Department of Health Care Finance

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

Version 1.0

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Department of Health Care Finance

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1.0 Introduction

Beginning December 19, 2015, Magellan Medicaid Administration, Inc. (part of the Magellan Rx Management Division of Magellan Health, Inc.) will process 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) in January 1, 2012. Department of Health Care Finance (DHCF) will accept the B1, B2, and 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 new 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 Point-of-Sale (POS). Pharmacy providers must be enrolled with DHCF Medicaid at 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 on 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

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

Hearing Impaired: 711

2.0 Program Information

2.1 New Claim Information

Upon implementation December 19, 2015, 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 do a re-bill. The timely filing rules apply to POS. Paper claims will not be accepted.

- Reversals are allowed at any time.
- 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 State 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.**
- CIIs (DEA code = II) must be filled within 30 days of being written.
- **CIIs are not allowed to be refilled**; a new prescription is required for each fill.
- **Controlled drugs other than CIIs** (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

2.4.1 Pricing Methodology

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

- Submitted Ingredient Cost;
- Gross Amount Due;
- District Allowed Amount (Wholesale Acquisition Cost [WAC] + 3 percent) plus dispensing fee;
- Federal Upper Limit [FUL]) (Federal Maximum Allowable Cost [FMAC]) plus dispensing fee; or
- State Maximum Allowable Cost (SMAC) plus dispensing fee

2.4.2 Dispensing Fees

The dispensing fee for this program is $4.50 per claim except for intravenous (IV) compounds.

The dispensing fee for compounds is divided into three categories: Non-IV, IV and Total Parenteral Nutrition (TPN).

- **Non-IV** claims will have a $4.50 dispensing fee.
- **IV** claims will have a $7.25 dispensing fee. An IV compound claim will be determined by the compound containing a medication with the SNOMED Code in the following table.

SNOMED Code Table	
SNOMED Code	**Description**
C444364	By infusion (route)
424494006	Infusion route
424109004	Injection route
418114005	Intravenous central route
419993007	Intravenous peripheral route
404817000	Intravenous Piggyback route
47625008	Intravenous route
372467006	Intralymphatic route

SNOMED Code Table	
SNOMED Code	**Description**
445755006	Intravascular route
38239002	Intraperitoneal route
58100008	Intra-arterial route
127492001	Nasogastric route
78421000	Intramuscular route

- **TPN** claims will have a $17.25 dispensing fee. A TPN claim will be defined as a compound claim that includes a drug with SNOMED code as identified in the previous table and an ingredient in Therapeutic Class C5B.

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 recipient is under the age of 21.
- The recipient is pregnant.
- The recipient is taking any contraceptive.
- The recipient is in a Long-Term Care (LTC) facility.

2.4.4 HIV/AIDS Warehouse Program

Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) medications are a benefit of the DC Medicaid FFS Pharmacy Program. Providers must be in the District Pharmacy Provider Network (DCPPN) for these drugs to be covered. Ingredient cost is covered by a replenishment model rather than cost reimbursement. Providers receive a dispensing fee of $10.50 for each prescription.

If a Provider is **not** in the DCPPN and submits an HIV/AIDS drug claim for a FFS beneficiary, they will receive an edit *6Z – Prov Not Elig to Perform/Serv/Dispense Product*.

For beneficiaries in LTC facilities, claims will be allowed for HIV/AIDS drugs within AHFS 081808 even if the LTC facility is not included in the DCPPN.

As of January 1, 2013, beneficiaries that are actively enrolled in a Managed Care Organization (MCO) receive their HIV/AIDS medications from an approved DCPPN provider as a FFS benefit.

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 before submitting the claim with a DAW 1.
- Claims for a Brand drug as for which the provider will accept generic pricing; (the provider must enter a DAW 5 on the claim).
- Claims for which no generic product is available in the marketplace: (the provider 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 PA.

2.6 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 are**

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

2.7 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. Note that District Medicaid does not conduct coordination of benefits with Medicare D.

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*.

If the beneficiary file does not indicate the presence of Other Coverage but there is Other Coverage present on the claim, the claim will process as if there was Other Coverage.

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.

3.0 Drug Coverage

3.1 Preferred Drug List

The District does use a PDL in determining coverage of specific drugs or drug classes. The PDL will be located on the DHCF pharmacy benefit website at https://www.dc-pbm.com/.

Claims submitted for drugs that are non-preferred will receive an NCPDP Reject code of *75 – PDL PA Required*.

3.1.1 PDL PA 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 three-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.

3.2 Drugs Requiring Prior Authorization

District Medicaid covers certain drugs but there may be limitations put on those drugs and a Prior Authorization is required if limitations are exceeded or criteria for use are not met. 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 following drugs have PA requirements:

- Schedule II Narcotics
- Injectable Drugs, with the following exceptions:
  - Insulin
  - Enoxaparin (Lovenox) *(see quantity limits below)*
  - Fragmin
  - Innohep
  - Epinephrine

  - Byetta
- Rebetron, Peg-Intron, Pegasys and Infergen
- Brand Medically Necessary with the following exceptions:
  - Insulin
  - B-12
- Cosmetic Drugs – Recipients age > 25 (Retin-A, Renova, Avita and Differin)
- Risperdal Consta and Invega Sustenna Injectables
- Antihyperkinesis Agents (ADHD/Narcolepsy)
- Suboxone/Subtex
- Pulmonary Arterial Hypertension Drugs
- Synagis
- Levocarnitine
- Growth Hormones
- Hepatitis C Drugs

3.2.1 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.
- Aerochambers are limited to 2 units per 365 days.
- Latanoprost (Xalatan) is limited to 2 x 2.5ml bottles in a 31 rolling day period.
- Glucose monitors/kits are limited to 1 kit per 365 days.
- Glucose test strips are limited to 100 test strips per 30 days.

ENOXAPARIN (Lovenox) Quantity Limits

If the claim is not submitted in milliliters, 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	.3	2	34	20.4
40 mg	.4	2	34	27.2
60 mg	.6	2	34	40.8

ENOXAPARIN	ML	Dose/Day	Days/Month	Limit/Month
80 mg	.8	2	34	54.4
100 mg	1.0	2	34	68
120 mg	.8	2	34	54.4
150 mg	1.0	2	34	68

3.3 Excluded Drugs

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

- Drugs that are considered DESI drugs
- Drugs that do not have a signed rebate on file
- 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 3.2 – Drugs Requiring Prior Authorization)*
- Diagnostic agents
- Erectile dysfunction drugs
- Non Prescription Cough and Cold
- Over-the-counter (OTC) drugs, with the following exceptions:
  - Acetaminophen
  - Antacids
  - Aspirin
  - Bowel diagnostic preparation kits
  - Calcium
  - Ferrous sulfate
  - Ferrous gluconate
  - Geriatric vitamins
  - Ibuprofen (200 mg strength)
  - Identified diabetic supplies (for *Section 3.1 – Preferred Drug List)*

- Insulin
- Pediatric vitamins
- Prenatal vitamins
- Salicylate
- Syringes and needles
- Some gastrointestinal products (senna extract)

3.4 Unit Dose

Unit Dose drugs will deny for retail prescriptions with the exception of the drugs that are listed below that are only available in Unit Dose form. LTC prescriptions will allow payment for all unit dose drugs as identified by First DataBank.

Exceptions:

Aldara Cream	Folitab 500	Niferex-PN	Vitafol
Accutane	Fosamax	Niferex-PN Forte	Xopenex Neb Sol
Actonel	Incivek	Nimotop	Zomig ZMT 5 mg
Afinitor	Ipratropium Neb Sol	Precare	Vancomycin
Albuterol Neb Sol	Lansoprazole	Precare Conceive	
Azithromycin (Z-pak and tri-pak)	Mesalamine emena	Prenatal RX	
Boniva	Metaproterenol Neb Sol	Prenatal-H	
Budesonide Neb Sol	Micardis	Primacare	
Cenogen-OB	Micardis HCT	Pulmicort Respules	
Cromolyn Neb Sol	NA CL Neb Sol	Remeron Soltabs	
Fero-Folic-500	Natafort	Sandimmune	
Ferrex PC	Natalcare CFE	Sumatriptin	
Ferrous Sulfate	Natalcare PIC	Testosterone Gel	
Fe-Tinic : District Only	Natalcare PIC Forte	Tolfrinic	
Fluconazole 150mg	Nephro-Vite +FE	Vinatal Forte	

3.5 Medicare D

By Federal guidelines, the District Medicaid does not process Coordination of Benefits for Medicare D claims as it does for all other Coordination of Benefits claims. The claim must be sent to Medicare D to be paid. Drugs not covered by Medicare D that are routinely covered by Medicaid will be reimbursed.

3.6 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 30-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 PBM agent or DHCF staff will communicate with a pharmacy provider to process claims for approved requests.

3.6.1 Vacation Supply

A physician can submit a request for a refill too soon after previous fill override for a patient's vacation 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
- A letter from the physician justifying the need

The request for a vacation override should be submitted 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 year with certain exceptions.

3.6.2 Stolen or Lost Medication

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

4.0 Prior Authorization

4.1 Standard Prior Authorization

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.

The District Medicaid Clinical Call Center will handle all PA requests including but not limited to those for the following:

- Non-PDL drugs
- Opioid narcotics and narcotic combinations
- Injectables
- Suboxone/Subutex
- Xeloda (Breast Cancer)
- Risperdal Consta (fax only)
- Invega Sustenna (fax only)
- Pulmonary Arterial Hypertension medications
- ADHD medications
- Hepatitis C medications (fax only)
- Growth hormone therapy
- Synagis
- Quantity Limits
- Early Refills

These and other ongoing PA programs provide access to necessary medications in a manner that is compliant with the medications' 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.

The prescriber must initiate the Prior Authorization 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 for PDL request.

A hyperlink of the Prior Authorization forms is included in *Section 7.0 – 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 auth per GSN per 30 days.

4.3 Long-Term Use Narcotics 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, 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.

5.0 Compounds

5.1 Multi-Line Compound Claim Submission

When multi-line compounds are submitted, they are adjudicated line by line. Each line will be subject to the claims processing rules for the program. If one or more ingredients are denied, 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 Prior Authorization, 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 Prior Authorization.

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.

6.0 Appendices

6.1 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: https://www.dc-pbm.com/

6.2 Appendix B: Prior Authorization Forms

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

7.0 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
DEA	Drug Enforcement Administration
DHCF	Department of Health Care Finance
DOS	Date of Service
FFS	Fee-for-Service
FMAC	Federal Maximum Allowable Cost
FUL	Federal Upper Limit
GSN	Generic Sequence Number
HIV	Human Immunodeficiency Virus
ID	Identification
LTC	Long-Term Care
MCO	Managed Care Organization
MD	Medical Doctor
N-PA	Narcotic Prior Authorization
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
POS	Point-of-Sale
RPh	Registered Pharmacist
SMAC	State Maximum Allowable Cost
TPL	Third-Party Liability
WAC	Wholesale Acquisition Cost