MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 214
Pharmacy Services

Table of Contents

Title 23: Division of Medicaid 1

Part 214: Pharmacy Services 1

Part 214 Chapter 1: General Pharmacy 1

Rule 1.1: Provider Enrollment and Pharmacy Participation 1

Rule 1.2: Pharmacy Services 2

Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted 2

Rule 1.4: Prior Authorization 4

Rule 1.5: Reimbursement 5

Rule 1.6: Prescription Requirements 6

Rule 1.7: Refills/Renewals of Prescription Drugs 9

Rule 1.8: Generic Mandates for Prescription Drugs 10

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 11

Rule 1.11: Smoking Cessation Agents 12

Rule 1.12: Beneficiary Signature 12

Rule 1.13: Retrospective Drug Utilization Review (DUR) 13

Rule 1.14: Participating Federally Qualified Health Center (FQHC) Providers 13

Rule 1.15: 340B Program 14

Part 214 Chapter 2: Pharmacy Disease Management 14

Rule 2.1: Provider Enrollment and Pharmacy Participation 14

Rule 2.2: Program Services 15

Rule 2.3: Components of Pharmacy Disease Management 15

Rule 2.4: Eligibility 16

Rule 2.5: Reimbursement 16

Rule 2.6: Pharmacy Disease Management Documentation Requirements 16

Title 23: Division of Medicaid

Part 214: Pharmacy Services

Part 214 Chapter 1: General Pharmacy

Rule 1.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the provider type specific requirements that follow:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

   2. Written confirmation from the IRS confirming the tax identification number and legal business name, and

   3. Copy of current pharmacy permit issued by the Mississippi Board of Pharmacy.

B. Pharmacies participating in the Mississippi Medicaid program must:

   1. Have a MS Board of Pharmacy permit for one of the following specified types of pharmacies:

      a) Retail pharmacy must hold a community pharmacy permit,

      b) Closed-door pharmacy must hold a specialty community pharmacy permit, and

      c) Institutional pharmacy must hold an Institutional I or Institutional II pharmacy permit.

   2. Be physically located within the state of Mississippi or within a thirty (30) mile radius of the state borders except if the servicing pharmacy provider is:

      a) Providing drugs to a Mississippi Medicaid beneficiary who is a resident of a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or psychiatric residential treatment facility (PRTF) or receiving specialized care that is located outside of the thirty (30) mile radius, or

      b) The source of a drug not obtainable from any pharmacy provider within the state of Mississippi within the thirty (30) mile radius.

C. The Division of Medicaid reimburses pharmacy providers only for prescriptions that are received:

   1. Via hand delivery by a beneficiary or his/her representative,

2. Directly via phone, fax, mail or other electronic means such as e-mail or electronic prescribing from a prescribing provider licensed under State law or an agent with medical training under the health professional's direct supervision. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6.]

D. For Change of Ownership Liability refer to Miss. Admin. Code Part 200, Chapter 4, Rule 4.3.

Source: Miss. Code Ann. §§ 43-13-121, 73-21-105, 73-21-106.

Rule 1.2: Pharmacy Services

A. The Division of Medicaid covers the following pharmacy services including, but not limited to:

1. Prescription drug coverage which includes all legend prescription drugs manufactured by a company that has signed a drug rebate agreement with certain specific Centers for Medicare and Medicaid Services (CMS) exceptions.

2. Over-the-counter (OTC) drug coverage which is limited to OTC drugs listed on the OTC Formulary.

3. Immunization coverage which includes certain vaccines. [Refer to Miss. Admin. Code Part 224, Rule 1.7].

B. The Division of Medicaid is not required to cover prescription drugs from manufacturers that do not participate in the federal drug rebate program.

Source: 42 USC §§ 1396b, 1396r-8; Deficit Reduction Act (DRA); Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted

A. The Division of Medicaid does not cover pharmacy benefits for full benefit, dual eligible individuals who are entitled to receive Medicare benefits under Part A, B, or C, except for drugs in the Medicare excluded categories.

B. Medicaid excluded or otherwise restricted drugs include, but are not limited to:

1. Drugs when used for anorexia, weight loss, or weight gain,

2. Drugs when used to promote fertility,

3. Drugs when used for cosmetic purposes or hair growth,

4. Over-the-counter (OTC) items except those listed on the Division of Medicaid's OTC formulary which are assigned an appropriate National Drug Code (NDC) on their label and are manufactured by a company that has signed a rebate agreement,

5. Drugs when used for the symptomatic relief of cough and colds except for cough and/or cold drugs listed on the OTC formulary and benzonatate,

6. Prescription vitamins and mineral products except for:

   a) Prenatal vitamins,

   b) Folic acid, and

   c) Cyanocobalamin (vitamin B_{12}) injections.

7. Covered outpatient drugs which the manufacturer requires, as condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee,

8. Those drugs designated less than effective by the Federal Drug Administration (FDA) as a result of the Drug Efficacy Study Implementation (DESI) program unless provided through expanded EPSDT services in Miss. Admin. Code Part 223.

9. [Deleted eff. 01/01/2014],

10. [Deleted eff. 01/01/2014],

11. Drugs when used for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the FDA.

12. Drugs that are investigational or approved drugs used for investigational purposes,

13. Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature,

14. Drugs dispensed after the expiration date,

15. Drugs classified as herbal and/or homeopathic products,

16. Moved to Miss. Admin. Code Part 214, Chapter 1, Rule 1.3.C,

17. Drugs produced by manufacturers that do not have signed rebate agreements with the federal government as required by the Omnibus Budget Reconciliation Act

(OBRA) of 1990, unless provided through expanded EPSDT services in Miss. Admin. Code Part 223, and

18. Compounded prescriptions except for hyperalimentation. The Division of Medicaid defines compounded prescriptions as mixtures of two or more ingredients.

C. The Division of Medicaid does not reimburse for the cost of shipping or delivering drugs.

Source: Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2502, 124 Stat. 119 (2010), as amended by Pub. L. 111-152, 124 Stat. 1029 (2010); Social Security Act §§ 1927(d)(2)(7); 1935(d)(1)(2); 42 CFR §§ 423.100, 423.772, 423.906(c); 42 U.S.C. §§ 1396r-8(a), 1396r-8(d); SPA 14-011; Miss. Code Ann. § 43-13-121.

History: Deleted Miss. Admin. Code Part 214, Rule 1.3 B 9 and 10 to correspond with SPA 14-011 (eff. 01/01/2014), moved Miss. Admin. Code, Part 214, Chapter 1, Rule 1.3.B.16 to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.3.C, eff. 07/01/2014; Revised Miss. Admin. Code Part 214, Rule 1.3.B. eff. 01/01/2013.

Rule 1.4: Prior Authorization

A. The Division of Medicaid requires prior authorization of certain covered drugs to ensure use as approved by the Food and Drug Administration (FDA) for specific medical conditions.

   1. Prior authorization of drugs must be obtained from the Division of Medicaid's Pharmacy Prior Authorization Unit or its designee before the drug may be dispensed.

   2. All prior authorization requests must be submitted electronically via web-portal or by facsimile.

   3. Only the Mississippi Medicaid enrolled prescribing provider or a member of the provider's staff may request prior authorization.

   4. Prior authorization requests submitted by agents of drug manufacturers will be denied.

B. The Division of Medicaid reimburses for a seventy-two (72) hour emergency supply of a prescribed drug when a medication is needed without delay and prior authorization is not available and applies to all drugs requiring a prior authorization either because they are:

   1. Non-preferred drugs listed in the Preferred Drug List (PDL), or

   2. A drug affected by clinical or prior authorization edits which would need prescriber prior approval.

Source: 42 USC § 1396r-8(d)(5); Miss. Code Ann. §§ 43-13-117(A)(9), 43-13-121, 73-21-129.

History: Revised Miss. Admin. Code Part 214, Rule 1.4.A.1-B.2 eff. 07/01/2013.

Rule 1.5: Reimbursement

A. Medicaid reimbursement for covered brand name and single source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twelve percent (12%) and a dispensing fee of three dollars and ninety one cents ($3.91), or

   d) Wholesale Net Unit Price/Wholesale Acquisition Cost (WAC) plus nine percent (9%) and a dispensing fee of three dollars and ninety one cents ($3.91). Wholesale Net Unit Price (WNUP) is the published unit price that a manufacturer charges a wholesaler, commonly referred to as the Wholesale Acquisition Cost (WAC).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines brand name drugs as single source or innovator multiple source drugs.

4. Medicaid defines single source generic drugs as those drugs going off patent and a single source generic house has exclusivity for a period of time.

B. Medicaid reimbursement methodology for multiple source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twenty five percent (25%) and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

C. Medicaid reimbursement methodology for covered over-the-counter (OTC) drugs is:

1. The lesser of:

    a) The usual and customary charge, or

    b) The estimated shelf price and a dispensing fee of three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines estimated shelf price as the lowest of the following:

    a) Mississippi Estimated Acquisition Cost (MEAC) for OTC drugs is defined as the Average Wholesale Price (AWP) less twenty five percent (25%), or

    b) Federal Upper Limit (FUL) is the unit price as published by the Centers for Medicare and Medicaid Services (CMS).

D. Medicaid does not reimburse claims at more than the usual and customary charge. Claims must be billed at the usual and customary charge. Medicaid defines usual and customary charge for prescription drugs as the price charged to the general public. Medicaid defines the general public as the patient group accounting for the largest number of non-Medicaid prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through a third party payer.

Source: Miss. Code Ann. § 43-13-121; Section 1902(a)(30)(A) of the Social security Act.; 42 CFR 447.332.; § 73-29-155.

Rule 1.6: Prescription Requirements

A. Pharmacists in the legal employ of the pharmacy provider or under the personal direction of a pharmacist employed by the pharmacy provider must submit claims for services rendered. Prescriptions must be dispensed at the provider's actual physical location of the pharmacy.

B. For purposes of this rule, the Division of Medicaid defines a prescribing provider as an enrolled Mississippi Medicaid provider duly licensed and acting within the scope of practice of his/her profession according to State law.

C. All non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by the Division of Medicaid.

    1. The tamper-resistant prescription pads/paper requirement applies to all Medicaid prescribing providers including physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs including over-the-counter drugs.

    2. Exemptions to this mandate include:

a) Prescriptions presented by other modes of transmission including facsimile, electronic or e-prescribed, and telephone,

b) Written orders prepared in an institutional setting, including intermediate care facilities and nursing facilities, provided that the beneficiary never has the opportunity to handle the written order and the order is given by licensed staff directly to the dispensing pharmacy, or

c) Transfer of a prescription between two (2) pharmacies, provided that the receiving pharmacy is able to confirm by facsimile or telephone call the authenticity of the tamper-resistant prescription with the original pharmacy.

3. Pharmacy providers must return all funds to the Division of Medicaid for any dispensed prescription which is written hard copy on a non-tamper-resistant pad/paper.

D. The pharmacy provider must ensure the integrity of telephone, electronic and/or faxed prescriptions.

E. All Medicaid beneficiaries are limited to five (5) prescriptions per month, including refills, with no more than two (2) brand name (single source or innovator multiple source drug is less expensive than the generic equivalent) drugs per month for each non-institutionalized Medicaid beneficiary. The Division of Medicaid provides coverage to all Medicaid beneficiaries including full benefit dual eligible beneficiaries. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.9 for medically necessary services for EPSDT eligible beneficiaries.]

F. The Division of Medicaid requires that all drugs be prescribed in a full month's supply which may not exceed a thirty one (31) day supply. The following exceptions are allowed:

1. Drugs in therapeutic classes commonly prescribed for less than a month's supply including, but not limited to, antibiotics and analgesics,

2. Drugs that, in the prescribing provider's professional judgment, are not clinically appropriate for the beneficiary to be dispensed in a month's supply,

3. Drug products where the only available package size of the product is one that exceeds the thirty one (31) day supply limit,

4. Certain drugs issued by the Mississippi Department of Health (MSDH) and approved by the Division of Medicaid, including, but not limited to:

a) Contraceptives which may be dispensed in a one (1) year supply, and

b) Tuberculosis (TB) medications which may be dispensed in a three (3) month supply.

5. Six (6) vials, sixty (60) ml each, of insulin may be dispensed at one time,

6. Oral contraceptives may be dispensed in three (3) month supplies,

7. Prenatal vitamins may be dispensed in three (3) month supplies,

8. Those products with cumulative maximum daily and/or monthly units as recommended by the Food and Drug Administration (FDA) and the manufacturer, and/or as recommended by the Drug Utilization Board and approved by the Division of Medicaid,

9. Those products limited by authority of the Division of Medicaid with the potential for misuse, abuse, or diversion for the public safety, well-being and/or health, or

10. A limited listing of maintenance medications, approved by the Division of Medicaid, which may be dispensed in no more than a ninety (90) day supply.

G. In emergency situations, the Division of Medicaid will reimburse for a seventy two (72) hour supply of drugs that require prior authorization. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.4.B.]

H. Pharmacy claims must be billed using the National Drug Code (NDC) number of the product dispensed. Pharmacy providers must bill the eleven (11) digit NDC for the drug and package size actually dispensed. This requirement is for all products, regardless of legend or over-the-counter (OTC) status.

I. Pharmacy prescription claims must be billed with the National Provider Identification (NPI) number for the individual prescriber.

1. The NPI number on a pharmacy prescription claim must be for the prescribing provider and not for an entity.

2. The pharmacy is responsible for maintaining current and accurate prescriber identification on file.

3. Access to provider identification information must be available to all pharmacy employees.

4. Non-compliance with Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6.I. may result in termination of point-of-sale (POS) privileges and/or recovery of false claims.

Source: 42 USC §§ 1396b (i) (21) and (23), 1396br-8(a) and (d), 1903(i)(23); Social Security Act, Pub. L. No. 74-271, 49 Stat. 620; U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, 121 Stat. 112; Miss. Code Ann. §§ 43-13-121, 73-21-115.

History: Revised Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6, C.3, G. and I. 07/01/2013; Revised Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6, E. 01/01/2013.

Rule 1.7: Refills/Renewals of Prescription Drugs

A. A written, faxed, e-prescribed, or telephoned prescription may be refilled, in compliance with the prescriber's order, up to a limit of eleven (11) times per year, if compliant with state and/or federal regulations and guidelines. Additionally, the following are applicable:

   1. The absence of an indication to refill by the prescribing provider renders the prescription non-refillable.

   2. Refills are reimbursable only if specifically authorized by the prescribing provider.

   3. The Division of Medicaid does not reimburse prescription refills:

      a) Exceeding the specific number authorized by the prescribing provider.

      b) Dispensed after one (1) year from the date of the original prescription.

      c) With greater frequency than the approximate interval of time that the dosage regimen of the prescription would indicate, unless extenuating circumstances are documented which would justify the shorter interval of time before the refilling of the prescription.

      d) With quantities in excess of the prescribing provider's authorization.

      e) Without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each filling event. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

      f) Until seventy five percent (75%) of the day's supply of the drug has elapsed as indicated on the prescription.

      g) For any controlled substance (Schedule III, IV, and V) until eighty five percent (85%) of the day's supply of the drug has elapsed as indicated on the prescription. Any attempt to refill a prescription through the Point-of-Sale system before the twenty-sixth (26th) day will be automatically denied.

      h) For any Schedule II narcotics.

B. Beneficiaries or providers cannot waive the explicit refill request and enroll beneficiaries in an electronic automatic refill in pharmacies.

C. The Division of Medicaid may permit an early refill of an original claim as long as the monthly service limits have not been exhausted under one (1) of the following

circumstances:

1. The beneficiary's life is at risk,

2. When an acute clinical condition is occurring, which would require extra medication to stop or mitigate further morbidity, or

3. The prescribing provider either increases the dosing frequency or the amount per dose.

   a) The prescribing provider must document the change in dosage or frequency by writing or phoning in a new prescription.

   b) The prescriber(s) who wrote the original prescription must initiate any request for additional medication.

4. If a beneficiary requires an early refill, the prescribing provider must request an exception override of this requirement by seeking approval from Division of Medicaid's Pharmacy Prior Authorization (PA) Unit.

D. The Division of Medicaid does not reimburse for replacement of prescription medications unless the beneficiary can show good cause, which must include documentation such as a police report or insurance claim, that the prescription medications were lost, stolen or otherwise destroyed beyond the beneficiary's control. A replacement may be approved only if the monthly service limit, if applicable, has not been reached.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 11/01/2014.

Rule 1.8: Generic Mandates for Prescription Drugs

Mississippi law requires that the Division of Medicaid does not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive.

A. Generic drugs classified as non-preferred by the Division of Medicaid require prior authorization.

B. In the absence of a specific request for the brand name drug from the prescribing provider to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent unless the branded agent is preferred and the generic agent is non-preferred.

C. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except Narrow Therapeutic Index (NTI) drugs as defined by the Division of Medicaid.

Source: Miss. Code Ann. §§ 43-13-117, 73-21-115, 73-21-117, 73-21-123, 73-21-127, 73-21-129.

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code, Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.10: Preferred Drug List

A. The Division of Medicaid recommends that prescribers use the drugs on the Preferred Drug List (PDL).

    1. The PDL is defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, nurse practitioners, and/or other health care professionals. Final approval of the PDL is the responsibility of the Executive Director of the Division of Medicaid.

    2. The PDL contains a wide range of generic and preferred brand name products approved by the FDA.

    3. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

B. Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria have been met.

C. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs still in clinical trials and/or investigative or experimental in nature.

D. Prior authorizations are reviewed and a determination notice provided within twenty-four (24) hours from receipt of request. If a PA is not available, a seventy-two (72) hour emergency supply must be dispensed. Pharmacists should use his/her professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is used. The seventy-two (72) hour emergency procedure must not be used for routine and continuous overrides.

E. The PDL is subject to change. [Refer to the Division of Medicaid's website for a current listing of prescription drugs on the PDL.]

Source: Social Security Act § 1927; Miss. Code Ann. § 43-13-121.

History: Effective – 07/01/2012.

Rule 1.11: Smoking Cessation Agents

The Division of Medicaid covers all FDA approved smoking cessation OTC and prescription drugs and nicotine replacement products when used to promote smoking cessation, except dual eligible as Part D will cover.

Source: Miss. Code Ann § 43-13-121.

History: Effective - 01/01/2013.

Rule 1.12: Beneficiary Signature

A. The pharmacy must obtain the signature of the beneficiary or his/her representative signature and their relationship to the beneficiary for each prescription received with the exception of beneficiaries living in long-term care facilities, i.e. nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) facilities and/or psychiatric residential treatment facilities (PRTF).

    1. Electronic signatures are acceptable.

    2. One signature per prescription is required.

    3. The pharmacist may sign for a prescription if the beneficiary or his/her representative is not capable of signing. When signing the pharmacist must:

        a) Document the circumstances preventing the beneficiary or his/her representative from signing for the prescription, and

        b) Sign the prescription signature record with his/her own name and the beneficiary's name.

    4. For shipped or delivered prescriptions, the pharmacy must obtain the signature of the beneficiary or his/her representative and their relationship to the beneficiary.

        a) The pharmacy must maintain signatures on-site and in an auditable manner.

        b) The Division of Medicaid will not reimburse for medications lost in transit and/or not received by the beneficiary.

B. Prescription signature records for received prescriptions must include the prescription serial number, date medication is received and the beneficiary or his/her representative's signature and their relationship to the beneficiary.

1. Prescription signature records must be retained for a period of five (5) years for audit purposes.

2. Prescription signature records for shipped prescriptions must be retained for a period of five (5) years and must include the delivery confirmation for audit purposes.

3. Prescription signature records must be maintained on-site and in an auditable manner.

C. The beneficiary or provider cannot waive the receipt signature requirement nor does "signature on file" meet this obligation.

Source: Miss. Code Ann. § 43-12-121.

History: Miss Admin. Code, Part 214, Chapter 1, Rule 1.12 A.-E. added 07/01/13 to include 04/01/12 compilation omission.

Rule 1.13: Retrospective Drug Utilization Review (DUR)

A. The Division of Medicaid utilizes a quality assurance program, Drug Utilization Review (DUR), to:

   1. Promote patient safety by an increased review and awareness of outpatient prescribed drugs including drug appropriateness,

   2. Enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use, and

   3. Educate physicians and pharmacists on appropriate, safe and effective drug therapy.

B. The Division of Medicaid's DUR Board is composed of twelve (12) participating physicians and pharmacists who are active MS Medicaid providers and in good standing with their licensing boards who meet quarterly.

Source: The Omnibus Budget Reconciliation Act (OBRA 90); Miss. Code Ann. § 43-13-107.

History: New Rule eff. 11/01/2014.

Rule 1.14: Participating Federally Qualified Health Center (FQHC) Providers

All drugs, as defined by the Veterans Health Care Act of 1992 Title VI, purchased by an in-house pharmacy of a Federally Qualified Health Center (FQHC) at a discounted price must be reported on the cost report and are reimbursed through the core services encounter rate and not billed through the Pharmacy Program.

Source: The Veterans Health Care Act of 1992 Title VI.

History: New Rule eff. 11/01/2014.

Rule 1.15: 340B Program

Providers participating in the 340B program must adhere to all the provisions in Miss. Admin. Code Part 200, Chapter 4, Rule 4.10.

Source: Sec. 340B of the Public Health Service Act (Pub. L. 102-585), as amended by the Patient Protection and Affordable Care Act (Pub. L. 111-148), Health Care and Education Reconciliation Act (Pub. L. 111-152) and Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 11/01/2014.

Part 214 Chapter 2: Pharmacy Disease Management

Rule 2.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists participating in the Medicaid program and providing disease management services must comply with the requirements outlined in Part 214, Chapter 1, Rule 1.1 in addition to the following requirements:

    1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Copy of current pharmacist's license or permit,

    3. Current certificate for disease management,

    4. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name on the W-9, and

    5. Credentials from the National Institute for Standards in Pharmacists Credentialing for the specific disease for which care is provided.

B. Pharmacy disease management provider agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than thirty (30) miles from the borders of Mississippi.

C. Only individual pharmacists can enroll as a pharmacy disease management provider. Pharmacies with multiple individual pharmacy disease management providers may apply for group management services under one (1) group provider number; but each individual pharmacist in the group must maintain his/her own individual provider number. Businesses

such as partnerships and corporations are not allowed to operate as pharmacy disease management providers.

Source: Miss. Code Ann. § 43-13-121, 42 CFR 455, Subpart E.

Rule 2.2: Program Services

A. Pharmacy Disease Management (PDM) services are those provided for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anti-coagulation therapy, or other disease states as defined by the Division of Medicaid. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes.

B. A referral for PDM services is required and services must be provided by a specially credentialed pharmacist. Pharmacy care records including a written referral and all laboratory test results must be transferred from the referring physician to the pharmacist. PDM services performed by the pharmacist must not duplicate services provided by the physician.

C. The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. He or she is to function in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. It is the responsibility of the pharmacist to:

1. Evaluate the patient,

2. Consult with the physician concerning the suggested/prescribed drug therapy,

3. Counsel the patient regarding compliance, and

4. Provide the patient with educational and informational materials specific to the disease and/or drug.

D. Communication is required between the referring physician and the pharmacist. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

E. The pharmacist provider must personally render all pharmacy disease management services billed to Medicaid. A relief pharmacist employed for pharmacy disease management services must bill Mississippi Medicaid using his/her own individual Medicaid provider number.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.3: Components of Pharmacy Disease Management

A. The primary components of this service are as follows:

1. Patient evaluation,

2. Compliance assessment,

3. Drug therapy review,

4. Disease state management, according to clinical practice guidelines, and

5. Patient/caregiver education.

B. The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with the beneficiary, such as a partitioned booth or a private room. This consultation is used to privately educate the beneficiary.

C. A copy of the pharmacy care records, including the documentation for services, must be shared with the patient's physician and remain on file in the pharmacist's facility and available for audit by the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.4: Eligibility

A. Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services.

B. Neither OBRA-mandated counseling nor JCAHO-mandated institutional discharge counseling qualify as a pharmacy disease management service.

C. Pharmacy disease management services are available to the parent or other responsible guardian when the beneficiary is a minor and/or mentally challenged and living at home.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.5: Reimbursement

A. Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the appropriate procedure code. An encounter must be at least fifteen (15) minutes and average thirty (30) minutes.

B. The number of encounters is limited to twelve (12) per beneficiary per fiscal year.

Source: Miss. Code Ann. § 43-12-121.

Rule 2.6: Pharmacy Disease Management Documentation Requirements

In addition to the documentation requirements applicable to all pharmacy providers, pharmacy

disease management providers must maintain additional documentation. The disease management pharmacist must maintain at his/her place of business proof of current certification for the specific disease state for which reimbursement is sought. A pharmaceutical care record, or patient record, must be maintained on each individual beneficiary for whom services are billed. These records must be retained and maintained in a manner conducive to audit, in alphabetical order and for a minimum of five (5) years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

A. A referral from the beneficiary's physician/nurse practitioner,

B. A copy of the protocol in accordance with the National Clinical Practice Guidelines authorizing pharmacy disease management of the beneficiary,

C. Documentation of all oral and written communication with the beneficiary's physician/nurse,

D. Copies of all laboratory data provided, and

E. All pharmacist notes, including progress reports, pertaining to the care of the beneficiary.

Source: Miss. Code Ann. § 43-13-117, 43-13-118, 43-13-121, 43-13-129.