District of Columbia Pharmacy Benefit Manager Services (PBMS) Fee-for-Service (FFS) Provider Manual

Version 5.0

March 9, 2023

Magellan Medicaid Administration, part of the Magellan Rx Management division of Magellan Health, Inc.

Revision History

Version	Date	Name	Comments
1.0		Implementation	Initial creation
2.0	11/16/2015	DHCF	Change of PBM Vendor
3.0	04/19/2018	DHCF	See summary of changes listed below: • Long Term Care • 340B Program • Diabetic Supplies • Mental Health • Dispensing Fee • Pricing Methodology • Pricing Disputes • Pharmacy Lock-in Program • Signature Log Requirements • Medicare Part B and D • POS Notice to Beneficiaries • Frequently Asked Questions • DC Healthcare Alliance Replenishment Program terminated on April 30, 2016. • ADAP Warehouse Program terminated on October 14, 2016.
4.0	08/30/2021	DHCF	See summary of changes listed below: • Dispense as Written Codes (DAW) • Vaccines • Death with Dignity • Medical Benefit Drugs

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1.0 Introduction

As of December 19, 2015, Magellan Medicaid Administration, Inc. (part of the Magellan Rx Management Division of Magellan Health, Inc.) processes claims on behalf of the District of Columbia (hereafter referred to as the "District") Department of Healthcare Finance (DHCF) Medicaid Pharmacy Program. **All claims must be submitted using the National Council for Prescription Drug Programs (NCPDP) Version D.0 Claim format as mandated by Health Insurance Portability and Accountability Act (HIPAA) on January 1, 2012. DHCF will accept the B1, B2, B3, and E1 transactions in the NCPDP D.0 format; no other transactions will be accepted.**

The hyperlink for the Payer Specification document is provided in *Section 6.1 – Appendix A: District D.0 Payer Specification*. Please make note of the Bank Identification Number (BIN), Processor Control Number (PCN), and Group Identification (ID) needed to submit a claim to the Magellan Medicaid Administration Pharmacy Drug Claim system, FirstRx℠.

FirstRx℠ allows providers access to recipient eligibility, pricing, drug coverage, Prospective Drug Utilization Review (ProDUR), and payment information at the Point-of-Sale (POS). Pharmacy providers must be enrolled with DHCF Medicaid at the time of claim submission in order to be reimbursed.

This provider manual will address the Medicaid Fee-for-Service (FFS) program rules. If you have questions about the information presented in this manual, contact the District's Medicaid Provider Help Desk at 1-800-273-4962.

1.1 Help Desk Contact Information

Provider Help Desk: 1-800-273-4962

Beneficiary Help Desk: 1-800-272-9679 *Language Assistance Services are available.*

Clinical Prior Authorization Fax: 1-866-653-1431

Hearing Impaired: 711

2.0 Program Information

2.1 New Claim Information

District pharmacy providers will be required to submit claims using the following information:

BIN:	018407
PCN:	DCMC018407
Group ID:	DCMEDICAID

2.2 Timely Filing

Pharmacies have 365 days from the first Date of Service (DOS) to submit an original claim and perform a re-bill.

- The timely filing rules apply to POS.
- Paper claims will not be accepted.
- Timely filing overrides will be considered for the following situations:
  - Retroactive eligibility
  - Third-Party Liability (TPL) delay

2.3 Refills

- All refills must be dispensed in accordance with District and Federal requirements
- Refill prescriptions must be dispensed in accordance with the orders of the physician **but no more than 12 months from the date written.**
- **Auto refills are not allowed**
- CIIs (DEA code = II) must be filled within 30 days of being written.
- CIIs partial fills are allowed according to DCMR § 48-903.08 and Code of Federal Regulations, 21 C.F.R. § 1306.13.
- CII incremental fills, where less than the full amount prescribed is dispensed to the member can support government regulatory requirements that are intended to help curtail the opioid crisis.
  - Incremental fill quantity should be submitted in the Quantity Prescribed field (NCPDP Field #460-ET).

- If the pharmacist is unable to supply the full quantity for a written or emergency oral prescription of CII, the remaining portion of the prescription may be filled within seventy-two (72) hours.

  A Prescription for Schedule II controlled substance for a patient in a Long-Term Care Facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units and in accordance with federal law. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist must contact the practitioner prior to partially filling the prescription.
- **Controlled drugs other than CIIs** (Drug Enforcement Agency [DEA] code = III, IV, V) may be refilled in accordance with the physician's orders, up to five refills (plus one original) or six months, whichever comes first.
- **Non-Controlled drugs** (DEA code = 0) may be refilled in accordance with the physician's orders, up to 11 refills (plus one original) or one year, whichever comes first.

2.4 Pricing

Refer to the DC Medicaid Payer Sheet.

2.4.1 Pricing Methodology

Claims processed for the District's FFS Pharmacy Program will be priced at the lesser of:

- National Average Acquisition Cost (NADAC);
- Wholesale Acquisition Cost [WAC] + 0 percent);
- District Maximum Allowable Cost (DMAC);
- Usual & Customary (U&C); and
- Federal Upper Limit (FUL) Pricing.

2.4.1.1 Pricing Disputes

- National Average Drug Acquisition Cost (NADAC) Disputes
  - Centers for Medicare & Medicaid Services (CMS), through its third-party contractor Myers and Stauffer (may change), has established a procedure to address pharmacy concerns about individual price discrepancies found in the weekly NADAC file.
  - To dispute NADAC pricing, pharmacies can complete a Request for Medicaid Reimbursement Review Form to be submitted to CMS.
  - CMS will then make a determination to adjust prices in the next weekly NADAC price file release, if necessary.

- Federal Upper Limit (FUL) Disputes
  - For questions or concerns related to the FUL program or pricing data associated, please e-mail FUL@cms.hhs.gov.
- MAC Disputes
  - MAC Weekly Price Updates
  - MAC Price Research Request Form

2.4.2 Dispensing Fees

The dispensing fee for the FFS Medicaid program is $11.15 per claim.

2.4.3 Co-pay

FFS beneficiaries will be charged a co-pay of $1.00 for every prescription.

The following exemptions apply to the co-pay rules:

- The beneficiary is under the age of 21
- The beneficiary is pregnant
- Written prescription (Rx) for contraceptives
- The beneficiary is in a Long-Term Care (LTC) facility
- Written Rx for smoking cessation products
- Written Rx for Medication Assisted Treatment (MAT) drugs
- 3-day emergency fill
- Vaccines
- HIV anti-retroviral medications

2.4.4 Co-pay Waiver

Co-pay waiver is for Medicaid beneficiaries seeking to fill prescriptions who state that they are unable to satisfy the co-pay requirement; these beneficiaries must be given their medications. If the pharmacy has agreed to accept Medicaid reimbursement for prescriptions, the pharmacy cannot refuse to fill a prescription for a Medicaid beneficiary because the co-payment cannot be paid. Federal law requires a pharmacy to release the medication to the beneficiary but does not require a pharmacy to waive or forgive the co-payment.

The pharmacy retains the authority to collect the co-payment amount owed for the released prescriptions from the beneficiary at a later time; however, the arrangement to collect outstanding co-payments should occur independently between the pharmacy and the Medicaid beneficiary.

If a pharmacy decides to waive the co-pay for a particular prescription, the DC Medicaid FFS PBM contractor has implemented a process to do so via the POS electronic claims system.

Refer to the DC Medicaid Payer Sheet.

2.5 Generic Mandatory

The District Medicaid FFS program is a Generic Mandatory program. Claims submitted for a Brand product that has an AB-rated Generic equivalent product available will deny with a message informing the pharmacy to use a Generic medication.

Exceptions to this rule include the following:

- Insulin
- Preferred brand drugs identified on the preferred drug list (PDL)
- Claims for which the prescriber has written "Brand Medically Necessary" on the prescription and the provider has received a PA from the District Medicaid Pharmacy Call Center; (the pharmacy must submit a DAW 1 on the claim).
- Claims for which no generic product is available in the marketplace; (the -pharmacy must submit a DAW 8 on the claim).
- Claims for a beneficiary who has failed use of the generic product and the provider has obtained a prior authorization (PA).

2.6 Dispense As Written (DAW) Codes

Effective April 1, 2021, the District will only allow providers to claim Medicaid reimbursement using designated DAW codes deemed acceptable to the DC Medicaid Pharmacy program with abbreviated explanations that align with the National Council on Prescription Drug Programs (NCPDP) claims transaction field description. In order to receive reimbursement for claims submitted, DC Medicaid Pharmacy Providers shall utilize the correct DAW codes based upon the information provided on a prescription and/or verbally verified (documented on the prescription for audit purposes) from the prescriber or their designee.

See DHCF Transmittal 21-12: Acceptable Dispense As Written (DAW) Codes for Submitted Pharmacy Claims.

The following codes are considered **acceptable** for the purposes of claiming for DC Medicaid reimbursement:

- For Medication Assisted Treatment (MAT) Drug Products:
  - **DAW – 0:** Substitution Allowed – No Product Selection Indicated
  - **DAW – 1:** Substitution Not Allowed by Prescriber – Brand Drug Dispensed
  - **DAW – 4:** Substitution Allowed – Generic Drug Not in Stock at Pharmacy – Brand Drug Dispensed
  - **DAW – 8:** Substitution Allowed – Generic Drug Not Available in Marketplace – Brand Drug Dispensed
- For All Other Prescribed Drugs:
  - **DAW – 0:** Substitution Allowed – No Product Selection Indicated
  - **DAW – 1:** Substitution Not Allowed by Prescriber – Brand Drug Dispensed *Medical Necessity Must Be Established*
  - **DAW – 8:** Substitution Allowed – Generic Drug Not Available in Marketplace – Brand Drug Dispensed
  - **DAW – 9:** Substitution Allowed – Insurance Plan Request Brand Drug – Brand Drug Dispensed

The following codes are considered **unacceptable** for billing for the DC Medicaid Program:

- For Any Prescribed Drug:
  - **DAW – 2:** Substitution Allowed – Patient Requested that Brand Product be Dispensed
  - **DAW – 3:** Substitution Allowed – Pharmacist Selected Product Dispensed
  - **DAW – 5:** Substitution Allowed – Brand Drug Dispensed as Generic
  - **DAW – 6:** Override
  - **DAW – 7:** Substitution Not Allowed – Brand Drug Mandated by Law

2.7 ProDUR

The District POS system will enforce a comprehensive ProDUR program. The system will automatically review each drug claim submitted by a pharmacist (prior to dispensing) to identify problems such as drug-drug interactions, therapeutic duplication, and incorrect dosage.

The pharmacy will receive a message back to identify any of the following potential problems with submitted claims:

- Drug – Drug Interaction
- Drug – Disease Contraindication
- Therapeutic Duplication
- Ingredient Duplication
- Pediatric Drug
- Early Refill
- Low Dose
- High Dose
- Geriatric Drug

Any claim submitted that poses a potential DUR problem will either deny and require pharmacy overrides or pay with a message returned on the response alerting the pharmacist to the potential problem.

The ProDUR exceptions that will result in a **denial** and require prior authorization are:

- Drug-Drug interaction with severity level 1;
- Therapeutic Duplication for CII controlled substances; and
- Early Refill.

2.8 Coordination of Benefits (COB)

District Medicaid is the payer of last resort; therefore, there are special rules in place when processing claims for District recipients that are covered by other insurance.

- Claims must always be submitted to the primary carrier prior to being submitted to the District for processing.
- If the beneficiary has other coverage on their recipient file and the claim does not include an Other Coverage Code of 2 or 4 indicating the claim has been sent to the primary payer for processing, the claim will deny with an NCPDP Reject code of *41 – Submit Claim to Other Processor*.
- The District will always use the District Medicaid program allowed amount when calculating reimbursement. If a third party's payment exceeds this amount, a zero paid amount from the District can result.
- In accordance with regulations at 42 CFR § 447.15, providers may not balance bill Medicaid beneficiaries amounts additional to the amount paid by the agency plus any deductible, coinsurance or copayment required by the state plan to be paid by the beneficiary.

2.8.1 Medicare Part B

By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. See Coordination of Benefits & Third-Party Liability.

Coordination of benefits (COB) for Medicare Part B services must be submitted as a Medicaid medical benefit and cannot be processed at point of sale.

Please use form CMS 1500 to submit the claims to the medical benefit. Claims should be sent to:

CMS1500 Claim Forms
P.O. Box 34768
Washington, DC 20043-4768

See https://www.dc-medicaid.com/dcwebportal/nonsecure/contactUs for details.

Part B pricing logic is available at: Crossover Pricing Logic.

Providers must accept assignment for Part B drugs coordination of benefits with Medicaid. Dual eligible beneficiaries should never be asked any additional payments for Part B drugs.

For more information refer to CMS bulletin at: Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program.

2.8.2 Medicare Part D

By federal guidelines, the District Medicaid program does not process COB for Medicare Part D claims as it does for all other COB claims. The claim must be sent to Medicare Part D to be paid. Some over-the-counter (OTC) drugs not covered by Medicare Part D that are routinely covered by Medicaid may be reimbursed .

Please refer to OTC list in section 3.3.

2.9 Pharmacy Lock-in Program

District Medicaid has a Pharmacy Lock-In Program that is designed to detect and prevent abuse or misuse of the Medicaid pharmacy benefit, as defined by specific criteria, restricting beneficiaries to one (1) specific pharmacy for a defined period of twelve (12) months. Protecting the beneficiary's safety is the ultimate reason for placement in Pharmacy Lock-In Program.

- DHCF will use the following guidelines established by the DUR Board to identify beneficiaries within the last ninety (90) days:
  - Three (3) or more controlled substance prescriptions per month; and/or
  - Three (3) or more prescribers for controlled substance prescriptions per month; and/or
  - Three (3) or more pharmacies for controlled substance prescriptions per month; and/or
  - Ten (10) or more prescriptions per month.

District Medicaid beneficiaries are notified thirty (30) days in advance regarding placement in the Pharmacy Lock-In Program. The initial letter provides the beneficiary an option to select amongst three (3) frequented pharmacies to choose as his/her designated pharmacy. This selection must be made within fifteen (15) days from the date of the initial letter. If the beneficiary does not make a selection, the beneficiary will be assigned a designated pharmacy.

A confirmation letter is mailed to the beneficiary that lists the designated lock-in pharmacy and the effective start and end date of the Pharmacy Lock-In Program. DHCF will notify all prescribers of the controlled substance prescriptions and the designated lock-in pharmacy in writing.

The lock-in pharmacy will be designated to fill all of the beneficiary's DC Medicaid-covered prescriptions. If a non-designated lock-in pharmacy submits a prescription claim for a beneficiary, the pharmacy will receive an error message: **"NCPDP reject code *50 – Non matched pharmacy number. Pharmacy Not Authorized – Beneficiary is in a Pharmacy Lock-in Program."***

3.0 Drug Coverage

3.1 Preferred Drug List (PDL)

The District uses a PDL in determining coverage of specific drugs or drug classes. The PDL will be located on the DHCF pharmacy benefit website at http://www.dc-pbm.com/provider/documents. Claims submitted for drugs that are non-preferred will receive an NCPDP Reject code of *75 – PDL PA Required*.

Refer to the Preferred Drug Program PA Form.

3.1.1 PDL Prior Authorization Override

Providers can override the PA requirement for a non-preferred drug by entering "3" (emergency) in the Level of Service field (NCPDP Field # 418-DI). The following restrictions will apply:

- The claim must be for a 3-day supply except where the package must be dispensed intact.
- The drug must be a covered drug.
- A patient is allowed one PDL PA override per Generic Sequence Number (GSN) per 30 days.
- Information for Pharmacy Providers on dispensing a 72-hour (3-day) emergency supply
  - The rule applies to any submitted pharmacy drug claim that results in a NCPDP Reject Code: 75 "Prior Authorization (PA) Required" and any drug(s) that is affected by clinical or PA edits and requires prior approval from the prescriber.
  - If the prescriber cannot be reached or is unable to request the PA, the pharmacy should submit an emergency 72-hour claim.
  - Pharmacist should use his/her professional judgment regarding whether there is an immediate need every time the 72-hour option is used.
  - The 72-hour emergency procedure should not be used for routine and continuous overrides.
  - If the medication is a dosage form that prevents a 3-day supply from being dispensed, it is still permissible to indicate that the emergency prescription is a 3-day supply, and enter the full quantity dispensed. Dispense the minimum quantity as a 3-day supply. Examples include, but are not limited to, multiple dose injectables, metered dose inhalers, nasal sprays, topical preparations and powders for reconstitution.

- Pharmacy claims requiring a PA will reject with the following code and messaging: 75 – Prior Authorization Required. Inform the Medicaid beneficiary, notify the prescriber that a PA is required, and contact the Pharmacy Benefit Manager (PBM) if needed. Follow the instructions in the PA error message and submit the indicated PA Type Code, Submission Clarification Code, and/or PA Auth Code if needed to obtain a paid claim for the 3-day emergency supply.

3.2 Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) Drug Coverage

Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) medications are a benefit of the DC Medicaid FFS Pharmacy Program.

For beneficiaries in LTC facilities, claims will be allowed for HIV/AIDS drugs within AHFS 081808.

As of January 1, 2013, beneficiaries that are actively enrolled in a Managed Care Organization (MCO) receive their HIV/AIDS treatment medications as FFS benefit. Alliance Patient HIV treatment drugs will be billed under the AIDS Drug Assistance Program (ADAP) Program. For details, please visit the ADAP Program.

3.2.1 HIV PrEP and PEP Coverage

Effective April 1, 2021, all providers and pharmacies submitting Medicaid pharmacy point-of-sale (POS) claims for FDA-approved medications and their generic equivalents when used for Pre-Exposure Prophylaxis (PrEP) and any Medicaid pharmacy POS claims for HIV medications when used for Post-Exposure Prophylaxis (PEP) must bill through the Fee for Service (FFS) Medicaid Pharmacy Benefit Manager (currently Magellan) to receive reimbursement from DHCF.

This policy applies to all pharmacy claims submitted on behalf of eligible Medicaid beneficiaries [Note: This policy change does not include Alliance or Immigrant Children's Program (ICP)] whether enrolled in either the FFS program or a Medicaid MCO]. **See DHCF Transmittal 21-13. PrEP and PEP Coverage for Medicaid Beneficiaries Enrolled in MCOs.**

3.3 Excluded Drugs

The following drugs are excluded from coverage for the District DHCF Pharmacy Program:

- Drugs that are considered Drug Efficacy Study Implementation (DESI) drugs (classification codes 5/6)
- Investigational drugs
- Drugs that do not have a signed federal rebate agreement on file with CMS
- Drugs that are obsolete – drugs are considered obsolete if the date of service is 366 days or greater than the obsolete date reported by First Databank.
- Food supplements
- Medical supplies (excluding syringes)
- Fertility drugs
- Anti-obesity drugs
- Drugs for cosmetic purposes (see *Section 4.1 – Drugs Requiring Prior Authorization)*
- Diagnostic agents
- Erectile dysfunction drugs
- Non-Prescription Cough and Cold
- The following categories of over-the-counter OTC medications shall only be covered when prescribed by a licensed provider:
  - Acetaminophen
  - Antacids
  - Aspirin
  - Bowel diagnostic preparation kits
  - Calcium
  - Ferrous sulfate
  - Ferrous gluconate
  - Geriatric vitamins
  - Ibuprofen (200 mg strength)
  - Identified diabetic supplies (*Section 3.7 – Diabetic Supplies)*
  - Insulin
  - Pediatric vitamins
  - Prenatal vitamins
  - Single agent vit B1, vit B6 , vit B12, vit D
  - Salicylate
  - Single ingredient antihistamines
  - Family planning products
  - Syringes and needles

- Some gastrointestinal products (senna leaf extract)
- Sodium bicarbonate 325 mg up to 650 mg
- Folic acid 400 mcg up to 800 mcg

3.4 Unit Dose

Unit Dose drugs will deny for retail prescriptions – with the exception of the drugs that are only available in Unit Dose form.

LTC prescriptions will allow payment for all unit dose drugs as identified by First Databank.

3.5 Overrides for Vacation Supply, Stolen, or Lost Medication

Under normal circumstances, and in the absence of justifying reasons, a request for a refill too soon after previous fill is denied if a participant does not utilize at least 80 percent (i.e., 24th day of the 31-day supply) of the previous prescription.

Any request for a refill too soon after previous fill to be overridden for travel purposes or due to stolen or lost medication can be submitted to the DHCF via fax. The Travel Medication/Supply Form should be faxed to 1-866-535-7622.The Pharmacy Benefit Management (PBM) agent or DHCF staff will communicate with a pharmacy provider to process claims for approved requests.

3.5.1 Travel/Vacation Supply

A physician can submit a request for a refill too soon after previous fill override for a patient's vacation, emergency, or work-related business travel purposes before the next refill time. The following documents should accompany the request for an override:

- A copy of the prescription for the medication requested;
- A copy of the round-trip travel itinerary; and
- A letter from the physician justifying the need.

The request for a vacation override should be submitted at least seven days prior to the intended day of travel to accommodate a review, which will take approximately two business days.

The quantity requested cannot exceed a 90-day supply. A maximum of one 90-day supply will be authorized per 365-day period with certain exceptions. Refer to the Travel Medication/Supply Form.

3.5.2 Stolen or Lost Medication

A request for a refill too soon after previous fill due to lost or stolen medication may be approved when there is/are acceptable reasons or when a patient produces evidence, such as a police report.

3.6 Vaccines

Immunizations and vaccines will be covered at POS per state regulations. An administration fee will be paid instead of a dispensing fee. Products will be limited to only the following types of vaccinations: hepatitis, shingles, human papillomavirus, tetanus, Tdap, meningococcal, haemophilus influenzae, pneumococcal, and influenza; per DC Health Policy.

The administration fee will be based on the assigned route of administration. Patient co-pay will be $0. Prior Authorization will be required for beneficiaries under 12 years of age.

Route of Administration	Administration Fees
Injection	$13.00
Subcutaneous	$13.00
Intramuscular	$13.00
Intradermal	$13.00
Nasal	$8.00

3.6.1 COVID-19 Vaccines

The billing and reimbursement rates for COVID-19 vaccines are based on the published guidance by CMS. If newer rates are published by CMS or a Medicare Administrator Contractor (MAC), the rates may be updated with retroactive payment adjustments as necessary. CMS only priced the administration of these services as the product is being provided for free initially. Refer to DHCF Transmittal #21-15 Updated Professional Services Billing Codes and Reimbursement Rates for COVID-19 Vaccines.

3.7 Diabetic Supplies

The District DHCF has contracted with Magellan Medicaid Administration to manage a DC Medicaid diabetic supplies program. This program applies to DC Medicaid FFS beneficiaries without other insurance or Medicare coverage.

- Refer to the Pharmacy Preferred Diabetic Supply List.
- Lancets are covered under Durable Medical Equipment (DME) benefit. The pharmacy must be a DME provider. Claims should be submitted to DHCF using Form 719A. Form 719A.

4.0 Prior Authorization (PA)

4.1 Standard PA

There are certain drugs that the District Medicaid has designated as requiring a PA in order for the claim to be paid. PAs in this category include the medication therapy management protocols implemented by the District in other programs. Drugs with limitations will see an NCPDP reject code 75 –Prior Authorization Required or an NCPDP Reject Code 76 – Plan Limits Exceeded. The District Medicaid Pharmacy Call Center phone number will appear on the response message to the pharmacy.

The District Medicaid Clinical Call Center (PBM) will handle all PA requests for:

- Non-PDL drugs
- Opioid narcotics and narcotic combinations
- Injectables (not all injectables)
- Buprenorphine/Naloxone and Subutex
- Xeloda (Breast Cancer)
- Long-Acting Injectable Atypical Antipsychotics (fax only)
- Pulmonary Arterial Hypertension medications
- ADHD medications
- Hepatitis C medications (fax only)
- Growth hormone therapy
- Synagis
- Quantity Limits
- Early Refills
- Travel Medication/Supply PA Form
- General Fax PA Request Form

These and other ongoing PA programs provide access to necessary medications in a manner that is compliant with the medications' Food and Drug Administration (FDA)-approved use and/or with national guidelines, evidence-based medicine, or nationally recognized standards of therapy.

The District Medicaid Clinical Call Center is available 24 hours a day, 7 days a week, and 365 days a year:

Provider Help Desk: 1-800-273-4962

Clinical Prior Authorization Fax: 1-866-653-1431

Hearing Impaired: 711

The prescriber must initiate the PA with the District Medicaid Clinical Call Center. If the PA is not initiated prior to the claim submission, the claim will deny with an NCPDP Reject *75 – Prior Authorization required* and have the pharmacy request the prescriber call to obtain a Prior Authorization. **A hyperlink of the PA forms is included in *Section 14.1 – Appendix B: District D.0 Payer Specification* at the end of this manual for reference.**

4.2 Expedited Narcotics PAs

A dispensing pharmacist may verbally request a one-time PA for a narcotic medication when a prescription is generated for a seven-day supply or less from any medical facility.

- The dispensing pharmacist can call the Pharmacy Call Center to request the one-time PA.
- The PBM Clinical Staff can authorize the one-time PA without having to contact the prescribing physician.
- This PA process is **not** intended for
  - Long-term use;
  - Multiple (more than two) narcotic prescriptions; or
  - Prescription quantities greater than a seven-day supply.
- A patient is allowed one expedited prior authorization per drug per 30 days.

4.3 Medication Assisted Treatment (MAT) Drug Products

Medication Assisted Treatment (MAT) drug products will be covered up to the FDA approved maximum daily dose, without a PA, for prescribers enrolled on the Suboxone panel. Additionally, MAT drug products prescribed and dispensed above the FDA approved maximum daily dose, will require PA. See the chart below:

MAT Drug Products	FDA Approved Maximum Daily Dose (No PA Needed)	MAT Drug Product Indication(s)	Benefit Type
methadone (Methadose® and Dolophine®)	120 mg	OUD	Access thru a DBH Certified Provider
Probuphine®	296.8mg (one-time every 6 months dose)	OUD	Medical Benefit
Suboxone®	24 mg/6 mg	OUD	Pharmacy Benefit
Zubsolv®	17.2 mg/4.2 mg	OUD	Pharmacy Benefit
Bunavail®	12.6 mg/2.1 mg	OUD	Pharmacy Benefit
buprenorphine/naloxone	24 mg/6 mg	OUD	Pharmacy Benefit
buprenorphine	24 mg	OUD	Pharmacy Benefit
naltrexone	50 mg	OUD and AUD	Pharmacy Benefit
Sublocade®	300 mg (one-time monthly dose)	OUD	Medical and Pharmacy Benefit
Vivitrol®	380 mg (one-time monthly dose)	OUD and AUD	Medical and Pharmacy Benefit
Lucemyra®	2.88 mg	Opioid Withdrawal Symptoms	Pharmacy Benefit
acamprosate calcium	1998 mg	AUD	Pharmacy Benefit
disulfiram	500 mg	AUD	Pharmacy Benefit

Policy HCDMA-19-001 transmittal will be located on the DHCF Medicaid Updates website at https://dhcf.dc.gov/page/2019-dhcf-medicaid-updates.

To be enrolled on the Suboxone panel, prescribers need to be enrolled with DC Medicaid. For provider enrollment status, please contact Maximus at 1-844-218-9700 or visit https://www.dcpdms.com.

Prescribers' buprenorphine waiver identification number ("X" number) from the DEA is also required to be included on the Suboxone panel. XDEA numbers must be submitted to Magellan for confirmation of active SAMHSA DATA waiver status.

Written Rx for medication assisted treatment (MAT) will be excluded from co-pay.

4.4 Long-Term Use Controlled Substances PAs

PAs for Schedule II medications intended for long-term use (e.g., diagnosis of Attention-Deficit Disorder [ADD], Attention Deficit Hyperactivity Disorder [ADHD], Narcolepsy, cancer pain, or prescriptions from pain management centers), may require an initial consult with the physician.

PA approval for medications with a qualifying diagnosis can be authorized for a period of up to 12 months.

Medication regimens and/or dosage changes may require an updated PA when deemed clinically necessary.

4.5 Quantity Limits

The following drugs have quantity limits and, if those limits are exceeded, providers will receive an NCPDP reject *76 – Plan Limits Exceeded*:

- Diaphragms are limited to 1 unit per 365 days.
- Inhalation spacers are limited to 2 units per 365 days.
- Glucose monitors/kits are limited to 1 kit per 365 days.
- Contraceptive products may be prescribed and dispensed in quantities up to a 12-month supply in a single claim.

Additional drugs with quantity limits are available on the DC Medicaid Pharmacy web portal.

4.5.1 Enoxaparin (Lovenox®) Quantity Limits

If the claim is not submitted in milliliters (MLs), then the claim should be denied with a message posted stating **Bill in MLs**. Quantity limits should match the chart below.

Enoxaparin	ML	Dose/Day	Days/Month	Limit/Month
30 mg	0.3	2	34	20.4
40 mg	0.4	2	34	27.2
60 mg	0.6	2	34	40.8
80 mg	0.8	2	34	54.4
100 mg	1.0	2	34	68
120 mg	0.8	2	34	54.4
150 mg	1.0	2	34	68

4.6 Morphine Milligram Equivalent (MME)

The MME policy/program is applicable to all **DC Fee-for-Service Medicaid** beneficiaries who are at risk of exceeding the customarily prescribed opioid daily dosages, which can be medically harmful and even fatal. This MME policy/program, however, is not intended for beneficiaries who have an active cancer diagnosis, sickle cell disease, or are in palliative care or hospice. **This policy/program does not limit prescriptions for Medication-Assisted Treatment (MAT) (e.g., Methadone, Buprenorphine, Naltrexone, etc.) that treat Substance Use Disorder (SUD).**

As of October 1, 2019, DHCF will require prior authorization for reimbursement of opioid prescriptions greater than 90 MME and/or a 7 days' supply. These changes will limit the Medicaid covered maximum days' supply and the maximum daily dose.

Policy transmittal will be located on the DHCF Medicaid Updates website at https://dhcf.dc.gov/page/2019-dhcf-medicaid-updates.

Additional information, including an MME calculator can be found at CDC Guidelines for Prescribing Opioids for Chronic Pain. DC Department of Health guidance can be found at XYC.

5.0 Compounds

5.1 Multi-Ingredients Compound Claim Submission

When multi-ingredients compounds are submitted, each ingredient will be subject to the claims processing rules for the program.

- If one or more ingredients are not covered, the entire compound will be denied.
- If the provider chooses to accept payment for those ingredients that are covered, they have the option to submit a valid value of 8 in the Submission Clarification Code field (420-DK) upon re-submission of the claim. This code will tell the system to reimburse the provider for those ingredients that are covered as total reimbursement.
- If there are ingredients that require a PA, the provider must call the Help Desk to obtain a PA in order to get the ingredient to pay. When calling for a PA, all criteria for each ingredient requiring PA must be met.
- Compound claims over $1,500.00 will deny and require PA.
- District Medicaid will only accept the submission of multi-line compound claims. Any claim that is submitted with a Compound Code of 2 and only includes one ingredient will be denied with NCPDP Reject 20 M/I Compound Code.

5.2 Total Parenteral Nutrition (TPN)

A TPN claim will be defined as a compound that includes an intravenous (IV) drug in HIC3 Therapeutic Class C5B, C9C, or M4B.

HIC3 Description	HIC3
Protein Replacement	C5B
Parenteral Amino Acid Solutions and Combinations	C9C
IV Fat Emulsions	M4B

Claims should be submitted with compound indicator = 2. Submission Clarification Code = 08 allows the pharmacy to accept payment for covered ingredients only. Cost exceeds max will require PA.

5.3 Death with Dignity

The District of Columbia passed the "Death with Dignity Act of 2016." The Act establishes a process by which competent, terminally ill residents of District of Columbia can legally obtain a physician's prescription for drugs to end their life in a humane and peaceful manner. Claims for Death with Dignity procedure should be submitted with ICD-10 code X83.8XXA. Additional information on Death with Dignity procedure is available at:

Department of Health Death with Dignity Contact Information

Phone: (202) 724-8800

Email: deathwithdignitydc@dc.gov

Website: https://dchealth.dc.gov/page/death-dignity-act-2016

6.0 Long Term Care (LTC) Pharmacy

- LTC pharmacies are identified by Primary Dispenser Type Code 4 (LTC Pharmacy associated with taxonomy code "3336L0003X").
- Co-pay will be $0 if
  - The Patient Residence Code on the claim = 2 or 3 and the patient is in group 400 or 410; and
  - The Pharmacy Dispenser Type code = 4 (Long Term Care).
- LTC pharmacies can submit claims for all DC Medicaid beneficiaries at the time of dispensing (real time).
- Medications requiring PA should be approved prior to dispensing by the LTC pharmacy.

7.0 District Specialty Pharmacy Network

7.1 Background

In 2010, the District DHCF worked with the Department of Behavioral Health (DBH) to address access-to-care barriers and to improve medication adherence for FFS Medicaid beneficiaries with behavioral health problems requiring the use of certain injectable antipsychotic medications. These physician-administered anti-psychotic medications were previously available only as a medical benefit through a physician "buy and bill" reimbursement process.

To address these access issues, a Mental Health Specialty Pharmacy Network (MHSPN) was created to allow selected physician-administered injectable antipsychotics to be billed as a pharmacy benefit through the pharmacy POS system. DHCF offered pharmacies interested in dispensing these medications directly to physician offices or other healthcare facilities that serve DC Medicaid beneficiaries the opportunity to "opt-in" as a provider for this pharmacy network.

Other injectable medications may be added to the Specialty Pharmacy Network to improve patient adherence.

7.2 Opt-in Enrollment

A DC Medicaid enrolled pharmacy wishing to participate in the MHSPN must complete the network enrollment application and meet the specified delivery and documentation requirements. Refer to the Specialty Pharmacy Network Application.

8.0 340B Drug Pricing Program

The 340B Drug Pricing Program enables health care organizations or covered entities (CEs) to purchase drugs at significantly reduced prices. The U.S. Department of Health and Human Services Office of Pharmacy Affairs (OPA) is responsible for administering the 340B Drug Pricing Program and is part of the Health Resources and Services Administration (HRSA).

DHCF is implementing its 340B policy effective January 1, 2018. Beginning on this effective date, DHCF recognizes covered entity pharmacies, but not contract pharmacies, as 340B providers. Only covered entity in-house pharmacies that opted to carve-in Medicaid can dispense 340B drugs to beneficiaries and submit claims to the PBM of the FFS Medicaid program. Currently, contract pharmacies are excluded from dispensing and submitting claims for 340B drugs.

New carve-in registrations are accepted by OPA only during the following specified periods:

- October 1 through 15
- January 1 through 15
- April 1 through 15
- July 1 through 15

Covered entities should submit the change request during the open registration period to be able to process DC Medicaid FFS claims on the first day of the next quarter.

Covered entities carve-in enrollment requirements:

- Submit a request for carving-in Medicaid to the 340B Office of Pharmacy Affairs Information System (OPAIS) https://www.hrsa.gov/opa/340b-opais/index.html.
  - Additional information is available at http://www.hrsa.gov/opa.
- Review the information on the HRSA Medicaid Exclusion File located at the OPA website for accuracy.
- The covered entity in-house pharmacy must be enrolled as a DC Medicaid FFS provider.
- Shipping address on the 340B OPAIS must match the pharmacy business address on the DC Medicaid Management Information System (MMIS).
- Please send HRSA approved application, pharmacy contact information, and NPI to DC340B@magellanhealth.com.
- Claims can be submitted once all documentation is approved by DHCF.
- Service date period will be based on DHCF approval.

9.0 POS Beneficiary Notification

The DHCF is requiring the District Medicaid program's participating pharmacies to distribute individualized written notices to Medicaid beneficiaries whose prescription medication claim request is denied after adjudication at the pharmacy point of sale. The notice explains the rights a beneficiary has when a prescription claim is denied by Medicaid, the responsibilities of the beneficiary, the responsibilities of the pharmacists, and provides a contact number for the District Medicaid PBM Call Center. A beneficiary who continues to believe the claim should be approved by Medicaid may request a Fair Hearing before an Administrative Law Judge.

This applies to all beneficiaries who are served by DC Medicaid, including those enrolled in all DC Medicaid Managed Care Organization.

Additional information available at Written Pharmacy Point of Service (POS) Notice.

Most prescription "problems" at the point of sale will generally be minor. They can be handled informally and quickly. As a Medicaid provider, however, **you are required** to direct the beneficiary whose claim has been rejected to the instructions on the beneficiary notification.

10.0 Counseling Signature Log Requirements

Documentation of receipt of prescriptions as well as the offer to receive counseling on the use of the prescriptions is required by the District for each prescription dispensed to an FFS beneficiary. Documentation must include, at a minimum, the prescription number, member name, date filled, date received, and a signature of the person receiving the prescription or offer to receive counseling (i.e., the member, member's representative, or a representative of the facility in which the patient resides).

For medications being delivered, a signature must be obtained. The signature logs are required for the auditor to review, if requested. If the auditor requests further review of a signature log on an audit due to a missing signature log, or if further investigation is needed, only an original signed statement from the member, member's representative, or a representative of the facility in which the patient resides, verifying receipt of the medication and the date it was received, can be provided to auditor within the time period allotted. The statement must include member contact information.

Signature log and offer to receive counseling documentation must be retained by the pharmacy in a readily retrievable record for a period of at least two (2) years.

10.1 Signature Log Requirements During State of Emergency

- In April 2020 DC Medicaid temporarily waived the beneficiary signature requirement for services provided during the COVID-19 Public Health Emergency (PHE). See DHCF Transmittal 20-16.
    - Required capture of Medicaid beneficiary signatures at the pharmacy counter or site of medication delivery will resume at the end of the PHE.

11.0 Audits

Pursuant to the authority set forth in §1902(a) (30) of the Social Security Act, and 42 C.F.R. § 456.23, and in conjunction with 29 DCMR § 1300, *et seq.* and 1900, *et seq.*, the District DHCF conducts post-payment reviews of health care services paid for with Medicaid funds. During such reviews, DHCF verifies that the services were provided to a specific Medicaid-eligible recipient and that the services are both covered and reimbursable under the Medicaid program

12.0 Medical Benefit Drugs

- Drugs covered under medical benefit are products administered, injected, or infused by a health care professional in physician's office, clinics, hospital out-patient center, and free-standing infusion center/clinic or by a mobile infusion therapy provider at home.
- Claims for medical benefit drugs are processed as a medical benefit through the MMIS system/Conduent. If help is needed about how to submit claims for medical benefit drugs and other services which are covered under medical benefit, providers should contact Conduent Provider Inquiry line at 202-906-8318.
- The information on the fee schedule (available at https://www.dc-medicaid.com/dcwebportal/home) is applicable for medical benefit drugs and providers are expected to follow the "buy-and-bill" policy.
- There are many drugs covered under medical benefit. Some of them require prior authorization (PA).
- The PA request is submitted via fax to Department of Health Care Finance (DHCF) and the fax number is: (202) 722-5685.
- The requirements for PA submission include:
  - A cover letter that contains requestors contact information such as phone and fax number;
  - Completing Form; and
  - Physician's current clinical note, which provides information including but not limited to patient's profile and history, disease condition, complete examination, diagnosis and staging, and previous treatment regimen and progress.

For any further information please contact DHCF at (202) 442-5952, (202) 478-1415 or (202) 442-9076.

13.0 Frequently Asked Questions

1. **How do I enroll or renew my pharmacy enrollment as a DC Medicaid pharmacy provider?**

   DHCF has partnered with MAXIMUS to implement a system for submitting your initial enrollment or re-enrollment application for the DC Medicaid program. The contact information is:

   Maximus
   1-844-218-9700
   Monday – Friday
   8:00 a.m. – 5:00 p.m.
   www.dcpdms.com

2. **Whom should I contact if I have questions about my Remittance Advice (RA) or payments?**

   Please contact Conduent Provider Inquiry line at 202-906-8318.

14.0 Appendices

14.1 Appendix A: District FFS D.0 Payer Specification

The District FFS D.0 Payer Specification document can be found on the DHCF Pharmacy Benefit website at http://www.dc-pbm.com/.

14.2 Appendix B: Prior Authorization Forms

Please refer to the list of current PA forms on the DHCF Pharmacy Benefit website at https://www.dc-pbm.com/.

15.0 Definitions, Abbreviations, and Acronyms

Acronym or Term	Definition
ADD	Attention Deficit Disorder
ADHD	Attention Deficit/Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
BIN	Bank Information Number
COB	Coordination of Benefits
CMS	Centers for Medicare & Medicaid Services
DAW	Dispense as written
DEA	Drug Enforcement Administration
DHCF	Department of Health Care Finance
DMAC	District Maximum Allowable Cost
DOS	Date of Service
FFS	Fee-for-Service
FMAC	Federal Maximum Allowable Cost
FUL	Federal Upper Limit
GSN	Generic Sequence Number
HIC3	Drug therapeutic class
HIV	Human Immunodeficiency Virus
ID	Identification
LTC	Long-Term Care
LTCF	Long Term Care Facility
MAT	Medicated-Assisted Treatment
MCO	Managed Care Organization
MD	Medical Doctor
N-PA	Narcotic Prior Authorization
NADAC	National Average Acquisition Cost
NCPDP	National Council for Prescription Drug Programs
OTC	Over-the-Counter
PA	Prior Authorization
PCN	Processor Control Number
PDL	Preferred Drug List
ProDUR	Prospective Drug Utilization Review

Acronym or Term	Definition
POS	Point-of-Sale
RA	Remittance Advice
RPh	Registered Pharmacist
TPL	Third-Party Liability
WAC	Wholesale Acquisition Cost