the brand or trade name of the drug but “medically necessary” is not written on the face of the prescription by the prescriber, the pharmacist must dispense a generic version of the drug.

5.7.2 Generic Substitution for Narrow Therapeutic Index and Atypical Antipsychotic Medications

A new prescription for a drug that is on the NTI list or is an atypical antipsychotic that is written under its brand or trade name must be filled with a generic version of the drug when one is available unless the prescriber has

indicated that the brand name drug is necessary by writing “medically necessary” on the prescription order for the drug. A refill prescription order for an NTI drug or atypical antipsychotic drug written under its brand or trade name may not be substituted with a generic version of the drug without written or verbal consent from the prescriber.

5.8 Maximum Allowable Cost (MAC)

The N.C. Medicaid Outpatient Pharmacy Program is required by federal regulations to utilize a federal Maximum Allowable Cost (MAC) or also referred to as the Federal Upper Limit (FUL) for some multiple source drugs. In addition, N.C. Medicaid also utilizes a state MAC list for generic and multi-source brand drug products. The state MAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. The State’s MAC reimbursement is based on 190 percent of the lowest priced generic. In cases where 190 percent results in a price less than the cost of the second-lowest generic product, at least an additional ten percent margin is added to the cost of the second-lowest drug to establish the MAC price. The additional margin is variable due to the wide range of differences in cost from product to product.

For established generic drugs with only one supplier, the MAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, MAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product.

Drugs subjected to MAC pricing must be in adequate supply. Drug shortage information is verified through the national pharmacy Web sites (<http://www.fda.gov/cder/drug/shortages/> and <http://www.ashp.org/shortage>) as well as through information provided by national drug wholesalers.

The federal and state MAC lists work in conjunction with one another. The lowest price at any given time will be the current reimbursement for a N.C. Medicaid claim.

5.8.1 MAC Override

It is possible to override either the federal or the state MAC limitations if a prescriber certifies that a specific brand of drug, which has a MAC limitation, is medically necessary for a particular recipient (refer to **Section 5.7, Generic Substitutions**). This certification must fall under federal and state regulations, which specify that the certification “Medically Necessary” must be in the prescriber’s own handwriting and signed by the prescriber. This can be written directly on the face of the prescription or on a separate document, which must be attached to the original prescription.

Dispense as Written (DAW) 1 on a POS claim is a MAC override.

5.8.2 Unacceptable Practices for Drugs with MAC Prices

- a. The prescriber is not allowed to indicate “Medically Necessary” over the telephone for the pharmacist to document on the prescription if the drug is a MAC drug.

Note: If the drug is not a MAC drug, the pharmacist may receive oral authorization not to substitute from the prescriber, write “Medically

Necessary” on the prescription, and initial it. If a telephone prescription requiring brand only is accepted, the prescriber must send a new prescription within 72 hours with “Medically Necessary” written on the prescription in the prescriber’s own handwriting.

- b. A prescriber’s signature over a printed statement indicating “Dispense as Written” or “Medically Necessary” with a check or X in a box on the prescription indicating “Dispense as Written” is unacceptable.
- c. A handwritten statement transferred to a rubber stamp and then stamped on the prescription is unacceptable.
- d. The abbreviation “DAW” on the prescription by the prescriber is unacceptable.

If a physician has properly authorized for the dispensing of a brand name drug product when that drug product is a MAC drug, the pharmacist can bill Medicaid for reimbursement based on the lower of the usual and customary charge or the Medicaid reimbursement rate of the brand name drug plus the dispensing fee. To indicate that the prescriber has documented “Medically Necessary” and bill for the brand, indicate DAW 1 on an online POS claim. Do not use DAW 1 for brand name, single source drugs. The MAC override should only be used to override a MAC price.

Refer to **Attachment H** for DAW codes.

5.9 Enhanced Specialty Discount on Single-Source Specialty Drugs

The General Assembly [Session Law 2008-107, Section 10.10(e)] mandates that the N.C. Medicaid Outpatient Pharmacy Program use a State-determined upper payment limit on select single-source specialty drugs that cost in excess of \$1,500 per month. The State-determined upper payment limit is called the enhanced specialty discount. The list of specialty drugs that are subject to the enhanced specialty discount is updated quarterly and is published on DMA’s Web site at <http://www.ncdhhs.gov/dma/pharmacy/>.

5.10 Narrow Therapeutic Index Drugs

N.C. General Statute 90-85.27 defines NTI drugs to mean those pharmaceuticals having a narrowly defined range between risk and benefit. Such drugs have less than a twofold difference in the minimum toxic concentration and minimum effective concentration in the blood or are those drug product formulations that exhibit limited or erratic absorption, formulation-dependent bioavailability, and wide inpatient pharmacokinetic variability that requires blood-level monitoring.

Drugs identified as having narrow therapeutic indices are designated as NTI drugs by the Secretary of the N.C. Department of Health and Human Services upon the advice of the State Health Director, the N.C. Board of Pharmacy, and the N.C. Medical Board, and are subject to the provisions of NCGS 90-85.28(b1).

The list of NTI drugs is reviewed on an annual basis and submitted to the Office of Administrative Hearings by the N.C. Board of Pharmacy for publication in the N.C. Register. Refer to **Attachment D, Narrow Therapeutic Index Drugs**, for the current list of drugs designated as NTI. Refer to G.S. 90-85.27 through G.S. 90-85.31 in **Section 5.7** for information regarding generic substitution, and **Section 5.8.1** for information regarding MAC Overrides.

5.11 Billing for Partial Fills

Medicaid does not pay for medication that the recipient has not received. Pharmacists cannot issue an IOU to a recipient when the pharmacy is unable to dispense the full amount of a prescription and then bill Medicaid for the total quantity of the prescription. If the remaining quantity is not dispensed and the pharmacist has received payment for the total quantity prescribed, it is considered fraudulent and appropriate action will be taken.

5.12 Incorrect Units for Unbreakable Packages

Billing inaccurate package sizes creates extra costs and delays for the Medicaid program when collecting drug rebates from manufacturers. Frequently, the quantity billed for drops does not match the package size, e.g., 5 ml is billed for the 10 ml NDC. Bill the quantity that matches the package size for the NDC billed. If a different package size is used for the refill, the prescription should be updated to match the drug dispensed with the drug on the label, as is required by law.

Effective October 12, 2003, the Medicaid program began accepting metric decimal quantities for providers using NCPDP 5.1. The actual manufacturer package size (or multiples of the package size) should be indicated on the claim.

The table below shows some examples of NDCs and the correct corresponding package size that should be used when billing these products. For example, Lovenox should be billed in milliliters, so if 10 syringes are dispensed for the NDC indicated below, the metric decimal quantity would be 6 ml.

NDC	Drug	Metric Decimal Quantity
00075150616	Nasacort AQ Nasal Spray	16.5
00597008214	Atrovent Inhaler	14.7
00597001314	Combivent Inhaler	14.7
00186107008	Rhinocort AQUA Nasal Spray	8.6
49502068503	Ipratropium BR 0.02% Soln	2.5
00075062160	Lovenox 60mg prefilled syringe	0.60
00013830304	Xalatan 0.005% Eye Drops	2.5
00069313019	Zithromax 200mg/5ml Suspension	22.5
00046087293	Premarin Vaginal Cream/App.	42.5
00065064835	Tobradex Eye Ointment	3.5
00054309036	Butorphanol 10mg/ml Spray	2.5
64116003106	Infergen 15mcg/0.5 ml	0.50
00085113201	Proventil HFA 90 mcg Inhaler	6.7
61570003775	Viroptic 1% Eye Drops	7.5

5.13 Prescription Advantage List

The PAL is a list of preferred medications developed by NCPAG and CCNC in cooperation with DMA. It is a voluntary effort that provides prescribers a guide for selection of less expensive medications in the most costly drug classes, when clinically appropriate. Refer to **Attachment N** for the PAL of Drugs.

6.0 Providers Eligible to Bill for the Service

6.1 Conditions of Participation

In order to participate in the N.C. Medicaid Outpatient Pharmacy Program, pharmacists must abide by the rules and regulations of the program, be in compliance with Title VI of the Civil Rights Act, agree that DMA or its representatives may conduct audits as necessary, and **accept payment for covered services as payment in full**. Pharmacies must be operating under permit or license to dispense drugs issued by the appropriate state or federal authority.

6.2 Changes in Pharmacy Status

All changes in pharmacy status must be reported to DMA Provider Services using the **Provider Change Form**. A copy of the form is available on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

6.2.1 Changing a Pharmacy Manager

The Notification of Change in Provider Status form is required by DMA. The form should indicate the new pharmacy manager's previous address and provider number.

6.2.2 Change of Ownership

The pharmacy must apply for a new provider number and complete a new participation agreement and Electronic Commerce Services agreement if there is an ownership change of greater than 50 percent. The pharmacy must submit a Notification of Change in Provider Status form to DMA Provider Services within 30 calendar days of the effective date of the change. A copy of the new owner's W-9 must be included with the form.

6.2.3 Change of Tax Identification Number

Any tax identification number changes must be reported to DMA Provider Services using the Notification of Change in Provider Status form. A copy of the new W-9 must be included with the form.

6.2.4 Closing a Pharmacy

The pharmacy must submit a Notification of Change in Provider Status form to DMA Provider Services within 30 calendar days of the effective date of the closing of the pharmacy.

7.0 Additional Requirements

7.1 Record Retention

10A NCAC 22F.0107 addresses the retention of records by Medicaid providers for Medicaid recipients and states

All Title XIX providers shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement. These records shall be retained for a period of not less

than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements. (History Note: Statutory Authority G.S. 108A-25(b); 108A-54; 108A-63; 1 108A-64; 42 CFR part 455; Eff. April 1, 1988.)

Pharmacy providers submitting paper claim forms must retain a copy of the claim form on-site for a period of at least five years. Pharmacy providers utilizing automated data processing systems as record keeping systems must be able to produce sight-readable documents of all original and refilled prescription information. The term sight-readable means that a representative of the State of North Carolina shall be able to examine the record and read the information from a CRT, microfiche, microfilm, or hard-copy printout. These records must be retained on-site for a period of at least five years.

Medicaid records must be easily retrievable and kept on-site. Payments that cannot be audited because records are not easily retrievable and on-site are subject to recoupment.

7.2 Pharmacy Audits

Pharmacy records are audited periodically. The purpose of these on-site audits is to ensure that the contractual agreement with DMA is being upheld. This contractual agreement between the pharmacy provider and DMA requires that the provider agrees to:

- a. file prescriptions numerically and in chronological order on-site, either in normally occurring order with other prescriptions filled by the provider or in a separate file;
- b. maintain as a permanent record on-site, an individual prescription for each drug submitted for reimbursement;
- c. follow rules published by the N.C. Board of Pharmacy for manual and computerized record-keeping related to drug ordering, dispensing, filling, and refilling;
- d. preserve these records on-site for a period of at least five (5) years.

7.3 Medicaid Recoupments

The Program Integrity Section conducts regular postpayment reviews in an ongoing attempt to ensure that Medicaid payments are made only for the services that are covered under Medicaid policy. When overpayments are identified, the provider is given written information about the errors and is required to refund the overpayment amount. It is vital that providers use these overpayment notices to educate billing staff concerning the importance of following Medicaid policies. If additional billing guidance is needed, the provider may request a visit from DMA's fiscal agent's Provider Services unit.

10A NCAC 22F.0601 addresses overpayments to Medicaid and states

- (a) The Medicaid agency will seek restitution of any and all improper payments made to providers by the Medicaid program. Recovery may be by lump sum payment, by a negotiated payment schedule not exceed one year or by withholding from the provider's pending claims the total or portion of the recoupment amount.
- (b) A provider may argue all or a part of a recoupment imposed by the Medicaid Agency by requesting a Reconsideration Review of the investigative findings and, thereafter, an Executive Decision.

(History Note: Authority G.S. 108A-25(b); 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456; Eff. February 1, 1982; Amended Eff. May 1, 1984.)

In order to keep recoupment amounts to a minimum, DMA encourages providers to refer to the general Medicaid bulletins and medical coverage policy information available on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>. Should you or your staff have questions about the policies or billings, it is vital to contact DMA's fiscal agent's Provider Services unit at 919-851-8888 or 1-800-688-6696.

If an audit results in a recoupment, the provider has three options:

- a. Send a check to repay the overpayment. (The check should be mailed to the address indicated in the post-payment letter.)
- b. Do nothing. The overpayment will be deducted from future claim payments to the provider.
- c. Request a reconsideration review. This review is now conducted by a DMA Hearing Officer. As instructed in the post-payment recoupment letter, documentation is submitted to the Hearing Office within 15 working days of receipt of the letter.

Questions may be addressed to DMA's Chief Hearing Officer at 919-647-8200 or the DMA Pharmacy Review Officer at 919-647-8000.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1999

Revision Information:

Date	Section Revised	Change
9/1/05	Entire policy	Changes were made throughout the policy to correspond with approved amendments to the State Plan.
11/1/05	Section 5.6.1 and Attachment G	Co-payment information was updated to reflect a change in the State Plan.
12/1/05	Section 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
2/1/06	Attachment A	Billing information for drugs covered under hospice was added to the attachment as section I and the remainder of the attachment was renumbered accordingly.
5/1/06	Section 4.1 and Attachment G	Erectile dysfunctions drugs and anorexia, weight loss and weight gain drugs were added to the list of noncovered services in compliance with mandated legislation.
5/1/06	Section 5.2.3	Information regarding how to bill for drugs that are packaged in an unbreakable package was clarified.
5/1/06	Section 5.2.4	Service requirements for Quantity and Episodic Drugs were added to the policy.
5/1/06	Attachments A, Item G	Information regarding cost avoidance claims processing was clarified.
5/1/06	Attachment P	The list of Episodic Drugs Quantity Dispensing Limits was added to the policy

Date	Section Revised	Change
6/1/06	Section 5.1, 5.1.1, and 5.1.2	The established limit of six prescriptions per month was deleted. Policy requirements associated with the new prescription limit including the medication therapy management program requirements were added to the policy.
6/1/06	Section 5.3	This section pertaining to the recipient opt-in program was deleted and replaced with section 5.1.3.
6/1/06	Section 5.4	This section pertaining to the establishment of a pharmacy of record was deleted from the policy.
6/1/06	Attachment A, Section E	Procedural information related to the six prescription payment for the pharmacy of record was deleted from the policy and the remaining sections were renumbered accordingly.
6/1/06	Attachment A, Section Q.5	Information related to pharmacy of record adjustment requests was deleted from the policy.
6/1/06	Attachment A, Section R	Procedural information related to exemptions from the prescription limitation was added to the policy.
6/1/06	Attachment A, Section S	Information related to the recipient opt-in program was added to the policy.
6/1/06	Attachment A, Section T	Information related to the Medication Management Fee was added to the policy.
6/1/06	Attachment B	The Six-Prescription Limit Override form was deleted from the policy.
7/1/06	Throughout	The term “dispensing fee” changed to “professional services fee.”
7/1/06	Section 5.1.1	The first sentence was revised to indicate that pharmacists may override the monthly prescription limit with three additional prescriptions per recipient per month for recipients aged 21 and older. The second sentence was revised to indicate that the decision to override the monthly prescription limit is at the discretion of the pharmacist and does not require consultation with the recipient’s physician.
7/1/06	Section 5.1.3	The sentence pertaining to the systematic removal of recipients from the Opt-in Program was rewritten to clarify the process.
7/1/06	Section 7.1 and 7.2	Clarification was added to indicate that pharmacy records must be maintained on-site.
7/1/06	Section 7.3	The phone number for the DMA Pharmacy Review Officer was corrected.
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
3/1/07	Attachment A, Section H	A requirement for the ICD-9-CM code to appear at the bottom of the form was added.
3/1/07	Section 5.8.1 and Attachment A, Section I	Removed references to NCPDP 1.1 batch billing

Date	Section Revised	Change
3/1/07	Attachment A, Section I	Added a requirement to bill claims over \$9,999.00 on paper
5/1/07	Section 5.6	Information regarding prescription drugs requiring prior approval was clarified.
5/1/07	Sections 5.7 and 5.7.1	Clarified paragraphs regarding North Carolina law.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
8/1/07	Section 5.1, subsections 1 through 4; Attachment A	Changed references to Medication Therapy Management Program to Focused Risk Management (FORM) Program; updated requirements.
8/1/07	Section 5.1.3	Clarified parameters for removal from the opt-in program.
8/1/07	Section 5.1.5	Added new section on FORM process oversight.
8/1/07	Throughout policy	Changed "professional services fee" to "dispensing fee."
8/1/07	Attachment A, S.2	Updated contact information.
11/1/07	Section 5.7	Added the information that DMA may use a certification form and procedures for medically necessary brand-name drugs.
11/1/07	Attachments A and F	Added clarification for claims submitted by 340B providers.
11/1/07	Attachment A, letter I	Added narcotic analgesics and narcotic analgesic combination drugs to the list of those that don't allow a hospice edit override.
11/1/07	Attachment E, E.3	Changed last paragraph to read "... except in three areas:" and added the third item (letter c).
1/1/08	Sections 5.1.2, 5.1.3	Added the word "unduplicated" to references to 11 or 12 prescriptions.
7/1/08	Section 2.2	Added legal citation for EPSDT information.
7/1/08	Section 4.2	Added drug samples and drugs obtained from patient assistance programs to noncovered services.
10/10/08	Section 5.9; Attachment A, sections B.3, B.5, and G	Added instructions for the Enhanced Specialty Discount Drug List; renumbered old sections 5.9 through 5.12 to 5.10 through 5.13.
2/1/09 (eff. 4/1/08)	Attachment N	Revised description of Prescription Advantage List.
5/1/09	Attachment D	Added tacrolimus to the list of Narrow Therapeutic Index drugs.
6/1/09 (eff. 5/22/09)	Attachment H	Added DAW 8 to the list of codes for dispense as written.
6/1/09	Attachment J	In the Note to Item 5, corrected "six-prescription limitation" to "eight-prescription limitation." This is a correction of an oversight, not a change in policy.

Date	Section Revised	Change
6/1/09	Attachment O	Added Zolpidem and Zaleplon to their respective drug classes; deleted GCN14281 from the Halcion and Triazolam row. This is a correction of an oversight, not a change in policy.
8/1/09	Attachment H	Added prescription origin codes.
8/1/09	Attachment O	Added triptans to the episodic drug list.
10/5/09	Section 5.8 and Attachment A, item B.4	The maximum allowable cost was change from 150% to 190% of the lowest priced generic.
10/5/09	Attachment A, item B.3	Methodology for the cost of the drug was changed from the Average Wholesale Price - 10% to the WAC + 7 percent; the federal or state MAC price; the enhanced specialty discount, if applicable; or the usual and customary charge and to indicate that WACs are updated weekly via File Transfer Protocol (FTP) from First Data Bank.
10/5/09	Attachment F, item h.	The calculated Medicaid price was changed from the MAC price or Average Wholesale Price - 10 % to the MAC price or the WAC + 7% + the dispensing fee.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. General Information

Each time Medicaid services are rendered, the provider must check the recipient's MID card to verify that the recipient is eligible on the date the service is rendered. The prescription should be verified for Medicaid coverage. All claim fields, whether submitted real time (POS), electronically, tape-to-tape or on paper via the pharmacy claim form must be completed. The pharmacist should retain a copy of the claim on file.

Refer to **Attachment F** for a summary of the billing requirements.

B. Directions for Drug Reimbursement

Reimbursement is determined using the cost per unit times the quantity dispensed plus the dispensing fee. Reimbursement is limited to the applicable price in effect on the date of service, not on the date of payment. Refer below to **B.3, Cost of the Drug**.

The Medicaid provider shall bill Medicaid at the applicable Medicaid rate plus the dispensing fee or the usual and customary charge to the general public, whichever is less. For more information, refer below to **B.2, Definition of Repeat or Refill Drugs in the Same Month of Service**.

B.1 Dispensing Fee

The dispensing fee of \$5.60 for generic drugs or \$4.00 for brand name drugs is added to the cost of the drug to equal the maximum allowed "Billed Amount" for each claim. Changes in the dispensing fee amount are reported in Medicaid Pharmacy Newsletters or on RA banner messages. The dispensing fee is automatically deducted from each repeated drug within the same calendar month.

B.2 Definition of Repeat or Refill Drugs in the Same Month of Service

The pharmacy program mandates that a dispensing fee, or professional fee, **shall not be paid for repeats or refills** of the same drug twice within the same calendar month; nor shall two prescriptions for the same drug be billed on the same day.

The following defines what constitutes the same or different drug in the same month of service:

- a. A drug in which the active portion is different and is not generically equivalent to any other drug dispensed to the same recipient in the same calendar month shall be considered a different drug.

Example: Tetracycline, pilocarpine, and meprobamate are three different drugs.

- b. A different dosage form (liquid, tablet, suppository, injection, etc.) of the same drug constitutes a different drug.

Example: Phenergan tablets and suppositories are two different drugs.

- c. A different strength of the same drug constitutes a different drug.
Example: Mellaril 10 mg and 50 mg are two different drugs.
- d. A different chemical form of the same basic drug does not constitute a different drug if the dosage form and strength is the same.
Example: Tetracycline hydrochloride and tetracycline metaphosphate buffered are the same drug.
- e. A generic equivalent by different trade name does not constitute a different drug.
Example: Tetracycline by Geneva, tetracycline by Rugby, and Achromycin are all the same drug.

B.3 Cost of the Drug

The cost of the drug is calculated from the lower of the cost on file (currently utilizing First Data Bank); the WAC plus 7 percent; the federal or state MAC price; the enhanced specialty discount, if applicable; or the usual and customary charge. WACs are updated weekly via FileTransfer Protocol (FTP) from First Data Bank. State MACs are updated monthly. Federal MACs are updated by CMS. The enhanced specialty discount drug list is updated quarterly. The state and federal MAC lists and the enhanced specialty discount drug list are published on DMA's Web site at <http://www.ncdhhs.gov/dma/pharmacy.htm>.

340B Provision as It Pertains to the Cost for the Drug

340B providers must be listed on the HRSA Web site (<http://www.hrsa.gov/opa/>). 340B providers must submit the actual purchased drug price plus the dispensing fee in the usual and customary charge field. Providers who anticipate joining the 340B consortium at a future date must notify N.C. Medicaid with the actual date. Providers who maintain two separate inventories—one for the 340B patients and a purchased inventory for non-340B patients—may not dispense a 340B-purchased drug and bill N.C. Medicaid the calculated Medicaid price for non-340B patients.

B.4 State Maximum Allowable Cost List

The state MAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. Reimbursement is based on 190 percent of the lowest priced generic. In cases where 190 percent results in a price less than the cost of the second-lowest generic product, at least an additional ten percent margin is added to the cost of the second-lowest drug to establish the MAC price. The additional margin is variable due to the wide range of differences in cost from product to product. SMAC is posted on the DMA Web site, <http://www.ncdhhs.gov/dma/pharmacy/>.

For established generic drugs with only one supplier, the MAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, MAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product.

Drugs subjected to MAC pricing must be in adequate supply. Drug shortage information is verified through the national pharmacy Web sites (<http://www.fda.gov/cder/drug/shortages/> and <http://www.ashp.org/shortage>) as well as through information provided by national drug wholesalers.

B.5 Enhanced Specialty Discount Drug List

The General Assembly [Session Law 2008-107, Section 10.10(e)] mandates that the N.C. Medicaid Outpatient Pharmacy Program use a State-determined upper payment limit on select single-source specialty drugs that cost in excess of \$1,500 per month. The State-determined upper payment limit is called the enhanced specialty discount. The list of specialty drugs that are subject to the enhanced specialty discount is updated quarterly and is published on DMA’s Web site at <http://www.ncdhhs.gov/dma/pharmacy/>.

B.6 National Drug Code

The NDC is an arrangement of eleven digits used to identify a drug product and package size manufactured or distributed by a specific manufacturer. It is comprised of three “fields” of data as follows:

AAAAA	BBBB	CC	Drug Code Structure
5	4	2	Number of digits in each field
AAAAA			The Manufacturer
5			
BBBB			The Drug Product
4			
CC			The Package Size
2			

Leading zeros must be used for proper placement of numbers or letters in the NDC number field of the pharmacy claim form or pharmacy software for electronic billing. Failure to record all 11 digits in the proper position will result in a claim denial.

Example: Inderal 20 mg Tablet 0046 422 81 should be spaced:
0 0 0 4 6 0 4 2 2 8 1

B.7 Defining the Drug Units

All quantities should be submitted in metric units. If the quantity is a decimal, then it should be billed as such. Refer to **Attachment G** for the instructions and examples that apply to drug units.

C. Billing Pharmacy Claims through Online Real-Time Point of Sale

DMA mandates that all providers use the online, real-time POS system to process pharmacy claims. Paper and modem claims are only allowed in certain instances. Each pharmacy needs to work with their software vendor regarding online Medicaid capabilities. Claims are submitted through the “switching” companies.

The online POS system automatically performs eligibility verification, drug validation, pricing, and edits and audits followed by Pro-DUR before the pharmacy dispenses a prescription. Immediate assurance of the amount to be paid for the prescription reimbursement submitted through online claims is sent on the next Medicaid checkwrite. POS reduces follow-up accounting for Medicaid claims by allowing for the correction of

any errors before the recipient gets the prescription. Pharmacists receive all of the reject codes immediately when a claim is submitted through POS; other submission methods are limited to returning the first reject encountered.

The same policies for MAC overrides, co-pay exemption, and prescription limit overrides are in effect for POS as for other claims processing media.

Refer to **Attachment H** for a summary of POS codes and other information for current claim format.

C.1 Requesting Online Point-of-Sale Processing for Medicaid Pharmacy Claims

Pharmacies may request the online claim submission option for N.C. Medicaid pharmacy claims by completing the **Pharmacy Online Request form** (see **Attachment I**) and returning it to the address or fax number on the form. Pharmacies must contact their pharmacy software vendor for:

- a. the Industry Identification Number (IIN), formerly known as the Bank Identification Number (BIN);
- b. a processor control number to bill N.C. Medicaid online, real time;
- c. any other necessary information to begin billing online using the current version of NCPDP.

C.2 Obtaining Point-of-Sale Software from a Vendor

Most software vendors are certified as capable of meeting the requirements to bill N.C. Medicaid online. You must ensure that the software is capable of performing the following functions:

- a. Override rejects for DUR conflicts, when needed, by resubmitting the rejected claim with DUR conflict, intervention, and outcome codes.
- b. Override the prescription limit when proper documentation is provided by the prescriber sending a "5" as the prior authorization (PA/MC code).
- c. Submit payments from other insurance plans for Medicaid claims in an "Other Payer" field.
- d. Override MAC prices with DAW 1 when proper documentation is provided by the prescriber.
- e. Send DEA number as the prescriber identifier.

C.3 Processing Charge

There are no state or federal funds for online claim processing, so there is a processing charge per **PAID** claim. There is **no** processing charge for rejects.

Online reversals (credits) are allowed for online claims for up to one year with a processing charge for each successful reversal. After one year, reversals must be done manually. The only way to reverse paper claims is to use the Pharmacy Adjustment Request form.

The processing charge for online claims is shown as a deduction on the same RA that shows the payment of the online claims. An amount equal to the processing charge times the number of paid and reversed claims is listed under the Point of Sale Service Charge section of the Claims Payment Summary of the RA. The Point of Sale Service Charge is deducted from the Net Pay Amount to derive the Adjusted Net Pay Amount. The Adjusted Net Pay Amount is equal to the amount

on the payment check. Online claims must be submitted by 12:00 midnight on Thursday in order to be included in the next check.

Refer below to **M, Point-of-Sale Reversals**, for additional information.

C.4 Online Point-of-Sale Processing Hours

Monday	2:30 a.m. - Midnight
Tuesday	2:30 a.m. - Midnight
Wednesday	2:30 a.m. - Midnight
Thursday	2:30 a.m. - Midnight
Friday	7:00 a.m. - Midnight
Saturday	2:30 a.m. - Midnight
Sunday	7:00 a.m. - Midnight

DMA's fiscal agent's Provider Services unit is available from 8:30 a.m. through 4:30 p.m. weekdays to answer general Medicaid pharmacy questions at 919-851-8888 or 1-800-688-6696. Calls between 4:30 p.m. to 5 p.m. weekdays should be directed to 919-233-6846.

All communication/technical POS problems should be directed to your "switch vendor" especially NCPDP reject codes 99 for Host Processing Error.

C.5 Placeholder for Compound Prescription Claims on Point-of-Sale

A placeholder for the prescription limit can be captured via the POS system for compound drug claims. In order for this to work, the pharmacist needs to send a prescription with the dummy Medicaid NDC number. If the placeholder is for a compound and is the first compound of the month for a patient, then 00990-0000-00 should be used as the NDC. If it is the second compound for the month, then 00990-1000-00 should be used. The pharmacist will receive a message that the transaction was accepted and a reminder that the claim must be submitted on paper to receive payment. If the placeholder is sent in error, it can be reversed just as any other POS claim.

C.6 Point-of-Sale Claims over \$9,999

Claims over \$9,999 require manual review for validity. These claims must be billed on paper.

C.7 Time Limit for Point-of-Sale Claims

POS claims must be billed within one year of the dispensing date.

D. Filing a Manual Claim

Where appropriate, a claim may be filed manually. The manual pharmacy claim form allows for billing 10 separate prescriptions within the same month of service. It may be used to bill for prescriptions dispensed to one recipient or for prescriptions dispensed to 10 different recipients.

Refer to **Attachment J** for instructions on completing the **Manual Pharmacy Claim Form** and a sample of the claim form.

E. Provider Retroactive Pharmacy Claims Billing

When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for

reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for services covered by Medicaid, with the exception of any third-party payments or cost-sharing amounts.

F. Billing Medicare before Medicaid

When Medicaid recipients have both Medicare and Medicaid coverage, pharmacy providers are required to bill Medicare first for the limited number of pharmaceutical products covered by that program. If the Medicare reimbursement does not equal 100 percent of the Medicaid allowable rate, the pharmacy provider may then bill Medicaid for the outstanding balance.

Due to restrictions imposed by Medicare on some drugs, such as restrictions to certain diagnoses, an override is available whereby Medicaid can be billed for these drugs when not covered by Medicare. For example, Imuran and methotrexate are only covered for the diagnosis of cancer, so Medicaid would need to be billed for any other diagnosis. To override the edit using POS, place a "1" (numeric) in the PA field. For electronic and paper claims, place an "O" (alpha) in the family planning field.

A co-pay should not be collected on any of the claims billed to Medicare. Once Medicare has paid, bill Medicaid for the remaining amount. The system will not deduct a co-pay for these crossover claims.

The N.C. Medicaid Outpatient Pharmacy Program will deny specific drugs that should be billed to Medicare first for identified patients who are eligible for drug coverage under Medicare Part B.

Refer to **Attachment K** for a list of drugs that must be billed to Medicare first.

Medicare accepts only claims billed on the CMS-1500 claim and/or 837.

Medicaid may be billed for the unpaid portion of a claim paid by Medicare by entering the following information in the appropriate fields on the form:

- a. the amount paid by Medicare in the Other Coverage Field;
- b. the Medicaid reimbursement rate in the Amount Billed Field (dollars/cents).

Medicaid will pay an amount equal to the Medicaid reimbursement rate less the amount paid by Medicare.

G. Billing Remainder of a Third-Party Prescription to Medicaid

Medicaid is always the payor of last resort when a recipient has other insurance that covers prescription drugs. If a recipient has **other insurance, including Medicare**, which pays for prescriptions, that insurance plan must be billed first. Medicaid may be billed for the unpaid portion of a claim paid by another insurance company by entering the following information in the appropriate fields on the claim:

- a. The amount paid by the other insurance in Other Coverage Field
- b. The Medicaid reimbursement rate in the Amount Billed field (dollars/cents)

Medicaid will pay an amount equal to the Medicaid reimbursement rate less the co-payment, where applicable, less the amount paid by the other insurance.

- Medicaid reimbursement rate
- Amount paid by other insurance
- Medicaid co-payment according to Medicaid Drug and Eligibility files

= Medicaid payment

The POS will check for current third-party coverage on the eligibility file. A message will be sent back by the POS system telling the provider that the recipient has third-party coverage for that date of service. The other third party should be billed as the primary payor, and then Medicaid can be billed as the second payor.

- c. If other coverage is indicated, the number '99' must be entered in field 338-5C
- d. When a claim is denied for other coverage, the POS system will deny the claim and will send the third-party information that is currently indicated on the eligibility file. The message will appear in the following format:

PBM or INS name/Payer phone number/BIN number/Policy #/ RX group number

Note: Will only display information currently available on the recipient eligibility file. The BIN will be listed if it can be identified).

- e. Pharmacy claims that are submitted on paper will also be subject to the coordination of benefits edit.

If a pharmacy claim is denied for third party and the patient indicates they have no other coverage, the edit can be overridden in the same manner as the Medicare Cost avoidance edit (place an 'O' in the family planning field).

- *Pregnant Women are Exempt from the Cost Avoidance Process.*

For recipients with MPW coverage (pink Medicaid identification card), the eligibility file automatically exempts the claim from the cost avoidance process.

With the Blue Medicaid Card, the Pharmacist can indicate pregnancy in one of three ways:

1. Indicate the diagnosis of V22.2 in the diagnosis field (424-DO) on the POS transaction
or
2. Use the "Pregnancy Indicator" (334-2C) field in the Patient Segment. A value of '2' will be used to indicate this override
or
3. Place a "4" in the P.A. (Prior Authorization type code) field (461-EU)

Override Codes for Cost Avoidance Process

Claim Segment defined as 308-C8 (Other Coverage Code)

- Required/Optional/Not Used: Optional
- Field Type: N
- Max length: 2
- North Carolina Medicaid Specifications (override codes)

01= No Other Coverage Identified

02 = Other Coverage Exists - Payment Collected (The member has other coverage and the payor has returned a payment amount. The payment amount is submitted in field 431-DV to the secondary payor (e.g.: Medicaid).

03 = Other Coverage Exists - This Claim Not Covered (Claim not covered under primary Third Party Plan. If primary denied the claim as Refill Too Soon, the claim would be submitted to the secondary payor with the Other Coverage Code 3. In this situation, claim would more than likely be too early for Medicaid as well)

04 = Other Coverage Exists - Payment Not Collected (Used when the member has other coverage and that payor has accepted the claim, but did not return any payment. This would be an example in which the member had a deductible amount to meet under the primary payor. The member is responsible for 100% of the payment, and the payor returns 100% of the payment, and the payor returns \$0.)

07 = Other Coverage Exists - Not in Effect at Time of Service (Other coverage exists but not on date of service)

The override codes listed above will be reported back to Medicaid on a monthly basis.

Example: After third-party insurer has paid, the claim can be billed to Medicaid with the other coverage amount indicated. For example, if a \$100.00 claim is billed to PCS and they pay \$65.00 (the patient has a \$20.00 co-pay), the claim is then submitted to Medicaid with \$100.00 billed amount and \$65.00 in the other coverage field (431-DV). The system will calculate the Medicaid allowable and then subtract \$65.00 from that amount. There should not be a reference to the \$20.00 co-pay.

H. Billing for Nursing Home Prescriptions and IV Therapy

Due to special packaging or storage requirements for nursing home prescriptions and the stability problems associated with IV therapy, a single prescription may have to be dispensed several times during the month in small quantities. Recipients of these prescriptions may quickly reach their prescription limit per month. Because of the special circumstances involved in their dispensing, **prescriptions for nursing home recipients and prescriptions for IV therapy may be billed once per month.** The monthly billed amount should reflect a total of all dispensing for that one prescription for the month less any credit that might have occurred during the monthly period.

I. Billing for Drugs Covered under Hospice

Recipients who are enrolled in the hospice program are covered under a per diem rate, which covers all services related to the recipient's terminal illness. The pharmacist is notified via the POS system if a recipient is enrolled in hospice. All drug claims will be denied with the message "recipient claim covered by hospice."

If the drug is to be used for an indication not directly related to the recipient's terminal illness, an override is available. A "1" entered in the PA field and the ICD-9-CM code for the recipient's terminal illness entered in the diagnosis field will override the hospice edit. It is acceptable to use a 3-digit ICD-9-CM code. Pharmacists should not use the ICD-9-CM code for the indication of the drug.

There are some drug classes where overrides are not allowed. These drug classes include narcotic analgesics and narcotic analgesic combinations, hematinics, antiemetics, and most chemotherapeutics.

The overrides are monitored by Program Integrity. Claims that are not covered by hospice that exceed the monthly prescription limit must be billed on paper an "O" in the family planning field and the ICD-9-CM code at the bottom of the form. Questions

concerning drug coverage for hospice patients should be directed to the recipient's hospice agency.

Pharmacists should contact DMA (919-855-4300) with questions regarding Medicaid coverage of pharmacy claims in the drug classes for which overrides are not allowed. If it is determined that Medicaid coverage is appropriate, the provider will be given billing instructions at the time of the call.

J. Compounded Drugs

J.1 Billing for Compounded Drugs

If the compound prescription contains all legend products, then the claim for the compound can be submitted either by using POS (NCPDP 5.1). However, claims over \$9,999.00 must be billed on paper.

NCPDP 5.1 (POS) Instructions

If the compound is billed using NCPDP 5.1 (POS), the total ingredients billed should match the compound ingredient component count. If they do not match, the claim will deny. The cost for each ingredient should be indicated and the dispensing fee should be included in the total billed amount listed on the header. If NDCs are included in the compound that are not covered by Medicaid, the claim will continue to process with the payable ingredients only. The POS system will assume "8" in the submission clarification field, which means "PROCESS COMPOUND FOR APPROVED INGREDIENTS."

Manual Claim Instructions

Each drug in the compound can be billed separately with its own NDC on the N.C. Medicaid paper claim form. A compound indicator is needed to avoid duplicate denials and extra dispensing fee payment errors. This indicator which will be one letter A through Z—excluding N, X, and Y—must be entered in the block formerly used for EPSDT. For example, the first compound billed for each recipient in each calendar month will be "A," the second will be "B," etc. Use the same letter for each line within the compound. If the refill or new prescription number is an equivalent drug to "A," then it should also have the "A" indicator. Refer to **Attachment J-2** for an example of a manual compound prescription claim.

Compounds containing OTCs must be billed using the N.C. Medicaid compound NDC or the pharmacist must elect to forfeit payment for OTCs and bill only the prescription items. When billing for these compounds, the N.C. Medicaid compound NDC (00990-0000-00) should be used on the detail line and the individual ingredients should be listed at the bottom of the claim form with the actual NDC, drug name, strength, quantity, cost per ingredient, and manufacturer

noted. Omitting any of this information will result in a denial. The total cost for all ingredients plus the dispensing fee should equal what is listed on the detail line as the billed amount.

Chemicals that do not have NDCs are not reimbursable. It is considered fraud to use a manufacturer's NDC if their product is not actually being used. If questionable claims are submitted, invoices may be requested to prove certain drugs were actually in stock. N.C. Medicaid does not accept the major ingredient's NDC for compounds because this results in over billing of units for manufacturer rebates. Failure to give the NDC number for each federal legend product contained in the compound will result in a denial with EOB 005, which states, "NDC # missing or invalid." Failure to list any ingredients or to list quantities will result in a denial with

EOB 946 "Compound information required."

J.2 Billing Multiple Compounds for the Same Recipient

If two different compounded prescriptions (that contain OTCs) are dispensed within the same calendar month for the same recipient, bill the second compounded prescription with NDC code 00990-1000-00 in the NDC field on the manual pharmacy claim form. Failure to list this code will result in a duplicate denial with the first compounded prescription. If a **third** compounded prescription is necessary, the code would be 00990-2000-00 and so on, increasing the digit in the sixth position as needed up to 00990-9000-00. If more than one compounded prescription has been dispensed and all of the ingredients cannot be described in the space provided in the ingredients field, file the additional compound(s) on a separate claim form.

J.3 Reimbursement for Compound Drugs

Medicaid will reimburse only for federal legend drugs contained in the compound that are manufactured by companies who have signed a national Medicaid Drug Rebate Agreement with CMS. If one prescription drug in the compound is not covered under the rebate agreement, reimbursement will be withheld for that drug only. The remainder of the compound will be paid if applicable. OTC products are reimbursed when included in a compound with at least one covered legend drug.

J.4 Summary of Compound Drug Reimbursement

Reimbursable compounds:

- a. Mixture of two or more physically inseparable ingredients, with at least one legend ingredient.
- b. Only legend drugs from manufacturers who signed the Drug Rebate Agreement will be reimbursed.

Non-reimbursable compounds:

<u>EOB</u>	<u>Requirement not met</u>
905	A compound without a legend-covered drug
905	A compound with only non-rebate drugs
038	OTC and DESI drugs as only ingredients
009	A compound equivalent to an OTC drug
009	OTC ingredients only
009	Two physically separable drugs (tablets and capsules) in the same bottle

K. Billing for Allergy Vaccines

Pharmacy claims submitted for reimbursement of allergy vaccines must include a copy of the invoice. The vaccine should be billed using the compound NDC number. Medicaid will reimburse for the cost of the drug and the dispensing fee. The shipping charges are not covered through the pharmacy program and may be billed to the recipient.

L. Pharmacy Claim Adjustments

The Pharmacy Adjustment Request form is used to request an adjustment to a Medicaid payment, when the adjustment cannot be processed online. Medicaid denials with no payment can be rebilled instead of adjusted. Examples of when to use the Pharmacy Adjustment Request form:

- a. crediting Medicaid for a billed and paid prescription that were never dispensed
- b. crediting Medicaid for a billed and paid prescription for Unit-dose drugs that were unused

Claims that are adjudicated online through POS must also be adjusted online, excluding the Pharmacy of Record adjustments.

Refer to **Attachment L** for a copy of the **Pharmacy Adjustment Request** form and instructions for completing the form. The form is also available online at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

M. Point-of-Sale Reversals

Claims submitted to Medicaid using POS may be credited with a POS reversal for up to **12 months** after the dispense date. It is recommended that pharmacies submit reversals weekly or, at a minimum, monthly. Pharmacies may obtain information on submitting a reversal, if needed, from their pharmacy software vendor. EDS cannot reverse claims submitted using POS.

POS reversals may be completed for claims submitted with incorrect quantities or NDCs. POS reversals also allow the pharmacist to help recipients who need additional medication when they have already received the maximum number of prescriptions by permitting the reversal of a less expensive prescription in order to allow billing of a more expensive prescription.

N. High Dosage Edit

The system checks for high dosage by comparing the units that are billed for the days supply limit indicated with what has been approved by the FDA. If the units billed on the claim exceed this limit, an edit will notify the provider that the units and days supply

need to be verified for accuracy. To override the edit and indicate that the units and days supply have been verified and are correct, enter a “2” in the prior authorization field or in the submission clarification field.

O. Time Limit Overrides

DMA frequently receives requests to waive the federally prescribed 12-month claims filing time limit. DMA has extremely limited authority to override the time limit when eligibility was not approved within the year or for court decisions or hearings, which authorize eligibility retroactively. Failure of the provider to file and follow up timely is not a basis for override and will result in denial of claims.

Medicaid claims, other than crossover and third party, must be received by EDS within 365 days from the date of service. Hospital inpatient, long-term care, and home health claims must be received within 365 days from the last date of service on the claim. Medicare/Medicaid crossover and other third-party claims must be received within 180 days from the date of payment or denial from the third-party payor or 365 days from the date of service, whichever is later. Proof that the claim was submitted timely includes:

- a. correspondence about the claim received from DMA or EDS;
- b. an explanation of Medicare or third-party benefits dated 180 days from the date of payment or denial;
- c. a copy of the remittance and status report (RA) showing the claim pending or denied.

It is the provider’s responsibility to file claims in a timely manner and to follow up within the time limit for claims not reported back on the RA. When claims are initially filed, providers should allow approximately 30 days for the transactions to appear on the RA. If there is no indication on the RA that the claim was received, providers may use the Automated Voice Response System to determine the status of the claim. If the claim has not been received by EDS, providers should resubmit immediately to prevent denial for timely filing.

P. Pharmacy Remittance Advice

The RA is a computer-generated document showing the status of all claims submitted to EDS along with a detailed breakdown of payment. The RA is produced at the same time that checks are issued.

Refer to **Attachment M** for instructions for using the RA.

Q. Resubmission of Rejected or Denied Claims

Q.1 Explanation of Benefit Codes

Rejected or denied claims are identified on the pharmacist’s RA with an explanation of benefit (EOB) code, which explains why the claim was rejected or denied. The EOB assists the pharmacist in correcting and resubmitting a rejected or denied claim.

Q.2 Resubmitting a Claim

All claims must be submitted to EDS within 365 days of the date of service. If a claim is paid incorrectly or a claim is rejected or denied, providers have 18 months from the date of the RA denial to resubmit a claim for processing.

Claims that are denied with no payment can be resubmitted as new claims. Examples of claims that are denied with no payment are:

- a. invalid date of service;
- b. missing or invalid information such as quantity or billed amount;
- c. NDC not on file.

Note: Claims that deny with this EOB message should be verified to ensure that the correct NDC was listed on the original claim form.

A Pharmacy Adjustment Request form is used to request adjustments to a Medicaid payment for prescription drugs. Use the Pharmacy Adjustment Request form to:

- a. override a MAC payment when medical necessity is properly documented;
- b. correct an erroneous quantity or NDC for a paid prescription;
- c. credit Medicaid for a billed and paid prescription that was never dispensed;
- d. credit Medicaid for a billed and paid prescription for unit-dose drugs that were unused;
- e. correct Pharmacy of Record denials when submitted with a copy of the Medicaid card stub.

A time limit override will only be granted if documentation supports that the claim was originally filed within the 365-day billing time limit. Attach the claim and a copy of the RA for the claim in question to the Medicaid Resolution Inquiry form and check the “Override Time Limit, Documentation Attached.”

Do not submit a new claim if a partial payment was received. If partial payment is received on a claim, providers must complete and submit a Pharmacy Adjustment Request form with a copy of the RA indicating the payment that was received. Clearly state the reason for the adjustment.

Q.3 Name/Number Mismatch

To avoid a name/number mismatch, do not use the recipient’s middle initial on the claim form. The recipient’s first and last name are sufficient. Enter the recipient’s MID number and name as shown on the MID card or, if the recipient’s name has changed, according to the eligibility file.

Q.4 Eligibility Follow-Up

Because a recipient’s eligibility status may change from one month to the next if the financial and/or household circumstances change, providers should request that recipients provide proof of eligibility each time a service is rendered. A copy of the recipient’s MID card with valid from and thru dates that cover the date of service, is guarantee of payment for covered services. The most common EOBs received for eligibility denials are these:

EOB Code	Message
011	Recipient not eligible on service date.
120	Recipient MID number missing
143	Recipient MID number not on state eligibility file
191	Recipient MID number does not match patient name

Refer to the following instructions to resolve a claim denied for eligibility.

Step 1 - Check for Errors on the Claim. Compare the recipient's MID card to the information entered on the claim form and reported on the RA. If the recipient's name or MID number were not entered correctly on the claim, complete corrections and submit as a new claim. Documents verifying eligibility are not required, but any other required documents for medical review or adherence to guidelines must be attached. If the claim is over the time limit, request a time limit override by submitting a completed Medicaid Resolution Inquiry form along with the claim and a copy of the RA showing the denial to EDS Provider Services.

Step 2 - Check for Data Entry Errors. Compare the recipient's MID card to the information entered on the claim form and reported on the RA. If the recipient's name or MID number were entered correctly on the claim, compare the claim form with the RA. If the recipient's name, MID number or the date of service were keyed into the system incorrectly, resubmit the claim. If the claim is over the time limit, request a time limit override by submitting a completed Medicaid Resolution Inquiry form along with the claim and a copy of the RA showing the denial to EDS Provider Services.

Step 3 - Mail Information Required for Eligibility Validation. Compare the recipient's MID card to the information entered on the claim form and reported on the RA. If the recipient's name or MID number were entered correctly on the claim, compare the claim form with the RA. If the recipient's name, MID number or the date of service were keyed into the system correctly, request a time limit override by submitting a completed Medicaid Resolution Inquiry form along with the claim, a copy of the recipient's MID card, and a copy of the RA showing the denial to the DMA Claims Analysis Unit at the address listed below. Do not send the override request to EDS; this delays payment of the claim.

Division of Medical Assistance
Claims Analysis Unit
2501 Mail Service Center
Raleigh NC 27699-2501

R. Indicating Exemption from the Prescription Limitation

An override for exemption from the prescription limitation is indicated by entering a "5" in the PA/MC field or by entering an "E" in the block on the paper claim form used to designate patient location (LOC). An override for exemption from both the prescription limit and the co-payment is indicated by entering an "8" in the PA/MC field or by entering a "B" in the block on the paper claim form used to designate LOC.

S. Recipient Opt-in (Restricted Pharmacy Services) Program

S.1 Opt-in Exemption for Recipients Residing in Long-Term-Care Facilities

Recipients residing in nursing facilities, intermediate care facilities/mental retardation centers, assisted living facilities, and group homes are exempt from mandatory pharmacy opt-in and the FORM program because medication reviews are required by OBRA 1990 guidelines and North Carolina rules and regulations governing adult care homes (10A NCAC 13G.1009 or 10A NCAC 13F.1009) and group homes (10A NCAC 27G.0209).

S.2 Recipient Opt-in and Living Arrangement Changes

Recipients who are restricted to one pharmacy can have their primary care physician or current pharmacy provider contact EDS to request changes to the pharmacy opt-in provider. Changes in a recipient's living arrangement may require a change to the pharmacy opt-in provider and it would be expected that the recipient's current pharmacy opt-in provider contact EDS to facilitate this change. To reach EDS between 8:30 a.m. and 4:30 p.m. on weekdays, dial 919-851-8888 or 1-800-688-6696.

S.3 Recipient Opt-in and Addition of Specialty Pharmacy Provider

Recipients may be assigned specialty pharmacy providers in addition to the pharmacy provider the recipient is opted into when necessary to receive medications only available through a specialty pharmacy provider. Specialty pharmacies are pharmacies that provide compounded drugs and high-cost injectables and infusion therapies used to treat chronic diseases with low prevalence, which are routinely administered in the outpatient setting and require special handling and distribution. Examples of drugs provided by specialty pharmacies include drugs that require compounding and drugs used in diseases such as hemophilia, growth retardation, RSV, and hepatitis C.

T. Professional Services Fee for Focused Risk Management (FORM) Program

A quarterly FORM professional service fee of \$30.00 per provider per opt-in recipient will be paid to one pharmacy each quarter that participates in the FORM program upon completion of the comprehensive review plan for each identified Medicaid recipient. Upon completion of the recipient's quarterly FORM intervention review, reimbursement will be submitted at the POS. The professional service fee submission will be transmitted using the NCPDP 5.1 field 477-BE (pricing segment).

The pharmacy provider will have up to one year from the date of service of the actual review to submit the FORM service fee.

**Attachment B: Table of Exemptions to Co-payment and Prescription Limit
Specific Edit Override Information**

Condition	Exemption			NCPDP			Manual (Paper) Claim
	Co-pay	Rx Limit	Both	Location	PA Code	Submission Clarification Field	
Eight-Rx-Limit Exemption							
Notation of Rx limit override dependent on pharmacy review (9 th , 10 th , and 11 th)	N	Y			5		Loc=E
Co-pay Exemption							
Family Planning	Y	N			Drug File		Drug File
Intermediate Care Facility	Y	N		2			7
Skilled Nursing	Y	N		7			8
Pregnancy	Y	N			4 or Eligibility File		Eligibility File
Exempt from co-pay only	Y	N			4		Not Existing
Eight-Rx-Limit and Co-pay Exemption							
Health Check < 21 years old	Y	Y			Eligibility File		Eligibility File
CAP	Y	N			Eligibility File		Eligibility File
Exempt from co-pay and 8-Rx limit	Y	Y	Y		8		B
Locations with No Automatic Exemptions							
Hospice	N	N		11			
Rest Home	N	N		5			6
Specific Edit Overrides							
Edit 907 (Dosage over FDA guidelines)	N	N				2	
Edit 946 (Medicare Edit)	N	N			1		

Condition	Exemption			NCPDP			Manual (Paper) Claim
	Co-pay	Rx Limit	Both	Location	PA Code	Submission Clarification Field	
Early Refill Override – Vacation (in addition to DUR override)	N	N				3	
Early Refill Override – Lost prescription (in addition to DUR override)	N	N				4	
Early Refill Override – Change in Therapy (in addition to DUR override)	N	N				5	

Attachment C: Requesting Prior Authorization for Prescription Drugs

The process to request authorization for the prescription drugs indicated in **Section 5.6** is as follows:

- a. The prescriber contacts the ACS Clinical Call Center (in Atlanta, Georgia) by telephone, fax, e-mail or mail. Hours of operation are Monday through Friday, 7:00 a.m. to 11:00 p.m. and Saturday through Sunday, 7:00 a.m. to 6:00 p.m.

Phone: 1-866-246-8505

E-mail: nc.providerrelations@acs-inc.com

Fax: 1-866-246-8507

Mail: ACS State Healthcare, Prior Authorization Department
365 Northridge Road, Ste. 400
Atlanta GA 30350

The prescriber offers information as specified on the prior authorization form for the drug being requested. Copies of the forms are available online at <http://www.ncmedicaidpbm.com>. All requests will be answered within 24 hours of receipt.

- b. If the request for prior authorization is approved, ACS updates the system. The POS claims processing system manages the PA information.
- c. The billing pharmacy submits the claim for reimbursement. If the prescriber has not obtained prior authorization, the POS will return a message of either PA REQ. PRESCRIBER CALL ACS or CLAIM DENIED. PA LIMITS EXCEEDED. If the billing pharmacy receives one of these messages, ACS may be contacted at 1-866-246-8505 to verify the status of the prior authorization request or notify the prescriber to call ACS.
- d. **72-Hour Emergency Supply**

If the prior authorization request is approved, the emergency supply should be billed through POS as part of the original fill.

If the prior authorization request is not approved, the emergency supply should be billed on a paper claim form and mailed to:

EDS
Attn: Pharmacy Claims Analyst
Pharmacy Department
4905 Waters Edge Drive
Raleigh NC 27606

The eligibility file is checked for patient location and to ensure claims process accurately. One of the following approved codes must be indicated for patient location:

- 2 Inter-Care
- 3 Nursing Care
- 4 Long-Term/Extended Care
- 7 Skilled Care Facility
- 8 Sub-Acute Care Facility

- e. **Retroactive Prior Authorization**

A prescriber or long-term-care pharmacist may request retroactive prior authorization (PA) for medications in the pharmacy PA program for dates of service up to one year after dispensing. (Note: Long-term-care pharmacists may not request prior authorization for Brand Name Schedule II narcotics or sedative hypnotics.) Retroactive requests may be made by

contacting the ACS clinical call center and will be considered on a case-by-case basis. If no other PA exists and the patient meets criteria for full approval, a retroactive PA may be entered to include backdates and forward for full approval period.

Additional information regarding the prior authorization process can be found on DMA's pharmacy Web site at <http://www.ncmedicaidpbm.com>.

Attachment D: Narrow Therapeutic Index Drugs

(As published in the N.C. Register, Volume 23, Issue 17, March 2, 2009)

The following list of NTI drugs is reviewed on an annual basis and submitted to the Office of Administrative Hearings by the N.C. Board of Pharmacy for publication in the N.C. Register.

Carbamazepine: all oral dosage forms

Cyclosporine: all oral dosage forms

Digoxin: all oral dosage forms

Ethosuximide

Levothyroxine sodium tablets

Lithium (including all salts): all oral dosage forms

Phenytoin (including all salts): all oral dosage forms

Procainamide

Tacrolimus: all oral dosage forms

Theophylline (including all salts): all oral dosage forms

Warfarin sodium tablets

Attachment E: Drug Use Review Program

Overview of the Drug Use Review Program

In accordance with the Social Security Act of 1927 and the Omnibus Budget Reconciliation Act (OBRA) of 1990, North Carolina established a Drug Use Review (DUR) program for outpatient drugs to assure that the prescriptions dispensed to Medicaid recipients are:

- a. Appropriate
- b. Medically necessary
- c. Not likely to result in adverse medical results

The program enhances the quality and appropriateness of patient care by educating physicians and pharmacists on common drug therapy problems to improve prescribing and dispensing practices for Medicaid recipients. The DUR program consists of the following components.

A. Division of Medical Assistance (DMA)

The DMA will establish the Drug Use Review Board (DUR). The DUR Board will not have rule making authority. The DMA can reject the recommendations of the DUR Board by notifying the Board in writing to allow the Board an opportunity to reconsider its decision. The criteria and standards for the drug therapy review adopted by DMA upon recommendation by the DUR Board shall be available to pharmacists, prescribers, and the general public.

B. DUR Board

The Board is composed of the DMA Use Review Coordinator, five licensed, actively practicing physicians, five licensed, actively practicing pharmacists and at least two additional individuals who have expertise in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs, drug use review, evaluation, and intervention or medical quality assurance. One pharmacist and one physician shall act as co-chair on the Board. Co-chairs are elected for a one year term by their peers and are eligible for a co-chair position after one year on the Board. The term of membership shall be 12 months, with the option to renew for two additional 1-year periods. The North Carolina Association of Pharmacists, the North Carolina Medical Society and the Old North State Medical Society shall be asked to make nominations for some positions on the Board. The Director will have the right to reject or accept nominations. The activities of the DUR Board include establishing standards, retrospective DUR, and ongoing educational interventions. At least quarterly, the Medicaid drug claims, in conjunction with other medical claims as needed for clinical purposes, shall be screened against the standards established by the DUR Board. The State assures it will prepare an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, and procedures as described in OBRA 90.

C. Prospective DUR

C.1 Purpose

The purpose of **Prospective Drug Utilization Review (Pro-DUR)** is to improve the quality of care and promote cost savings by preventing adverse drug events

before a prescription is dispensed or used. Pro-DUR is an additional source of information for the pharmacist to use in making decisions affecting pharmaceutical care.

A prospective review of drug therapy is conducted at the time a new prescription is filled or delivered. This review involves comprehensive screening of the prescription. Potential drug therapy problems based upon predetermined standards include, but are not limited to:

1. Therapeutic duplication
2. Drug–disease contraindications
3. Drug–drug interactions
4. Drug interactions with non prescription or over-the-counter drugs
5. Drug–disease interactions
6. Incorrect drug dosage or duration of therapy
7. Drug allergy interactions
8. Clinical abuse/misuse

Pharmacies participating in Medicaid must conduct the Pro-DUR screening. To comply with these standards, pharmacies must use either a prospective DUR software database or written standards consistent with the DUR Board policy. Additional Pro-DUR screening is provided for claims submitted using POS.

The National Council of Prescription Drug Programs (NCPDP) Pro-DUR alerts the dispensing pharmacist of potential conflicts. This requires an intervention or outcome coding before payment is made for the prescription. If the pharmacist determines that the prescription should be dispensed, the pharmacist must document his/her professional judgment by responding to the DUR alert. If more than one DUR alert is received, it is only necessary for the pharmacist to respond to the first alert. All of the criteria required to respond to the DUR alert is included in the DUR information sent with the alert. A DUR conflict must be documented with NCPDP DUR Outcome and Intervention codes in order to receive payment for a resubmitted prescription.

C.2 Procedure for Responding to DUR Alerts

1. The pharmacist receives a DUR alert message(s) on the computer screen; claim is rejected for DUR.
2. The pharmacist reviews and resolves identified DUR conflict(s) by contacting the prescriber, talking with the patient, and/or using other resources or professional judgment.
3. If the pharmacist decides not to dispense the prescription, the pharmacist accepts the reject.
4. The pharmacist does not resubmit the claim and does not receive payment.
5. If the pharmacist decides to resolve and dispense the prescription, the pharmacist resubmits the correct claim with a DUR Conflict code, DUR Intervention code, and DUR Outcome code.

6. If the alert is for an early refill, the pharmacist must include one of the approved reason codes in the prescription clarification field:

- 03 Vacation Supply** To be used if the patient is going out of town and needs medication refilled early. **Note:** This will not allow more than 34 days to be indicated in the days supply field.
- 04 Lost Prescription** To be used if the patient has lost their medication.
- 05 Therapy Change** To be used if the dosage is changed on a current medication.

Note: Vacation supply and lost prescriptions are not allowed for controlled substances.

7. The pharmacist receives a paid response if DUR documentation was used and the prescription was filled.

Up to three DUR alerts can be returned for a prescription in the NCPDP standard. If there are more than three DUR alerts, a DUR overflow message will be returned. If the pharmacist wants to dispense a prescription that creates more than three alerts and wants to know the overflow alerts, he/she may call DMA's fiscal agent's Provider Services unit at 919-851-8888 or 1-800-688-6696.

DUR alert messages contain standard codes and language, but may be displayed in various ways, depending on the pharmacy software in use.

If an override is not requested for a prescription that is rejected with a DUR Conflict code, it will be assumed that the prescription was not filled. Return of a Not Filled Outcome code is not required.

Medicaid Pro-DUR is based on a patient's prescriptions from all prescribers and all pharmacies utilizing criteria established by the State and by a controllable database updated by First DataBank.

Submitting an accurate days supply is very important. The day's supply divided by the quantity is used to calculate the daily dose for Pro-DUR. Excessively high or low daily doses result in rejects for High and Low Dose DUR alerts. In addition to high and low daily dose edits, there are also edits for an early fill before 75 percent of the prescription is used and for a 34-day maximum (or 90 days if applicable). The maximum days supply cannot be overridden.

C.3 Counseling

Pharmacists **must** offer to discuss those matters with each Medicaid recipient presenting a prescription, which they, in their professional judgment, deem to be significant. This **counseling** may include but is not limited to the following:

1. Name and description of the medication
2. Dosage form, dosage, route of administration, and duration of therapy
3. Special directions, precautions for preparation, administration, and use by the patient
4. Common severe side effects, adverse effects or interactions, drug allergies, and therapeutic contraindications
5. Techniques for self-monitoring

6. Proper storage
7. Refill information
8. Actions in case of a missed dose

Although the patient may refuse counseling, the offer must be made.

C.4 Information on Medicaid Recipients

The pharmacies are required to make a reasonable effort to obtain, record, and maintain **information on Medicaid recipients** receiving prescriptions to include at least the following information:

1. Patient's name, age, gender, address, and phone number
2. Individual patient history including a list of medications and devices
3. Pharmacist's comments

The Division of Medical Assistance will monitor compliance with the requirements for prospective DUR screening, counseling, and maintenance of patient information as required by federal law and regulations.

D. Retrospective DUR

D.1 Overview

OBRA 90 requires that DMA use Medicaid paid claims data to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients or patterns associated with specific drugs or groups of drugs and patterns of fraud and abuse. These analyses are based on explicit predetermined standards including the screens as described in the prospective review process. Pharmacist and prescriber response to the interventions undertaken shall be tracked. The DUR Board may establish selection criteria for intensified review and monitoring of individual pharmacists and prescribers.

OBRA 90 also requires that the DUR program introduce remedial strategies, when necessary, to improve the quality of care for Medicaid recipients and to conserve program funds. These strategies include educational intervention, general or specific information dissemination, written, oral or electronic reminders, face-to-face discussion or intensified review or monitoring of practitioners. The DUR Board determines the interventions that will be used and, after the appropriate amount of time, evaluates the results to determine the effectiveness on improved drug therapy. The DUR Board may also establish referral processes to the Board of Pharmacy, the Board of Medical Examiners, the Board of Dental Examiners, other health care licensing agencies, or DMA Program Integrity Section for pharmacists or prescribers. This can occur if pharmacists or prescribers continue to demonstrate patterns of prescribing or dispensing which put the Medicaid recipient at risk from drug therapy problems even after repeated warnings through Drug Use Review interventions.

Retrospective DUR (Retro-DUR) is well-suited for identifying aggregate provider-centered prescribing problems. The integration of prospective DUR online and retrospective DUR has the potential to promote improved prescribing practices and patient outcomes. Retro-DUR can detect new relationships and problems among medications and diseases and can be used ongoing to update the Pro-DUR systems.

Retro-DUR is theoretically designed to accomplish the following:

1. Detect the full range of prescribing problems
2. Recommend corrective actions for controlling costs and improving patient outcomes
3. Improve rational prescribing
4. Identify preventable drug therapy problems
5. Remind physicians of basic principles and provide up-to-date information needed for optimal prescribing
6. Promote proactive pharmacy intervention processes
7. Evaluate the effectiveness of interfacing Medicaid programs

DUR is education of prescribers and pharmacists to improve the quality of care for Medicaid recipients while reducing expenditures. Primary tangible cost reductions will be affected by

1. Prescribing and dispensing of equally effective, less expensive drugs such as generic drugs
2. Decreasing the incidences of unnecessary therapeutic duplications
3. Averting prescribing problems that may precipitate unnecessary physician visits, ER visits, and hospitalizations

D.2 Profiling Systems Used by the Retrospective Drug Use Review Program

The DUR Program uses two retrospective profiling methods to characterize drug use patterns and to help providers assure the quality of care in prescribing medications. These methods are Provider Profiling and Recipient Profiling.

Provider Profiling

The Provider Profiling System uses the Drug Enforcement Agency (DEA) number to identify prescribing practices that deviate from accepted norms. These norms are taken from the published literature or developed by the DUR Board. Medicaid provider numbers are used to identify similar dispensing practices.

The Provider Profiling System accommodates criteria within the following major multi-factor problem types:

1. Overtreatment
2. Undertreatment
3. Treatment failure
4. Drug-to-diagnosis interactions
5. Drug-to-drug interactions
6. Iatrogenic effects
7. Adverse effects
8. Therapeutic duplication
9. Drug use without diagnosis
10. Drug use without laboratory/diagnostic procedures
11. Empiric prescribing
12. Specialty-prescriber use issues

Providers who are accepted in the Provider Profiling System receive an educational letter and a profile showing every drug claim paid using the prescriber's DEA or state-approved provider identifier for each Medicaid patient who received the specific drug therapy. The packet also includes prescribing information related to the specific drug therapy and response sheets for providers to indicate the appropriateness and usefulness of the intervention to the individual's practice.

Recipient Profiling

Recipient Profiling is designed to use specific criteria to characterize drug utilization patterns among recipients. The criteria can identify the following multi-factor problem types:

1. Overutilization
2. Underutilization
3. Treatment failure
4. Drug-to-diagnosis interactions
5. Drug-to-drug interactions
6. Iatrogenic effects
7. Adverse reactions

Profiles, which show the entire medical and drug claims paid for a particular recipient, are produced. DUR staff and the DUR review committee review these profiles and decide if the providers involved in the recipient's care should receive educational letters explaining the concern for the appropriateness and necessity for the drug therapy and the possibility of said therapy resulting in clinically significant adverse effects. The packets sent to prescribers and pharmacists include the educational letter, recipient profile, pertinent information relating to the drug therapy issue, and response sheets indicating the usefulness of this intervention to the individual's practice.

E. Medicaid Statutory DUR Requirements and Impact on Pharmacies

OBRA required that the drug use review (DUR) program be implemented by January 1, 1993. The following guidelines are provided to assist retail pharmacies in complying with the DUR program.

E.1 Patient Profiles

Statutory Requirement

Section 1927 of the Act requires **the pharmacist** to make a **reasonable effort** to obtain, record, and maintain for Medicaid recipients the following information:

- a. Name, address, telephone number, age (or birth date), and gender
- b. Individual history where significant, including disease state(s), known allergies, drug reactions, a comprehensive list of medications, and relevant devices
- c. Pharmacist comments relevant to the patient's drug therapy

Impact on Pharmacies

- a. **The pharmacist**, as defined in State Pharmacy Practice Acts, **is responsible** for collecting, recording, and maintaining patient profile information.
- b. **The pharmacist** may rely upon **ancillary personnel** to collect, record, and obtain patient profile information, but **the pharmacist must review and interpret** patient profile information and clarify confusing or conflicting information.
- c. Once patient information is obtained, **this information shall be reviewed and updated by the pharmacist** or registrant **before each prescription is filled or delivered**, typically at the point-of-sale or point-of-distribution to screen for potential drug therapy problems listed under the “screening” section below.
- d. A **“reasonable effort”** to obtain profile information will be a good faith effort to obtain from the patient or representative the foregoing patient’s information.
- e. It is expected that **the pharmacist** will be guided by **professional judgment** as to whether and when individual history information should be sought from the physician or other health care providers.

E.2 Screening

Statutory Requirement

- a. Section 1927 (g)(2)(A) of the Social Security Act (the Act) **requires Pro-DUR** at the point-of-sale or distribution **before each prescription is filled or delivered** to Medicaid recipients. This review shall include screening for potential drug therapy problems due to any of the following:
 - Therapeutic duplication
 - Drug–disease contraindications
 - Drug interactions
 - Incorrect dosage or duration of drug treatment
 - Drug allergy interactions
 - Clinical abuse/misuse
- b. Prospective DUR screening **must use predetermined standards that are based upon** the following compendia:
 - American Hospital Formulary Service Drug Information
 - United States Pharmacopoeia Drug Information
 - American Medical Association Drug Evaluations
 - Peer reviewed medical literature which has been critically reviewed by unbiased independent experts.

Impact on Pharmacies

1. **Prospective DUR screening is the responsibility of each Medicaid participating pharmacy.**
2. Medicaid will supplement DUR on POS claims with alerts for
 - Therapeutic duplication
 - Drug–disease contraindications

- Drug interactions
 - Incorrect dosage
3. Pharmacies may use commercially available DUR database packages to assist with prospective DUR. Pharmacies are not required to have their databases/software certified by the State DUR Board.
 4. Such data base packages must be able to screen for the therapeutic problems specified in the statute using explicit standards.
 5. It is not expected that these databases will contain **patient-specific diagnosis or allergy information**. When, in the **pharmacist's professional judgment**, obtaining such information is essential to the health and well-being of the patient, the pharmacist should consult the patient or the patient's health care provider.
 6. **Pharmacies without computers**, or those who choose not to use prospective DUR database packages, **must undertake prospective DUR screening manually. To perform prospective DUR screening manually, the pharmacist** must screen using **predetermined standards**, which are **based upon** the listed compendia.

E.3 Patient Counseling

Statutory Requirement

Section 1927 (g)(2)(A)(ii)(I) of the Act requires that **pharmacists offer** to discuss with **each Medicaid recipient** or a caregiver, **in person** whenever practicable, or by toll free telephone for long distance calls, matters which in his/her **professional judgment** the pharmacist deems significant. Such counseling is subject to standards for counseling under the State Pharmacy Practice Act. Such counseling **is to be provided unless refused** by the Medicaid recipient or caregiver.

The statute lists the following subjects for inclusion in counseling:

- a. The name and description of the medication
- b. The route of administration, dosage form, dosage, and duration of drug therapy
- c. Special directions and precautions for preparation, administration, and use by the patient
- d. Common severe side or adverse effects of interactions and therapeutic contraindications that may be encountered, including how they may be avoided and the actions required if they occur
- e. Techniques for self-monitoring drug therapy
- f. Proper storage
- g. Prescription refill information
- h. Action to be taken in the event of a missed dose

Impact on Pharmacies

- a. **The pharmacist**, as defined in State Pharmacy Practice Acts, **is responsible** for the **offer to counsel** and for **conducting of counseling** when it occurs.
- b. The **pharmacist** may have **ancillary personnel** make the offer of counseling, but **the pharmacist must personally conduct counseling if the offer is accepted**.

- c. Pharmacies whose primary patient population are accessible through local measured or toll free exchange are not required to offer toll free service.
- d. **Pharmacists will be required** to, at least, **document refusal** to accept an offer of counseling. States may impose additional documentation requirements with regard to counseling. **Records** resulting from compliance with the DUR requirements shall be maintained for **five (5) years** in accordance with Medicaid guidelines.
- e. States may choose to apply counseling requirements to all recipients of prescriptions, not just Medicaid recipients.
- f. Counseling requirements apply to both **new and refill prescriptions**. However, **professional judgment** shall be exercised in determining whether or not to **offer counseling for prescription refills**.
- g. Alternative forms of patient information (such as written material) may be used to supplement patient counseling, but **cannot be used as a substitute for counseling**.
- h. The content of counseling is governed solely by the **professional judgment of the pharmacist**.

The Medicaid DUR requirements have been incorporated into the State of North Carolina Pharmacy Practice Act and are therefore consistent with the requirements of the Board of Pharmacy except in three areas:

- a. The Medicaid requirements address **manual prospective DUR screening** in the absence of a computer DUR database/software package.
- b. All records or documentation pertaining to DUR for Medicaid patients must be retained for five (5) years rather than the State Board of Pharmacy requirements of three (3) years.
- c. A recoupment of the total claim may be imposed on the pharmacy provider for non-adherence to this statutory requirement.

F. Requirement for Accurate Data on Pharmacy Claims

The DUR program depends on the submission of accurate data on pharmacy claims to minimize false positives and unnecessary referrals to pharmacies.

The following fields on the pharmacy claims are **very important**.

F.1 Days Supply

The DUR Program uses this information to compute the dose per day, which is often an indication of the therapeutic use. For example, a once daily dosing of cimetidine 400 mg would indicate that the medication is maintenance therapy as opposed to acute therapy. The information provided in this field is also used as an indicator for determining if the recipient overutilizes or underutilizes medications, as well as identifying potentially inadequate dosing and excessive dosing.

F.2 Prescriber Identification Number

The correct Medicaid prescriber identification number is critical in identifying the prescribers and pharmacists involved in the recipient's drug therapy. A recipient with multiple prescribers often risks medication complications of a different magnitude as opposed to a recipient using one primary provider. One of

the functions of DUR is to determine if the recipient's use of multiple prescribers results in overutilization of services. The N.C. Medicaid Program currently uses the DEA to identify the prescribers on the pharmacy claim. It is imperative that the DEA be entered accurately on the claim. If the prescriber does not have a DEA, then the pharmacist should notify the DUR staff at DMA.

F.3 Quantity Dispensed

The accuracy of the data entered in this field is critical to the DUR Program and the Drug Rebate Program. The quantity and days supply are used to calculate the dose per day.

G. Pont-of-Sale/Online Prospective Drug Use Review

G.1 Introduction

According to the Omnibus Budget Reconciliation Act of 1990 (OBRA), pharmacists must maintain patient medication records; must screen prescriptions for potential therapeutic problems before medications are delivered to patients; and must counsel patients on all new or changed prescriptions and on refills when the pharmacist deems it warranted or the patient requests it.

G.2 OBRA '90 and Outpatient Drug Use Review

OBRA mandates that each state Medicaid agency establish a comprehensive DUR program. The law also requires that states establish a DUR Board to assist in reviewing criteria, establishing standards and assessing their effect upon the quality of care delivered to Medicaid beneficiaries. The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical events.

DUR is an administrative process of utilization review and quality assessment. It includes predetermined criteria to describe appropriate medical care and standards to define the allowable deviation from the criteria.

The predetermined criteria used in the DUR program must meet the following requirements:

- a. Source materials must be consistent with the peer-reviewed medical literature, American Hospital Formulary Service Drug Information, United States Pharmacopoeia Drug Information, and American Medical Association Drug Evaluations.
- b. Differences among source materials are resolved by a consensus of physicians and pharmacists.
- c. Criteria are non-proprietary and readily available to providers of services.
- d. Criteria are clinically based and scientifically valid.
- e. Criteria are tested against claims data prior to adoption.
- f. Predetermined standards for prospective and retrospective DUR are compatible.
- g. Criteria are subject to ongoing evaluation and modification either as a result of actions by their developer or by the DUR Board.

G.3 Objectives

The objective of online prospective DUR is to assist pharmacists in screening select drugs for potential drug therapy problems before the prescription is delivered to the patient.

G.4 Point-of-Sale System Operations

Prior to DUR processing, pharmacy claims are processed by the online adjudication system to verify recipient eligibility, ensure validity (valid dates, NDC numbers, pharmacy and prescriber provider numbers), determine appropriate payment, and comparison with previously paid claims to enforce program service limitations and nonpayment for duplicate claims. The online system utilizes the same processing methodology as paper claim submissions.

G.5 Prospective Drug Use Review System

DUR processing begins after the claim is certified payable. Incoming drug claims are compared to the patient's pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for all problems discovered by this review.

Online prospective DUR provides for review of drug therapy before each prescription is filled or delivered to the patient and includes screening for potential drug therapy problems due to any of the following:

- a. Drug–drug interactions
- b. Therapeutic duplication
- c. Incorrect drug dosage (low dose or high dose)
- d. Overutilization (clinical abuse/misuse)
- e. Underutilization (clinical abuse/misuse)

Pro-DUR screens the patient's profile across multiple pharmacies and prescribers to improve the quality of care and reduce costs by supplying pharmacists with information regarding potential adverse drug incidents and overutilization. N.C. Medicaid Pro-DUR documents pharmaceutical care with National Council for Prescription Drug Programs (NCPDP) DUR intervention and outcome codes required to override DUR alerts. Accurate days supply is essential for Pro-DUR minimum and maximum dosages.

Prospective DUR applies to systemic drug dosage forms as well as non-systemic forms. Systemic routes of administration include parenteral, buccal, inhalation, translingual, sublingual, transdermal, oral, rectal, vaginal, mucous membrane and nasal dosage forms. Non-systemic refers to dental, irrigation, urethral, ophthalmic, otic and topical dosage forms.

G.6 National Council for Prescription Drug Programs (NCPDP) Standards

Pharmacy claim telecommunication standards dictate the order and content of the fields relayed to the pharmacist when a DUR alert is generated. A description of these fields follows.

- a. Conflict Code

Alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria.

b. Clinical Significance/Severity Index Code

Indicates database-assigned significance of the conflict.

0 = Not applicable, 1 = Major, 2 = Moderate, 3 = Minor

c. Other Pharmacy Indicator

Informs the pharmacist of the originating location of the claim with which the incoming drug claim conflicts.

0 = Not applicable, 1 = Your Pharmacy, 3 = Other Pharmacy

d. Previous Date of Fill

The last recorded date of the active medication in the patient's history file with which the incoming drug claim conflicts.

e. Quantity of Previous Fill

Quantity of previously filled prescription with which the incoming drug claim conflicts.

f. Database Indicator

Identifies source of DUR conflict information.

0 = Not applicable, 1 = First DataBank.

g. Other Prescriber Indicator

Identifies the prescriber of the previously filled prescription with which the incoming drug claim conflicts.

0 = Not applicable, 1 = Same Prescriber, 2 = Other Prescriber

h. Free Text Message

30-character field that transmits decoded information regarding the DUR conflict.

N.C. Medicaid will use this for the Drug Name and Strength of the conflicting drug, the health condition contraindicated in drug-disease conflicts, or the minimum and maximum dose for utilization conflicts.

i. NCPDP DUR Codes

Conflict Codes from Medicaid	Additional Message Text
DD - Drug-Drug Interaction	"Drug Name with Strength" of interacting drug
TD - Therapeutic Duplication	"Drug Name with Strength duplicates this Rx"
ER - Overuse Precaution	"Refill is ____ days early"
LR - Underuse Precaution	"Refill is ____ days late"
DC - Drug-Disease Precaution	"Condition contraindicates use of prescribed drug"
LD - Low Dose Alert	"Minimum dose, Maximum dose, dose unit"
HD - High Dose Alert	"Minimum dose, Maximum dose, dose unit"

(continued)

NCPDP Codes, continued

Intervention Codes from Pharmacist
M0 - Prescriber Consulted
P0 - Patient Consulted
R0 - Pharmacist Consulted Other Source
00 - No Intervention
Blank Not Specified
Outcome Codes from Pharmacist
1A – Filled, False Positive
1B - Filled Prescription as is
1C - Filled with different dose
1D - Filled with different directions
1E - Filled with different drug
1F - Filled with different quantity
1G - Filled with prescriber approval
2A - Prescription not filled
2B - Prescription not filled – directions clarified

j. Approved Prescription Clarification Codes for Early Refill

03	Vacation Supply	To be used if the patient is going out of town and needs medication refilled early.
04	Lost Prescription	To be used if the patient has lost their medication.
05	Therapy Change	To be used if the dosage is changed on a current medication.

Note: Vacation supply and lost prescription codes are not allowed on controlled substances.

G.7 DUR Alert Message Examples

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. The following examples are provided to acquaint the reader with the standard content of DUR messages. These may differ from the message actually displayed on the pharmacist's computer screen.

- a. On July 6, 1996, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving warfarin prescribed by the same physician and filled at another pharmacy. The messages related to the alert are:

CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19960630 (June 30, 1996)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin

- b. On July 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:
- | | |
|-----------------------------|--------------------------|
| CONFLICT CODE: | ER - OVERUTILIZATION |
| OTHER PHARMACY INDICATOR: | 1 = Same Pharmacy |
| PREVIOUS FILL DATE: | 19960628 (June 28, 1996) |
| QUANTITY OF PREVIOUS FILL: | 90 |
| OTHER PRESCRIBER INDICATOR: | 1 = Same Prescriber |
- c. The pharmacist attempts to dispense a refill of levothyroxine on June 15, a date equal to greater than 125 percent of previous prescription's days supply:
- | | |
|-----------------------------|------------------------|
| CONFLICT CODE: | LR - UNDERUTILIZATION |
| OTHER PHARMACY INDICATOR: | 1 = Same Pharmacy |
| PREVIOUS FILL DATE: | 19960501 (May 1, 1996) |
| QUANTITY OF PREVIOUS FILL: | 30 |
| OTHER PRESCRIBER INDICATOR: | 1 = Same Prescriber |
- d. The pharmacist attempts to dispense acetaminophen w/codeine, three tablets every 4 hours (dose exceeds usual adult daily maximum):
- | | |
|---------------------|--------------------|
| CONFLICT CODE: | HD - HIGH DOSE |
| DATABASE INDICATOR: | 1 = First DataBank |
- e. The pharmacist attempts to dispense propranolol 20mg, 1 daily (dose is less than usual adult daily minimum):
- | | |
|---------------------|--------------------|
| CONFLICT CODE: | LD - LOW DOSE |
| DATABASE INDICATOR: | 1 = First DataBank |

G.8 DUR Alert Priority

Up to three DUR alerts for a prescription can be relayed to the pharmacist on line. To access any additional alerts pertaining to the prescription, the pharmacist should call the E.D.S. POS Help Desk at **1-800-688-6696**.

Multiple alerts on a prescription are prioritized according to the following hierarchy (**subject to DUR Board approval**):

- Overutilization
- Drug-Drug Interactions
- Therapeutic Duplication
- Incorrect Dose
- Drug-Disease Contraindications
- Underutilization

G.9 DUR Alert Definitions

Overutilization

Overutilization is use of a drug in quantities or for durations which put the patient at risk of an undesirable effect due to a course of drug therapy. The Overutilization screening system warns pharmacists when patients attempt to obtain early refills. The pharmacist must indicate one of the approved reason codes in order for this alert to be overridden. The approved codes are as follows:

- 03 – Vacation supply
- 04 – Lost prescription
- 05 – Therapy dosage change

Drug–Drug Interactions

Drug–drug interactions create the potential for an adverse medical event when patients receive simultaneous prescriptions with conflicting pharmacology. The Drug–Drug Interaction screening system warns pharmacists when a patient receives drugs, which result in a different pharmacologic response from that which is expected when the drugs are given separately. This screen accounts for serum half-life when editing for active medications in the patient’s medication history. The pharmacist is notified when severity level 1 interactions occur, i.e., those that are the most significant, usually requiring action to reduce risk of serious injury.

Therapeutic Duplication

Therapeutic duplication is the prescribing of two or more drugs from the same therapeutic class such that the combined daily dose increases the risk of toxicity or incurs additional program costs without additional therapeutic benefit. The Therapeutic Duplication screening system warns pharmacists when a claim is submitted for a systemically absorbed drug that shares the same therapeutic class or a non-systemic drug with identical route of administration and same therapeutic class as another drug currently in the patient’s active medication history.

Incorrect Dosage

An incorrect dosage is one which lies outside the adult daily dosage range necessary to achieve therapeutic benefit. The Incorrect Dosage screening system alerts pharmacists when doses fall outside the normal adult range for common indications for the drug. Patient-specific information is not required since dose ranges are predicated on a 70 kg adult male with normal hepatic and renal function. Geriatric doses are not included in the incorrect dosage alert.

Drug–Disease Contraindication

Drug–disease contraindications create the potential for an adverse medical event when patients receive prescriptions, which are contraindicated in the patient’s disease state. A drug–disease contraindication occurs when certain drugs are prescribed for recipients with specific medical conditions that may be aggravated by the new drug prescribed. Diseases are inferred from the indication of drugs on the recipient’s profile.

Underutilization

Underutilization is use of a drug in insufficient quantity to achieve a desired therapeutic effect. The Underutilization screening system warns pharmacists when subtherapeutic patterns of prescription use are detected by a patient’s failure to renew prescriptions for maintenance drugs on a timely basis. This alert is for informational purposes only.

G.10 Online DUR Criteria

Drug–Drug Interactions (DD)

Processing: The drug interaction edit screens each new claim against all active medications in the patient’s pharmacy claims history file. To account for residual drug in the body, a factor of 15 percent is added to each active claims’ days supply. Severity level 1, major significance, interaction alerts are sent to the pharmacist.

Alert: DD - Drug–Drug Interaction

Message: (Label name)

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing medication profile to identify interacting drugs.

Therapeutic Duplication (TD)

Processing: The Therapeutic Duplication edit screens incoming prescriptions against all active drugs in a patient’s claims history. Duplication exists when a patient receives two systemically absorbed drugs or two non-systemic drugs by the same route of administration that share the same therapeutic class.

Alert: TD - Therapeutic Duplication

Message: (Label name)

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing drug profile to identify products in the same therapeutic categories.

Incorrect Dosage (LD/HD)

Processing: The Incorrect Drug Dosage screen creates warnings when the prescribed dose is outside the usual adult range for common indications for that drug. Pediatric doses are checked using ten levels of age/weight minimum and maximum doses for recipients less than 18 years old.

Alerts: HD - High Dose

LD - Low Dose

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must screen prescriptions against the usual adult daily dose for a 70 kg adult male with normal hepatic and renal function.

Drug–Disease Contraindication (DC)

Processing: The Drug–Disease Contraindication edit screens each new claim against all medications in the patient’s pharmacy claims history file. A Drug–Disease Contraindication occurs when certain drugs are prescribed for recipients with specific medical conditions that may be aggravated by the new drug prescribed. Diseases are inferred from the indication of drugs on the recipient’s profile.

Alert: DC - Drug–Disease Contraindication

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing medication profile to identify any drug–disease contraindications.

Overutilization (ER)

Processing: The Overutilization screen warns the pharmacist of early fills and/or potential abuse situations. This screen identifies prescriptions submitted for another supply of the same drug when the patient’s medication history shows greater than 25 percent of the previously dispensed days supply remains or 9 days early if the previous claims days supply is greater than 34 days. The process to override an early fill alert is to respond to the DUR alert and to indicate one of the approved reason codes in the Rx Clarification Field (also referred to as the Submission Clarification Code). The approved codes are as follows:

03 – Vacation supply 04 – Lost prescription 05 – Therapy dosage change

Alert: ER - Overuse Precaution

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must maintain accurate prescription dates of service. Prior to dispensing any medication, prescriptions must be checked against the existing drug profile to identify products with identical route of administration and active ingredient(s). If previous prescriptions for identical products have at least 25 percent of the days supply remaining or 9 days early if the previous claims days supply is greater than 34 days, early refill is present.

Underutilization (LR)

Processing: The Underutilization screen creates warnings when subtherapeutic patterns of prescription use are detected. Alerts are generated when patients fail to renew prescriptions for maintenance drugs on a timely basis. Pharmacists are notified when the renewal request interval is greater than 125 percent of the previous days supply. This alert is sent for informational purposes only. No override is needed to fill the prescription.

Alert: LR - Underuse Precaution

Manual DUR Protocol: Pharmacists using explicit written criteria (manual DUR) must maintain accurate prescription dates of service. Prior to dispensing any medication, prescriptions must be checked against the existing drug profile to identify products with identical route of administration and active ingredient(s). If previous prescriptions for identical products exceed 125 percent of the days supply, late refill is present.

G.11 Procedure for Responding to DUR Alerts

- a. Pharmacist receives DUR alert message(s) on computer screen; claim is rejected for DUR
- b. Pharmacist reviews and resolves identified DUR conflict(s) by contacting the prescriber, talking with the patient, and/or using other resources or professional judgment

- c. If the pharmacist decides not to dispense the prescription, the pharmacist accepts the reject. Pharmacist does not resubmit claim and does not receive payment.
- d. If the pharmacist decides to resolve and dispense the prescription, the pharmacist resubmits the correct claim with a DUR Conflict code, DUR Intervention code, and DUR Outcome code. (See additional information needed to override an early fill alert).
- e. Pharmacist receives a paid response if the prescription was filled with DUR documentation.

DUR alert messages contain standardized codes and language, but may be displayed in various ways, depending on the pharmacy software in use. The **content of the DUR Alert message** includes:

a. Conflict Code

This two-character alphabetic code identifies the conflict between the submitted drug claim and information in the patient's history file or predetermined screening criteria.

b. Clinical Significance/Severity Index Code

This numeric value indicates the database-assigned significance of the conflict.

0 = Not applicable, 1 = Major, 2 = Moderate, 3 = Minor

c. Other Pharmacy Indicator

This numeric value identifies the originating location of the history claim with which the submitted drug claim conflicts.

0 = Not applicable, 1 = Your Pharmacy, 3 = Other Pharmacy

d. Previous Date of Fill

This value identifies the last recorded date of service for the active medication in the patient's history file with which the submitted drug claim conflicts.

e. Quantity of Previous Fill

This value identifies the quantity of the prescription in the patient's history file with which the submitted drug claim conflicts.

f. Database Indicator

This value identifies the source of DUR screening criteria.

0 = Not applicable, 1 = First DataBank, 2 = Medi-Span, 3 = Red Book, 4 = Processor Developed, 5 = Other

g. Other Prescriber Indicator

This numeric value identifies the prescriber of the history claim with which the submitted drug claim conflicts.

0 = Not applicable, 1 = Same Prescriber, 2 = Other Prescriber

h. Free Text Message

This 30-character field provides additional information regarding the DUR conflict.

N.C. Medicaid will use the Drug Name and Strength of the conflicting drug, the health condition contraindicated in drug–disease conflicts, or the minimum and maximum dose for utilization conflicts.

H. Point-of-Sale/Pro-DUR Transaction Flows

- Flow 1 POS No Pro-DUR Screening
- Flow 2 POS No Pro-DUR Alerts
- Flow 3 POS/Pro-DUR Alerts Found - Provider Overrides
- Flow 4 POS/Pro-DUR Alerts Found - Provider Cancels
- Flow 5 POS/Pro-DUR Alerts Found - Provider Cancels and Resubmits
- Flow 5a POS/Pro-DUR Alerts Found - Provider Changes Rx and Resubmits
- Flow 6 POS/Pro-DUR Alerts Found - No Provider Response
- Flow 7 POS Provider Sends Conflict/Intervention/Outcome Codes on a New Claim;
DUR Conflicts DD, TD, ER
- Flow 7a POS Provider Sends Conflict/Intervention/Outcome Codes on a New Claim;
DUR Conflicts HD, LD, LR
- Flow 8 POS Reversal Transaction - Transaction is Accepted
- Flow 9 POS Reversal Transaction - Edit Errors are Found
- Flow 10 POS Reversal Transaction - Original Claim Not Found on File

1

POS/Pro-DUR Transaction Flow No Pro-DUR Screening

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds edit errors. Pro-DUR screening is bypassed.
3. **Processor** sends “rejected” response (response status = “R”).
4. **Pharmacist** receives reject response; there will be no Medical Assistance reimbursement for providing service.

2

POS/Pro-DUR Transaction Flow No Pro-DUR Alerts

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. No Pro-DUR screens fail.
3. **Processor** sends “payable” response (response status = “P”).
4. **Pharmacist** receives “payable” response.

3

POS/Pro-DUR Transaction Flow Pro-DUR Alerts Found—Provider Overrides

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
4. **Pharmacist** receives “rejected” response. Resolves DUR conflict(s); selects **one** conflict code; resubmits claim with 6-character conflict/intervention/outcome code indicating override.
5. **Processor** POS receives claim with conflict/intervention/outcome code; POS matches claim to suspended claim; Pro-DUR screens overridden.
6. **Processor** sends “payable” response (response status = “P”).
7. **Pharmacist** receives “payable” response.

4

POS/Pro-DUR Transaction Flow Pro-DUR Alerts Found—Provider Cancels

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
4. **Pharmacist** receives “rejected” response. Realizes there will be no Medical Assistance reimbursement for providing service. Selects **one** conflict code. Sends informational transaction with 6-character conflict/intervention/outcome code indicating cancellation.
5. **Processor** POS receives transaction with conflict/intervention/outcome code; POS matches claim to suspended claim.
6. **Processor** sends acknowledgment of cancellation (response status = “P”; payable amount = \$0).
7. **Pharmacist** receives acknowledgment.

5

POS/Pro-DUR Transaction Flow Pro-DUR Alerts Found— Provider Cancels & Resubmits

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
4. **Pharmacist** receives “rejected” response. Changes claim’s drug, quantity, and/or days supply. Cancels original claim. Sends informational transaction with 6-character conflict/intervention/outcome code indicating cancel.
5. **Processor** POS receives claim with conflict/intervention/outcome code; POS matches claim to suspended claim.
6. **Processor** sends acknowledgment of cancellation (response status = “P”; payable amount = \$0).
7. **Pharmacist** receives acknowledgment.
8. **Pharmacist** submits new claim with changed drug, quantity, and/or days supply.

5a

POS/Pro-DUR Transaction Flow Pro-DUR Alerts Found— Provider Changes Rx & Resubmits

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
4. **Pharmacist** receives “rejected” response. Changes claim’s drug, quantity, and/or days supply. Resubmits with 6-character conflict/intervention/outcome code indicating override.
5. **Processor** POS receives claim with conflict/intervention/outcome code; POS matches claim to suspended claim. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
6. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
7. **Pharmacist** receives “rejected” response. Resolves DUR conflict(s). Selects one conflict code. Resubmits claim with 6-character conflict/intervention/outcome code indicating override.
8. **Processor** POS receives and matches claim to suspended claim. Pro-DUR screens overridden.
9. **Processor** sends “payable” response (response status = “P”).
10. **Pharmacist** receives “payable” response.

OR

7. **Pharmacist** receives “rejected” response. Sends informational transaction with 6-character conflict/intervention/outcome code indicating cancel.
8. **Processor** POS receives and matches to suspended claim.
9. **Processor** sends acknowledgment of cancellation (response status = “P”; payable amount = \$0).
10. **Pharmacist** receives acknowledgment.

6

POS/Pro-DUR Transaction Flow

Pro-DUR Alerts Found—No Provider Response

1. **Pharmacist** submits a claim.
2. **Processor** POS receives claim and finds no edit errors. Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends claim. Provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) (response status = “R”).
4. **Pharmacist** receives “rejected” response but supplies no return response.
5. **Processor** Claim remains suspended and is subsequently cancelled by the system.

7

POS/Pro-DUR Transaction Flow

Provider Sends C/I/O Codes on a New Claim DUR Conflict Codes DD, TD, ER

1. **Pharmacist** submits a claim with conflict/intervention/outcome codes for DUR conflicts DD, TD, ER.
2. **Processor** POS receives claim with conflict/intervention/outcome codes. POS does not find a suspended claim that matches the new claim. The conflict/intervention/outcome codes are ignored and Pro-DUR screening is performed. Claim is treated as a first-time submission (any of the other flows may occur).

7a

POS/Pro-DUR Transaction Flow Provider Sends C/I/O Codes on a New Claim DUR Conflict Codes HD, LD, LR

1. **Pharmacist** submits a claim with conflict/intervention/outcome codes for DUR conflicts HD, LD, LR.
2. **Processor** POS receives claim with conflict/intervention/outcome codes. POS does not find a suspended claim that matches the new claim. The conflict/intervention/outcome codes are recorded and Pro-DUR screening is performed. One or more Pro-DUR screens fail. POS suspends the claim. The provider must respond to override the alert or cancel the claim.
3. **Processor** sends “rejected” response with conflict code(s) **except** those on original claim (response status = “R”).
4. **Pharmacist** receives “rejected” response. Resolves DUR conflict(s); selects one conflict code; resubmits claim with 6-character conflict/intervention/outcome code indicating override.
5. **Processor** POS receives claim with conflict/intervention/outcome code; matches claim to suspended claim; Pro-DUR screens overridden.

OR

4. **Pharmacist** receives “rejected” response. Sends informational transaction with 6-character conflict/intervention/outcome code indicating cancel.
5. **Processor** POS receives and matches claim to suspended claim; sends acknowledgment of cancellation (response status = “P”; payable amount = \$0).
6. **Pharmacist** receives acknowledgment.

8

POS/Pro-DUR Transaction Flow Accepted Reversal Transaction

1. **Pharmacist** submits a reversal.
2. **Processor** POS receives reversal; finds no edit errors; finds original claim in “paid” status; reverses claim; sends acknowledgment of reversal (response status = “A”).
3. **Pharmacist** receives acknowledgment.

9

POS/Pro-DUR Transaction Flow Rejected Reversal Transaction

1. **Pharmacist** submits a reversal.
2. **Processor** POS receives reversal; finds edit errors; sends “rejected” response (response status = “R”).
3. **Pharmacist** receives “rejected” response.

10

POS/Pro-DUR Transaction Flow Reversal Transaction—Original Claim Not on File

1. **Pharmacist** submits a reversal.
2. **Processor** POS receives reversal; finds no edit errors; does not find original claim; sends “rejected” response (response status = “R”).
3. **Pharmacist** receives “rejected” response.

I. Drug–Drug Interaction Example

Amiodarone and Warfarin interact with a Severity Level of 1. The recipient's claim history shows that 30 days supply of Amiodarone 200 mg was filled on August 1, 2004. The incoming claim, on date of service September 3, 2004, is for 5 mg of Warfarin.

Processing

Evaluate Recipient History

Each of the recipient's history claims is evaluated to determine the date on which the drug is no longer active in the recipient's system. The formula to determine the active end date is as follows:

1. Multiply the Days Supply by the Days Supply Percentage for Drug–Drug (usually 115%)
2. Add the number of days to the Date of Service

Using this formula, Drug 1 is active until 09/05/2004 ($30 \times 1.15 = 35$ Days; 08/01/2004 plus 35 days = 09/05/2004). The drug is considered active if the calculated end date is greater than the incoming drug's date of service.

Determine Drug–Drug Interaction

The Drug–Drug precautions are searched using the active history drug as Drug 1 and the incoming claim drug as Drug 2. If a match is found, an alert is issued.

Results

This drug combination will cause a severity level 1 Drug–Drug alert (DD) to be returned.

J. Over Utilization/Early Refill Example

The recipient's claim history shows that 30 days supply of Propranolol 40 mg tablet was filled on August 1, 2004. Incoming claim information is for Propranolol 40 mg tablet on August 22, 2004.

Processing

Evaluate Recipient History

The recipient's history is searched for a drug matching the incoming claim. If a match is found, the following formula is applied to the history claim to determine if the refill is too soon:

1. Multiply the Days Supply by the Days Supply Percentage for Over Utilization (usually 75%)
2. Add the number of days to the Date of Service

For this example, the calculated date is 08/24/2004. ($30 \times 0.75 = 23$; 08/01/2004 plus 23 days = 08/24/2004). The refill is considered early if the calculated date is greater than the incoming claim's date of service.

Results

An Over Utilization alert (ER) will be returned since the calculated date, 08/24/2004, is greater than the date of service, 08/22/2004.

K. Under Utilization/Late Refill Example

Theophylline 300 mg tablet is prescribed as a maintenance drug. The recipient's claim history shows 30 days supply filled on July 1, 2004. Incoming claim information is for date of service August 15, 2004.

Processing

Note: Processing for this screening is for maintenance drugs only.

Evaluate Recipient History

The recipient's history is searched for a drug matching the incoming claim. If a match is found, the following formula is applied to the history claim to determine if the refill is late:

1. Multiply the Days Supply by the Days Supply Percentage for Under Utilization (usually 125%)
2. Add the number of days to the Date of Service

For this example, the calculated date is 08/08/2004 (30 x 1.25 = 38 Days; 07/01/2004 plus 38 days = 08/08/2004). The refill is considered late if calculated date is less than the incoming claim's date of service.

Results

An Under Utilization alert (LR) will be returned, since the calculated date, 08/08/2004, is less than the date of service, 08/15/2004.

L. Low Dose/High Dose Example

Low Dose/High Dose Precautions		
Drug	Minimum Dose	Maximum Dose
Cimetidine 400 mg tablet	1 tablet	6 tablets
Captopril 50 mg tablet	1 tablet	9 tablets

Incoming Claim Information		
Drug	Quantity	Days Supply
1. Cimetidine 400 mg tablet	30 tablets	60
2. Captopril 50 mg tablet	360 tablets	30

Processing

The Dose is calculated by dividing the Quantity by Days Supply. The Dose is then compared to the Low Dose/High Dose criteria.

A low dose alert will be returned if the calculated dose is less than the minimum dose for the drug.

A high dose alert will be returned if the calculated dose is greater than the maximum dose for the drug.

For claim 1, the dose is 0.5 tablet per day (30 divided by 60).

For claim 2, the dose is 12 tablets per day (360 divided by 30).

Results

Claim 1 will return a low dose alert (LD) since 0.5 is less than the minimum dose of 1 tablet per day.

Claim 2 will return a high dose alert (HD) since 12 is greater than the maximum dose of 9 tablets per day.

M. Therapeutic Duplication Example

Drug	Name	Therapeutic Class
1	Diazepam 10 mg oral tablet	H2F
2	Triazolam 0.125 mg oral tablet	H2F
3	Triamcinolone topical cream	P5C
4	Flunisolide topical ointment	P5C

Recipient Claim History		
Drug	Date of Service	Days Supply
Drug 1: Diazepam 10 mg tablet	08/01/2004	30
Drug 3: Triamcinolone topical cream	08/15/2004	5

Incoming Claim Information	
Drug	Date of Service
Drug 2: Triazolam 0.125 mg tablet	08/15/2004
Drug 4: Flunisolide topical ointment	08/18/2004

Processing

Evaluate Recipient History

The recipient's history is searched for a drug in the same therapeutic class. If a match is found, the following formula is applied to determine if the prescription is still active:

1. Calculate end Rx date by adding Days Supply to Date of Service.

For this example, the calculated end Rx date for Drug 1 is 08/31/2004 (08/01/2004 + 30 days = 08/31/2004). The calculated date for Drug 3 is 08/20/2004 (08/15/2004 + 5 days = 08/20/2004).

If incoming claim's date of service is less than end Rx date, an alert is returned.

Determine Therapeutic Duplication

Two drugs are considered therapeutic duplicates under the following conditions:

1. The drugs belong to the same Therapeutic Class AND both drugs are systemic.
2. The drugs belong to the same Therapeutic Class, the incoming drug is not systemic, AND both drugs have the same route of administration.

Results

For Drugs 1 and 2, the history drug and the incoming claim drug belong to the same Therapeutic Class, both drugs are systemic and the incoming claim's date of service is less than the calculated end Rx date; therefore, a Therapeutic Duplication alert (TD) is returned.

For Drugs 3 and 4, the history drug and the incoming claim drug belong to the same Therapeutic Class, the incoming claim drug is NOT systemic but matches route of administration, and the incoming claim's date of service is less than the calculated end Rx date; therefore, a Therapeutic Duplication alert (TD) is returned.

Attachment F: Summary of Medicaid Billing Requirements

- a. The subscriber ID is the recipient's MID number consisting of nine (9) digits plus one (1) alpha character in the tenth position.
- b. The prescriber's DEA number or NPI number are the numbers used to identify the prescriber of the prescription.
- c. Co-payments are \$3.00 for generic drugs, selected OTC products that are covered and brand name drugs. (Refer to **Attachment C** for a summary of exemptions.)
- d. The maximum days supply for all drugs, except birth control medications and prepackaged hormone replacement therapies, is a 34-day supply unless the medication meets the criteria described in **Section 5.2, Dispensing Limitations**, to obtain a 90-days supply.
- e. The dispensing fee is deducted for additional prescriptions dispensed within the same month.
- f. Compounds – Refer to **Attachment A, Compounded Drugs**.
- g. Nursing Home providers may combine all of the prescriptions dispensed during a month as one prescription and submit it at the end of month.
- h. The Amount Billed should be the lower of usual and customary charge or the calculated Medicaid price. The calculated Medicaid price is the **MAC price or WAC + 7% + the dispensing fee**. Federal or state MAC prices are used unless it is overridden with auditable required documentation.

340B Provision

340B providers must be listed on the HRSA Web site (<http://www.hrsa.gov/opa/>). 340B providers must submit the actual purchased drug price plus the dispensing fee in the usual and customary charge field. Providers who anticipate joining the 340B consortium at a future date must notify N.C. Medicaid with the actual date. Providers who maintain two separate inventories—one for the 340B patients and a purchased inventory for non-340B patients—may not dispense a 340B-purchased drug and bill N.C. Medicaid the calculated Medicaid price for non-340B patients.

- i. MAC overrides are allowed if the prescriber hand writes brand “Medically Necessary” on the face of the prescription. MAC overrides are billed with DAW 1.
- j. Other Payor amounts must be included when applicable for Medicaid, as the payor of last resort, to pay the calculated Medicaid price minus the co-pay and the Other Payor Amount field.
- k. Exclusions from payment:
 - a. OTCs (except insulin and selected OTC products per **General Medical Policy No. A-2**)
 - b. devices
 - c. diaphragms
 - d. DESI drugs
 - e. compounds equivalent to DESI drugs
 - f. fertility medications
 - g. medications for cosmetic purposes
 - h. medications for non-FDA approved uses
 - i. drugs from manufacturers who have not signed Drug Rebate agreements

- j. inpatient hospital prescriptions
- k. drugs administered in the prescriber's offices, which should be submitted by the prescriber using J codes
- l. routine immunizations
- m. durable medical equipment
- n. prescriptions dispensed by providers who are not enrolled with Medicaid
- o. IV fluids (Dextrose 500 ml or greater) and irrigation fluids used by Medicaid recipients in an inpatient facility are not billed through the N.C. Medicaid Outpatient Pharmacy Program; they are billed by the facility as ancillary services.
- p. Erectile dysfunction drugs
- q. Weight loss and weight gain drugs
- r. Drug samples
- s. Drugs obtained from any patient assistance program

Attachment G: Defining the Drug Unit

1. **Tablets, capsules, and suppositories:** The unit is “one” or “each.” For example, if 10 tablets are dispensed, the quantity is 10.
2. **Ointments, creams, balms, and bulk powders:** The unit is “gram.” For example, if a 15 gram tube of ointment is dispensed, the quantity is 15.
3. **Liquids, suspensions, solutions, large volume IV solutions, and irrigations:** The unit is “ml.” For example, if a 4 ounce bottle of liquid is dispensed, the quantity is 120.
4. **Injectable items:**
 - a. If the product is **in solution**, the unit is “ml” and the quantity is the volume size. For example, if a 100 ml bag of Sodium Chloride is dispensed, the quantity is 100.
 - b. If the product is a **partial-fill**, the unit is “ml” and the quantity is the amount of fill volume containing the actual drug. For example, if Dextrose 5% 250 ml in a 500 ml bottle is dispensed, the quantity is 250.
 - c. If the product is a **powder filled vial for reconstitution before injection**, the unit is “one” or “each.” For example, if a vial of injectable Ampicillin has to be reconstituted into solution by the pharmacist, the quantity is 1. Note that when a product comes with a separate vial or ampule or diluent it is still treated as a powder for reconstitution under this policy.
5. **Packets:** The unit is “one” or “each” regardless of whether the packet is labeled with the weight or not. For example, if 10 packets of Questran are dispensed, the quantity is 10.
6. **Disposable enemas:** If the individual enema is labeled by volume, the unit is “ml” and the quantity dispensed is the number of milliliters in the enema container. If the individual enema is not labeled by volume, the unit is “one” or “each” and the quantity is 1 for each enema.
7. **Aerosols, jellies, and gels:** If the product is labeled in weight, the unit is “gram.” For example, if an aerosol is dispensed as 16.8 grams, the quantity is 16.8. Similarly, if the product is labeled in volume, the unit is “ml.” If the product is not labeled by weight or volume, the unit is “one” or “each”.
8. **Reconstituted non-injectable liquid dosage forms:** For antibiotic oral suspensions, eye drops, and other non-injectable forms that require reconstitution prior to dispensing and that are labeled by volume, the unit is “ml.” For example, if a 150 ml Amoxicillin Oral Suspension is dispensed, the quantity is 150.
9. **Granulex Spray:** The unit is “ml.” For example, if a 4 ounce can is dispensed, the quantity is 120.
10. **Antihemophilic factor (AHF) products:** The unit is “one” which equals one International Unit (IU) of AHF. For example, if 1000 IU of AHF is dispensed, the quantity is 1000.
11. **Combination packages:** For drug products that contain more than one drug in separate dosage forms and that are packaged and dispensed in an “unbreakable” container, the unit is “one” or “each.”
12. **Metric package sizes:** The quantity or total number of units is always the actual metric package size as supplied by the manufacturer/distributor. If the actual metric package is unavailable, the following conversions are used:

1 fluid ounce = 30 ml	1 ounce = 30 gm
1 pint = 480 ml	1 pound = 454 gm

Attachment H: Summary of Point-of-Sale Codes and Other Information for Current Claim Format

1. Use of PA Code field (NCPDP 5.1):

- | | |
|------------------------------------|---|
| “1” -PA Code | USED TO OVERRIDE THE MEDICARE EDIT* |
| “4” -PA Code | CO-PAY-EXEMPT |
| “5” -PA Code | RX-LIMIT-EXEMPT |
| “8” -PA Code | BOTH-EXEMPT (combines both “4” and “5”) |
| “2” -Submission Clarification Code | SUPPLY-OVERRIDE |
- *This override can be used to override the Medicare edit, when a drug is not covered by Medicare (the reason for non-coverage should be noted on the prescription).

2. Use of NCPDP location values instead of unique NC values:

<u>Type of Facility</u>	<u>NCPDP Location</u>	<u>Paper Location</u>
Adult Care Home	5	6
Intermediate Care Facility/MR	2	7
Nursing Facility	7	8

3. Dispense as Written Codes Currently Available

The following DAW codes are currently accepted on N.C. Medicaid claims:

- | | |
|-------|--|
| DAW 0 | no product selection indicated |
| DAW 1 | Physician indicated brand is “Medically Necessary” |
| DAW 5 | Indicates a generic is being dispensed |
| DAW 7 | Substitution Not Allowed—Brand Drug Mandated by Law (can be used for NTI drugs or atypical antipsychotics) |
| DAW 8 | Substitution Allowed—Generic Drug Not Available in Marketplace |

4. Use of Prescription Origin Code in NCPDP field 419-DJ:

- | | |
|---|------------|
| 1 | Written |
| 2 | Telephone |
| 3 | Electronic |
| 4 | Facsimile |

Note: Zero and null values are not accepted.

Submit Usual and Customary in addition to Gross Amount Due (Amount Billed on current paper and ECS formats).

Attachment I: Pharmacy Online Request for North Carolina Medicaid Claims

The information below is a request to submit North Carolina Medicaid pharmacy claims via Point-of-Sale (online) with a processing charge of up to \$.075 per adjudicated claim and per reversal of an online claim up to 6 months after the online claim's date of service. The online charges will be deducted from the same RA (Remittance Advice) that pays the claims. The pharmacy may contact their software vendor or preferred "switch" regarding certification for submission of North Carolina Medicaid pharmacy claims and the required BIN or IIN. The pharmacy software in use must be certified by a certified "switch" or VAN (such as NDC, Healtheon/WebMD, QS1) before a pharmacy is allowed to submit online claims. The pharmacy will be notified by EDS of the start date for online claim submission.

Any questions regarding online charges need to be addressed to the online Help Desk at (919) 233-6846 or 1-800-688-6696.

Pharmacy Name

Medicaid Provider Number

Pharmacy Address

Pharmacy City, State, Zip

Pharmacy Contact Person for Medicaid Online Questions

Pharmacy Software Vendor Name

Software Version in Use

Software Vendor Address

Software Vendor City, State, Zip

Vendor Phone Number

Contact Person

Return to:

EDS

Online Pharmacy Help Desk

P.O. Box 300001

Raleigh NC 27622

OR Fax to (919) 859-9703

Attachment J: Instructions for Completing the Manual Pharmacy Claim Form

The pharmacy claim form is a multiple claim form presenting lines for billing 10 separate prescriptions within the same month of service. It may be used for one recipient or 10 different recipients. Space has been provided at the bottom of the claim form for listing ingredients used in compounded prescriptions. Please be sure claims are legible and all information is within the appropriate blocks before submitting the claims.

- Item 1 **PHARMACY NAME - PHARMACY NUMBER:** Enter the pharmacy name and seven-digit provider number clearly in this area. Smear or illegible numbers may cause denial of claims. If your provider number contains six digits, place a leading zero in front of the number to make seven digits.
- Item 2 **SERVICE DATE:** Enter the month and year of service (dispense date). Note that claims for only one calendar month of service can be submitted on the same claim form.
- Item 3 **MEDICAID ID NUMBER:** Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the Medicaid Identification Card. If filing two or more consecutive lines for the same recipient, you may write the word "SAME" in the Medicaid ID number field. **DO NOT LEAVE THIS SPACE BLANK.**
- Item 4 **RECIPIENT'S NAME, LAST, FIRST:** Enter the recipient's last name and first name as they appear on the Medicaid Identification Card. If the first name is not indicated, enter the first initial. If filing two or more consecutive lines for the same recipient, you may write the word "SAME" in the Recipient's Name field.
- Item 5 **LOCATION (LOC):** Enter the correct number for patient location or exemption from prescription limitation or co-pay. Code "6" indicates that the recipient is in a Rest Home, "7" indicates that the recipient is in an intermediate care facility (ICF), and "8" indicates that the recipient is in a skilled nursing facility (SNF). A "B" in this field indicates that the patient is exempt from the six-prescription limitation and the co-pay. This would be used for a patient in a SNF, ICF, or a mental hospital. A "P" in this field indicates a pregnancy-related prescription thus exempting co-payment deduction.
- Note:** For all other patients (including rest home patients) who are exempt from the eight-prescription limitation, indicate the "E" in this field. All patients must abide by the eight-prescription limitation unless they are in one of the exempt categories listed in **Section 5.1, Prescription Limitations.**
- Item 6 **SEX:** Indicate the recipient's sex. Enter "M" to signify male or "F" to signify female.
- Item 7 **RX NUMBER:** Enter the pharmacy file (prescription) number assigned to the prescription.
- Item 8 **O/R:** Indicate whether it is the original dispensing of a prescription or a refill with an "O" for the original or an "R" for refill.
- Item 9 **PRESCRIBER NAME OR DEA NUMBER:** Enter the prescriber's DEA Number.
- Item 10 **OTHER COVERAGE:** List the amount paid by another insurance company (including Medicare) on that specific prescription.
- Item 11 **DAY FILLED:** Enter the day of the month the medication was dispensed. Do not enter month and year in this space. Multiple months may not be billed on the same form.
- Item 12 **DRUG NAME, STRENGTH, AND DOSAGE:** Enter legibly the name and strength including dosage form of drug dispensed. If the dispensed drug has a brand name, the brand name must be entered instead of the generic name.

- Item 13 **MANUFACTURER (MFG):** The manufacturer's name is required for all generically dispensed drugs and for all brand name drugs that are not nationally distributed products. The manufacturer's name is not required for nationally distributed brand name products. Please be sure to list all local manufacturers along with the pertinent information to aid in identification of a particular drug.
- Item 14 **NDC:** Enter the 11-digit National Drug Code. Legibility and proper format are essential.
- Item 15 **QUANTITY DISPENSED (QUAN):** Enter the quantity in **metric decimal units** for the number of ml or gm dispensed. For tablets, capsules or suppositories, enter the count or number dispensed. Do not use Roman numerals. For compounded prescriptions, please list the total quantity dispensed in this field.
- Item 16 **ESTIMATED DAYS SUPPLY:** Based upon the quantity, daily supply from the Sig, data on the prescription, and upon your professional judgment, enter the number of days that the dispensed quantity will last the patient when used at the prescribed dosage. This information is required for drug utilization review.
- Item 17 **EPSDT:** No longer required information. This field is currently being used to indicate that a claim is part of a compound. Refer to **Attachment A, Compounded Drugs**.
- Item 18 **FAMILY PLANNING:** Information is obtained on the drug file, no need to indicate family planning. **Do not collect co-payment on prescriptions for birth control.**
- Item 19 **AMOUNT BILLED (DOLLARS/CENTS):** Enter the total amount for each prescription including the cost of the drug plus the dispensing fee. **Do not deduct the lower of the usual and customary charge or co-payment.** For all repeat prescriptions within the same calendar month, the Medicaid dispensing fee and co-payment amounts will be deducted when the claim is processed. If other coverage is indicated, the Amount billed should still reflect the total billed amount.
- Item 20 **CLAIM TOTAL:** Enter the sum of the individual "Amount Billed" fields on the claim form. This is for your benefit; we do not process this total.
- Item 21 **SUBMISSION DATE:** Enter the month, day, and year of claim submission.
- Item 22 **PAGE NUMBER:** Enter the page number for this submission date.
- Item 23 **CLAIMANT SIGNATURE:** Each claim form must be signed by the owner or authorized agent who signed the pharmacy program participation agreement. A rubber stamp facsimile of the authorized signature may be used with the understanding that the owner or authorized agent assumes responsibility for information submitted on the invoice and acknowledges this responsibility by authorizing his signature to be stamped on the claim form. The provider's signature on the Medicaid Electronic Claims Agreement is binding as certification that the paperless claims are true, accurate, and complete. To avoid EOB 1350 for claims not signed, please fill out a signature on file form.
- Item 24 **COMPOUNDED PRESCRIPTIONS:** List the drug name, strength, quantity, NDC code, and cost for each ingredient contained in the compound. If more than one compounded prescription has been dispensed, file the second compound on a separate claim form if all ingredients cannot be described in the space provided in this field.
- Note:** Compounds containing only legend drugs should be submitted using NCPDP 5.1.

After completing the claim form correctly with all the required fields, sign the form if you do not have a Signature on File, and mail to:

EDS
P.O. Box 300001
Raleigh NC 27622-3001

Within 30 days of receipt of a manual claim, the claim will be processed for payment. Payment cycles are published in the Pharmacy Newsletters. Payment notification is in the form of a Remittance Advice with a check or Electronic Funds Transfer (EFT).

Attachment J-1: Sample of Manual Claim Form

<p>ICN (DO NOT WRITE IN THIS SPACE)</p>	<p>ORIGINAL</p> <p>SERVICE DATE</p> <p>MO _____ YR _____</p>	<p style="text-align: center;">PLEASE STAMP</p>								
<p>ROUTE ORIGINAL TO</p> <p>EDS P.O. BOX 300001 RALEIGH, NC 27622-3001</p>	<p>PHARMACY LOCATION</p> <p><input type="checkbox"/> Rest Home</p> <p><input type="checkbox"/> Intermediate Care Facility</p> <p><input type="checkbox"/> Skilled Nursing Facility</p>	<p>PHARMACY NAME _____</p> <p>PHARMACY NUMBER _____</p>								
<p>Please Print or Type BLACK OR DARK BLUE ONLY</p>		<p>AMOUNT BILLED</p>								
0	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
1	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
2	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
3	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
4	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
5	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
6	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
7	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
8	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
9	MEDICAID ID NUMBER _____	RECIPIENT'S NAME LAST _____	FIRST _____	LOC _____	SEX _____	RX NUMBER _____	O/R _____	PREScriBER NAME OR DEA NUMBER _____	OTHER COV. _____	
DAY FILLED _____	DRUG NAME _____	STRENGTH _____	DOSAGE _____	MFG. _____	QUAN _____	EST. DAYS SUPPLY _____	EPICOST _____	FARM PLAN _____	DOLLARS _____	CENTS _____
<p>[FOR EACH COMPOUNDED] LIST NAME, STRENGTH, QUANTITY, MFG. AND COST OF EACH INGREDIENT BELOW</p>									<p>CLAIM TOTAL</p>	
<p><small>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT, OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.</small></p>						<p>SUBMISSION DATE</p> <p>MO _____ DAY _____ YR _____</p>	<p>PAGE NO. _____</p>	<p>X _____</p> <p>CLAIMANT SIGNATURE</p>		
<p>372-012 (12-92)</p>										

Attachment J-2: Example of Manual Claim Form for Compounded Drugs

<p>ICN (DO NOT WRITE IN THIS SPACE)</p>	<p>ORIGINAL</p> <p>SERVICE DATE</p> <p>12 2006</p> <p>MO. YR.</p>	<p>PLEASE STAMP</p> <p>PAM DRUG # 0123456</p>																																																																																																																																																																																				
<p>ROUTE ORIGINAL TO</p> <p>EDS P.O. BOX 300001 RALEIGH, NC 27622-3001</p>	<p>PHARMACY LOCATION</p> <p><input checked="" type="checkbox"/> Rest Home <input checked="" type="checkbox"/> Intermediate Care Facility <input type="checkbox"/> Skilled Nursing Facility</p>	<p>PHARMACY NAME</p> <p>PHARMACY NUMBER</p>																																																																																																																																																																																				
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<p>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT, OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.</p>																																																																																																																																																																																						
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**Attachment K: Drugs That Must Be Billed to Medicare
before Billing Medicaid**

Generic Name	Brand Name
acetylcysteine 10%, 20%	Mucomyst
albuterol, concentrated form	Proventil solution per mg
albuterol, unit dose form	Proventil solution per mg
antihemophilic factor , human	Alphanate
antihemophilic factor , porcine	Hyate
antihemophilic factor, hum rec	Helixate, Kogenate, Refacto
atropine	Atropine
azathioprine	Imuran 100 mg vial
azathioprine	Imuran 50 mg(oral)
bitolterol mesylate, conc. form	Tornalate solution per mg
bitolterol mesylate, unit dose	Tornalate solution per mg
busulfan	Myleran 2 mg
capecitabine	Xeloda (oral) 150 mg, 500 mg
cromolyn sodium, unit dose	Intal solution per 10 mg
cyclophosphamide	Cytosan (oral) 25 mg
cyclosporine	Sandimmune 25 mg, 100 mg(oral)
cyclosporine, modified	Neoral 100 mg/ml
cyclosporine, modified	Neoral 25 mg, 100 mg
darbepoetin alfa	Aranesp
dolasetron mesylate	Anzemet 50 mg, 100 mg
doxorubicin	Adriamycin per 10 mg
epoetin alfa	Epogen, Procrit
epoprostenol	Flolan 0.5 mg
etoposide	Vepesid (oral) 50 mg
factor IX	Alphanine
factor IX	Mononine
factor IX, complex human	Bebulin, Profilnine, Proplex T
factor IX, human recombinant	Benefix
factor VIIa, recombinant	Novoseven
factor VIII	Bioclate
factor VIII	Helixate FS
factor VIII	Hemofil – M
factor VIII	Koate
factor VIII	Kogenate
factor VIII	Monarc M
factor VIII	Recombinate
factor/von Willebrand factor complex (human)	Humate-P
floxuridine	FUDR 500 mg vial
fluorouracil	Adrucil vial per 500 mg
ganciclovir sodium	Cytovene 500 mg
glycopyrrolate 0.2 mg/ml	Robinul 0.2 mg/ml

Generic Name	Brand Name
granisetron	Kytril 1 mg
ipratropium bromide 0.02% solution	Atrovent solution per mg
isoetharine	Isoetharine solution
isoetharine, concentrated form	Isoetharine 1% sol per mg
isoproterenol	Isoproterenol (amp & syringe)
leucovorin	Leucovorin Calcium per 50 mg
levalbuterol solution	Xopenex Solution
lymphocyte immune globulin	Atgam 50 mg/ml
lymphocyte immune globulin, rabbit	Thymoglobulin 25 mg vial
melphalan	Alkeran (oral) 2 mg
metaproterenol	Metaproterenol 0.4% sol
metaproterenol, conc. form	Alupent solution
metaproterenol, unit dose	Alupent solution
methotrexate	Methotrexate (oral)
muromonab-cd3	Orthoclone OKT3 1 mg/ml
mycophenolate mofetil	Cellcept 200 mg/ml
mycophenolate mofetil	Cellcept (oral) 250 mg, 500 mg
ondansetron	Zofran 4 mg, 8 mg, 24 mg
ondansetron	Zofran 4 mg/5ml
pentamidine	Pentamidine 300 mg (vial)
pulmozyme	Pulmozyme ampul
saline	Saline 0.45% & 0.9%
sirolimus	Repimune 1 mg
sirolimus	Repimune 1 mg/ml
tacrolimus	Prograf (oral) 1 mg, 5 mg
tacrolimus anhydrous	Prograf 0.5 mg, 5 mg/ml
vincristine	Vincasar 1 mg
vincristine	Vincristine 2 mg, 5 mg

Note: This list is not all inclusive and is subject to change. A complete list is available through the POS system.

Note: Medicaid is always the payor of last resort.

Attachment L: Completing the Pharmacy Adjustment Request Form

The instructions for completing the Pharmacy Adjustment Request form are listed below. The **Pharmacy Adjustment Request form** is available on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Line	Instruction
Recipient Medicaid Number	Enter the recipient's MID number as it appears on the MID card.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Pharmacy Name and Provider Number	Enter the name of the pharmacy and the pharmacy's Medicaid provider number.
Rx Number	Enter the prescription number assigned by the pharmacy to the prescription on claim to be adjusted.
Drug Name	Enter the name of the drug dispensed including the strength and the dosage form (abbreviated).
NDC	Enter the 11-digit NDC for the prescription.
Quantity	Enter the corrected quantity to be billed using up to five digits.
Billed Amount	Enter the corrected total to be billed for the prescription claim.
Date Filled	Enter the date the prescription was filled using the MM/DD/YY format.
Claim Number	Enter the ICN of the previously paid or denied claim.
Denial EOB	Do not enter information in this block unless the claim was denied with EOB 0985, <i>Exceeding Prescription Limitation</i> .
Insurance Paid	Indicate a correction of omission of Other Payer Amount by placing an "X" in this box. Indicate in the "Adjustment Reason" block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payor amount to the adjustment request.
Adjustment Reason	State why a correction is needed.
Paid Amount	Enter the amount of the last Medicaid payment for the claim identified by the ICN listed in the "Claim Number" block.

Attachment M: Pharmacy Remittance Advice (RA)

1. Retain all RAs to assist in keeping claims and payment records current.
2. The last RA the provider receives each year serves as the annual 1099 form.
3. Refer to the RA first if questions arise about a particular claim.
4. If the RA cannot resolve questions on claims payment, please correspond with EDS using the following procedures:
 - a. Attach a copy of the claim and the specific RA page showing where the questionable payment occurred to the Adjustment/Inquiry form.
 - b. Indicate on the form the reason for questioning payment and other pertinent information.
5. The RA is also a status report. It gives the current status of active claims. Should a submitted claim not appear by the third RA, please inquire about it using the following procedure:
 - a. Attach a copy of the claim in question to the inquiry form.
 - b. Assure all the required data and signature is on the copy.
 - c. Call the AVR system.

Each page of the RA includes an Identification Header. Refer to the following table for an explanation of the information contained in the Identification Header.

A.	Provider Name and Address	Pharmacy name and address
B.	Provider Number	The 7-digit number assigned to the provider for participation in the N.C. Medicaid program. Alpha suffixes, if applicable, will be shown.
C.	Report Sequence Number	Assigned sequentially for the provider's convenience to identify the RA. The first RA received each year will be numbered 1, the second 2, etc. Using this number to organize the RAs will help ensure that none are missing.
D.	Date	The date the RA was produced. It will match the date on any corresponding checks.
E.	EDS Report Sequence Number	EDS' Cumulative Report Sequence Number for all RAs for all providers for the year.
F.	Page	The number assigned sequentially, starting at 1, to each page comprising the current RA.
G.	Pre-Printed Totals Heading	These headings do not apply to pharmacy details. They are the headings for Totals lines.

The RA is subdivided into the five sections. Each section includes information identified by the following column headings:

1.	Recipient ID	The recipient's (patient's) 10-digit identification number. Usually a 9-digit number with an alpha character in the 10th position.
2.	Last Name	The recipient's last name. The RA is alphabetical by the last name within each subsection of claim types.
3.	First Name	The recipient's first name.
4.	MI	The recipient's middle initial.
5.	SVC Date	The service date (date dispensed).
6.	RX Num	The 6-digit prescription number or the last 6 digits of a 7-digit prescription number.
7.	Drug Code	The NDC of the drug dispensed.
8.	Drug Name	The drug name for the drug code from the First DataBank file.
9.	Qty	The quantity dispensed.
10.	Claim Number	The unique 13-digit number assigned to each claim form by EDS for control purposes. Please reference this number when corresponding with EDS about a claim.
11.	Total Billed	The amount billed by the provider.
12.	Total Allowed	The amount allowed as Total reimbursement by Medicaid including co-payments for the claim.
13.	Co-Pay	The amount the recipient paid or should have paid.
14.	Total Paid	The Total Allowed minus (any Dispensing Fee Repeats for dispensing in the same month) minus the co-pays minus any payments by other Third Party.
15.	EOB Code	The EOB is a numeric representation of the message that explains why the claim was adjusted, denied, pended or paid. A listing for each EOB appearing on the RA is located at the end.
16.	Summary Line	The number of claims addressed in the subsection identified at the left of the summary line.
17.	Total Billed	The total amount billed by the provider.
18.	Non-Allowed	The Total Billed minus the amount allowed by Medicaid.
19.	Total Allowed	The amount allowed for the claims.
20.	Payable Cutback	The difference between what Medicaid allows and what Medicaid will pay for a particular charge based on the RCC or reimbursement amount.
21.	Payable Charge	The amount paid plus co-pay or the total allowed minus the dispensing fee repeats.
22.	Other Deducted Charges	Co-payments.
23.	Paid Amount	The total allowed minus any dispensing fee repeats for dispensing in the same month minus the co-payments.

The five sections of the RA are listed below. Detailed information about the information in these sections follows the table:

1.	Paid Claims	Lists all the claims paid since the previous checkwrite.
2.	Adjusted Claims	Indicates the status of claims when requests for action have been made to correct erroneous payment or any other adjustment.
3.	Denied Claims	Identifies claims that have been denied for payment because of various improper or incomplete claim entries.
4.	Claims in Process	Lists the claims that have been received and entered by EDS but are pending payment because further review of the claim is needed.
5.	Claims Payment Summary	Summarizes all payments and credits made to the provider by the Medicaid program for the specific checkwrite period, titled "Current Processed," as well as for the year, titled "Year to Date Total." Lists all EOB codes on the RA with explanations.

At times, special "**banner messages**" will appear on the last page of the RA inside a box outlined with asterisks. Attention should be given to these messages as they contain information that will facilitate claims processing.

A. **Adjusted Claims**

This section of the remittance advice shows the status of claims when requests for action have been made to correct overpayment, underpayment or payment to the wrong provider. Some of the most common causes of adjustments are clerical errors, incorrect claims information or incorrect procedure coding. There are no subsections under this heading. However, the word "Adjustment" will identify any adjusted claims. "Credit To" and "Debit To" indicators will identify what portion of the adjustment has taken place.

A "Debit To" indicator means additional monies have been paid to the provider. Beside the "Debit To" portion of an adjustment, a complete detailed breakdown of a positive corrected payment will be reflected as was explained in the Paid Claims Section. It will be identified by an ***Adjustment*** "Debit To," followed by this information:

1. The original claim number being adjusted.
2. The date the original claim was paid.
3. The positive amount being paid.

A "Credit To" indicator shows monies that will be recouped from the provider for incorrect payments. The "Credit To" portion of an adjustment is reflected in negative amounts. Beside an ***Adjustment*** "Credit To" indicator are the following identifications:

1. The original claim number being adjusted.
2. The original paid date.
3. The amount to be recouped.

The following represents the three types of adjustments that can be made:

- A. Repayments A positive adjustment is necessary when the provider has been underpaid or is owed money. This adjustment will appear as a positive amount in the Paid Amount column. Only the amount that is owed to the provider will be paid.
- B. Recoupments A negative adjustment is necessary when there has been a duplicate payment or the wrong provider has been paid. A recoupment occurs when the full amount of a payment is taken back from the provider.

Adjustment “Credit To” will appear as a notation that an amount of money has been taken from the provider. The recoupment amount is actually applied in the Financial Items section of the RA; therefore, the “Credit To” amount should be coordinated with the “Applied Amount” in the Financial Items section to assure what negative adjustments were actually recouped from the check amount. These amounts can be identified by the recipient’s Medicaid identification number, the initial date of service, and the recipient’s last name and initial.

- C. Recoup-Repay Recoup-repay adjustments occur when the full amount of an incorrect payment is recouped from the provider and then repaid correctly. This type of adjustment may occur when there is a change in procedure coding or in claim data. A recoup-repay adjustment appears as one entry in the Adjustment section. If an overpayment occurred, an ***Adjustment*** “Credit To” indicator will appear as identification that a negative amount of money has been taken back from the provider. This amount will also appear in the Financial Items section of the RA. It can be identified by the recipient’s Medicaid identification number, the initial date of service, and the recipient’s last name and initials. If additional money is due the provider, an ***Adjustment*** “Debit To” indicator will show that a positive amount of money has been repaid to the provider.

Only the difference in the money amount will appear on the check. Please be aware that negative amounts will appear in both the Adjustments section and the Financial Items section but will only be deducted on the Financial Items section (see the Applied Amount Column in the Financial Items section of the RA). The Summary totals at the end of the Adjustments section include only positive amounts.

B. Denied Claims

This section identifies those claims that have been denied for payment because of various improper or incomplete claim entries. Some of the most common reasons for claim denial are eligibility status, billing for noncovered services, and filing time limits. The claims in this section are broken down into subsections to indicate the type of bill that was processed. Recipients’ names are sequenced alphabetically under each subsection. A zero will appear in all columns to the right of “Non-Allowed.” An explanation code specifying the reason for denial will appear in the far right-hand column.

Summary totals appear after each subsection followed by a grand total of the section. Denied claims are finalized and no additional action will be taken on the claims unless the provider submits an adjustment request.

C. Claims in Process

This section lists those claims which have been received and entered by EDS but are pending payment because further review of the claims is needed. Please do not rebill a claim shown in this section, as it is already in the system.

D. How Refunds to the Medicaid Program are Shown on the RA

When money is returned to the Medicaid program due to erroneous billings, overpayments, etc., the receipt and application of a refund is shown on the RA. Processed refunds are reflected in the Financial Items (next to last page of RA) and the Claims Payment Summary (last page of RA) sections.

Example: A Medicaid refund of \$100 for Patient John Doe (Medicaid Identification Number 9XXXXXXXXXX) will be displayed with Explanation of Benefit (EOB) 113 in the Financial Items Section of your RA.

EOB 113 - "Refund Amount Applied to 1099 Liability"

This will **NOT** affect your payment. The Claims Payment Summary page (last page of RA) will appear as follows:

Claims Payment Summary					
	Claims Amount	Withheld Amount	Net Payment Amount	(1) Credit Amount	(2) Net 1099 Amount
Current Processed	\$1,000.00	\$0.00	\$1,000.00	\$100.00	\$900.00
Year to Date Total	\$2,000.00	\$0.00	\$2,000.00	\$100.00	\$1,900.00

Only columns (1) and (2) are affected by the refund. The 1099 liability has been reduced to ensure only payments you keep are reported to the IRS. Note: Claims Paid, Withheld, and Net Payment amounts are not impacted. For this cycle, a check will be received or electronic transfer into a bank account for a \$1,000. Year to date will show a \$2,000 total.

Attachment N: Community Care of North Carolina Prescription Advantage List

The Prescription Advantage List (PAL) was developed by the North Carolina Physician Advisory Group (NCPAG) and Community Care of North Carolina (CCNC), in cooperation with DMA, as a voluntary effort to help control rising pharmacy costs in N.C. Medicaid. While this list is voluntary, the physician leadership of the NCPAG and CCNC hopes that prescribers will use it as a guide to prescribe less-expensive medications whenever possible and clinically appropriate.

The PAL includes some of the medication classes that result in the most cost to N.C. Medicaid. By evaluating the net cost per unit of each medication, including rebates, we ranked the medications in each class in order from least to most expensive and placed them in their respective tiers.

The tiers are calculated on a quartile distribution system, based on the net cost per unit of all medications in the drug class. The lowest-cost medications are tier 1 medications, and the most expensive medications are tier 4 medications.

Note: No judgment as to efficacy is implied by this list, which is intended as an educational tool based on cost alone.

The PAL Pocket Card was developed to assist physicians to change prescribing behaviors for selected commonly prescribed high-cost, high-utilization drugs when good generic alternatives are available. The drugs chosen for the PAL Pocket Card were identified using more stringent criteria than the tier methodology described above. The following criteria had to be met in order for the drug to be listed on the PAL Pocket Card:

- The drug was identified as a drug (or drug class) commonly prescribed by N.C. Medicaid providers. A list of the top 200 drugs most often prescribed to N.C. Medicaid recipients was used to identify drugs to be listed.
- The drug is in a class with a significant (>25%) cost differential between drugs, based on cost analysis from the most recent quarter available and a review of 6–9 months of prior data to see trends of cost per drug and drug dose.
- The Drug Effectiveness Review Project (DERP) or other briefs provided evidence to compare efficacy and safety between the drugs in the class. Trials with head-to-head comparisons of drugs within the class were used when available.

The CCNC PAL and PAL Pocket Card are available on DMA's Web site at <http://www.ncdhhs.gov/dma/pharmacy/>.

Attachment O: Episodic Drugs Quantity Dispensing Limits

Drug Classes: H2E, H8B, H3F				
Sedative hypnotics, non-barbiturate hypnotics, melatonin MT1/MT2 receptor agonists, antimigraine preparations				
Evidence considered: FDA labeling, OHSU DERP, NCPAG consult				
Prior authorization criteria and forms are located on DMA's Web site at http://www.ncmedicaidpbm.com				
Drug	GCN	Quantity Limit per Month	Maximum Days Supply	Prior Authorization Allowed for Excess Quantities
Ambien, Ambien CR	00870, 00871, 25456, 25457	15	34	Yes
Sonata	92723, 92713	15	34	Yes
Prosom, Estazolam	19181, 19182	15	34	Yes
Dalmane, Flurazepam	14250, 14251	15	34	Yes
Restoril, Temazepam	13840, 13841, 13845, 24036	15	34	Yes
Halcion, Triazolam	14280, 14281, 14282	15	34	Yes
Doral	40870, 40871	15	34	Yes
Lunesta	23925, 23926, 23927	15	34	Yes
Rozerem	25202	15	34	Yes
Amerge	81111, 81112	12	34	Yes
Axert	12472, 13587	12	34	Yes
Frova	14977	12	34	Yes
Imitrex, Sumatriptan	05700, 05701, 05702, 16854, 24708, 26666, 26667, 50740, 50741, 50742, 50744	12	34	Yes
Maxalt/Maxalt-MLT	19591, 19592, 19593, 19594	12	34	Yes
Relpax	15173, 15174	12	34	Yes
Treximet	99597	12	34	Yes
Zomig/Zomig MLT	14324, 18972, 42098, 46131, 46132	12	34	Yes