Mississippi Medicaid

Provider Reference Guide

For Part 214

Pharmacy Services

This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.

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PHARMACY SERVICES INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The Mississippi Medicaid Prescription Drug Program conforms to the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) as set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). A pharmacy provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. He/she cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary, except in cases of retroactive eligibility. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payment to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

ADDITIONAL COVERAGE FOR CHILDREN UNDER AGE 21

Beneficiaries under the age of twenty-one (21) may have more prescription drug coverage if medically necessary under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

BENEFICIARY ELIGIBILITY

A beneficiary's MS Medicaid or green card should be checked at every pharmacy visit to validate the current identification number. Eligibility status can be verified through the AVRS system at 866-597-2675 or 601-206-3090. Pharmacists are to use their professional discretion to verify patient identity.

RETROACTIVE ELIGIBILITY

Retroactive Pharmacy Claims can be processed electronically through the POS system for up to one calendar year from the original date of service on a Medicaid beneficiary. Retroactive Pharmacy Claims older than 12 months may be processed via paper submission on a MS Medicaid Pharmacy

Claim Form or via the web portal, as long as the claim submission date is not more than 24 months from the original date of service. See Web Portal Pharmacy Claims submission for detailed instructions for submitting Retro Pharmacy Claims.

CLAIM PAYMENTS

Providers who wish to inquire about their check amount are referred AVRS at 866-597-2675 or 601-206-3090.

FRAUD

If you suspect a case of fraud, please contact MS Medicaid's Program of Integrity at 1-800-880-5920 or 601-576-4162 or http://www.medicaid.ms.gov/contact/report-fraud-and-abuse/fraud-and-abuse-complaint-form/.

BENEFICIARY SIGNATURE

The beneficiary or his/her representative must sign for the prescription each time it is filled. One method in use is the signature book or form, which indicates the date medication is received, prescription serial number, a signature, and if necessary, relationship to the beneficiary. A counseling acceptance/refusal form maintained in date order and fulfilling the above stated requirements will be satisfactory. A signature is required for each medication received by individuals, with the exception of beneficiaries residing in long-term care facilities. MS Division of Medicaid defines long term care facilities as nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and Psychiatric Residential Treatment Facilities (PRTF).

Electronic signatures are acceptable for Medicaid beneficiaries. If multiple prescriptions are dispensed, there must be a signature for each and every prescription dispensed. One signature for multiple entries is not acceptable. The method of attaining beneficiary signatures must comply with the MS Board of Pharmacy, state, and federal requirements, if applicable.

If someone other than the beneficiary receives the prescription, it is the pharmacy's responsibility to obtain the signature of the actual person receiving the drug, in addition to the beneficiary's name and their relationship to the beneficiary. If the beneficiary or his/her representative is not capable of signing for the prescription, then the pharmacist may do so, stating the circumstances that would not allow the beneficiary or his/her representative to sign for the drug. The pharmacist must sign the prescription signature book/record with his/her own name and the beneficiary's name. If a prescription is delivered to a beneficiary, the pharmacy is responsible for obtaining signatures and maintaining these signatures on-site and in an auditable manner.

If a prescription is shipped or delivered to a beneficiary, the pharmacy is responsible for obtaining signature(s) of the individual (s) receiving delivery of the medication. The pharmacy is responsible for maintaining these signatures on-site and in an auditable manner. Prescriptions delivered by means other than pharmacy delivery personnel must have a signature by the beneficiary or his/her representative on file. Providers shall take necessary steps to prevent loss of medications in the shipping process, as Medicaid will not reimburse for medications not received by the beneficiary.

Beneficiaries and/or providers may not waive the signature requirement. Having a beneficiary's and/or responsible party for the beneficiary's signature on file will not suffice and does not meet this obligation.

Signatures must be retained for audit purposes for a period of five (5) years. If the medications have been shipped, then the beneficiary signature as well as delivery confirmation must be retained by the provider for audit purposes for a period of five (5) years.

CO-PAYMENT

Refer to MS Administrative Code, Title 23, Part 200, Chapter 3 Rule 3.7 for Beneficiary Cost Sharing policy.

Providers are prohibited for advertising and/or soliciting business by waiving a beneficiary's copayment responsibility.

CO-PAYMENTS

Co-pays for all drugs (Brand, Generic or OTC) are $3.00 per prescription. When filing claims use the following Exemption Codes if incorrect copayment amount is returned:

- Infants (newborns only) - **K**

- Children under age 18 **- C**

- Pregnant women - a "**P**" must be written on the prescription

- Long Term Care Beneficiaries - **N**

- Family Planning Beneficiaries - **F** (yellow card holders)

COST AVOIDANCE/PRESCRIPTION DRUG CLAIMS

Medicaid is the payer of last resort. Federal regulations require that Medicaid agencies identify any third-party resources to meet the medical expenses of Medicaid beneficiaries. Third party Liability or TLP assures that Medicaid is the last payer to reimburse for covered Medicaid services. Medicaid participating providers must seek reimbursement from other liable services such as private and/or public insurance companies. It is the responsibility of the servicing pharmacy to pursue all requirements of the primary insurer including, but not limited to, prior authorizations, or drug utilization reviews.

Medicaid covered drugs which require prior authorization (PA) from DOM will continue to require PA for claims if the primary insurer approves the drug and DOM reimburses any part of the costs.

Medicaid co-payment, if applicable, is required, regardless if any part of the claim is paid by DOM.

For the Medicare/Medicaid or dually eligible beneficiary, Medicaid is responsible for coverage of CMS mandated Part D excluded drug categories only. Medicaid considers Medicare Part D payment as payment in full. For additional information regarding Medicare/Medicaid drug benefits and DOM's pharmacy program, please refer to the Medicare Covered Drugs and Non- covered Pharmacy Services section of the Pharmacy Services Provider Reference Guide.

For additional information regarding cost avoidance and prescription drug claims, please refer to Title 23, Part 306: Third Party Recovery of the MS Administrative Code.

COVERED PHARMACY SERVICES

The Mississippi Medicaid Prescription Drug Program conforms to the Medicaid Prudent Pharmaceutical Purchasing Program as set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90).

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandated major changes in coverage and reimbursement for Medicaid–covered outpatient drugs. OBRA '90 created the Medicaid Drug Rebate Program which requires drug manufacturers to have a national rebate agreement with the federal government to receive federal funding for outpatient drugs provided to Medicaid beneficiaries. This law also required Medicaid programs to cover all prescription drugs manufactured by a company that has signed a drug rebate agreement, with certain specific exceptions. The exceptions are listed in the MS Administrative Code, Title 23; Medicaid, Part 214 Pharmacy Services, Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted.

Although the pharmacy program is an optional program, DOM offers a comprehensive Pharmacy Program for Medicaid beneficiaries. Covered drugs are limited to Food and Drug Administration (FDA) approval or medically accepted indications and dosing limits. Medically accepted indications refer to any use supported by one or more of the following official compendia:

- American Hospital Formulary Service-Drug Information (AHFS-DI),

- United States Pharmacopoeia-Drug Information (USP-DI) or its approved replacement and/or successor publication, and/or

- The DrugDEX Information System.

To view a listing of manufacturers that participate in the drug rebate program, please reference: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Covered-Outpatient-Drugs-Policy.html

DISASTER BILLING: OFFICIALLY DECLARED EMERGENCIES

During officially declared emergencies, pharmacists should enter a value of '13-Payor Recognized Emergency' in NCPDP Field '420-DK' when it is necessary to override the following service limit edits:

- 2 brand/non-preferred or 5 prescription limit, or Early refill.

At the time a declared emergency announcement is made, the fields noted above will be opened for the specified time period. Pharmacy providers are advised to use professional judgment in emergency situations. The Division of Medicaid may conduct audits after such events to ensure appropriate care was taken in dispensing medications for affected beneficiaries. Providers and beneficiaries residing and/or receiving care not in an evacuation area must have documentation on file to justify rationale for early/excess fills. Medicaid monies may be recouped if supporting documentation is not found.

For your easy reference, this document is posted under on the pharmacy services webpage at http://www.medicaid.ms.gov/wp- content/uploads/2014/04/BillingFor72HourEmergencySupply.pdf.

DOCUMENTATION REQUIREMENTS

All providers participating in the Medicaid program are required to maintain records which disclose services that have been rendered and billed under the program and, upon request, make premises and such records available to representatives of DOM, the Office of Attorney General, or the Office of the Inspector General (OIG) in substantiation of any or all claims. These records should be retained and maintained in an auditable manner a minimum of five years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations in the verification of services that have been paid for by Medicaid to eligible beneficiaries, the pharmacist must maintain auditable records that will substantiate claim(s) submitted to Medicaid. At a minimum, the records should include the following:

- The prescription meeting all pertinent regulatory authorities,

- Wholesale invoices of drug merchandise purchased,

- A complete and accurate beneficiary signature record,

- Delivery confirmation, if applicable, and

- Licensure and ownership documentation including the employee roster.

Copies of prescriptions, invoices, signature records, delivery confirmation, licensure, ownership documentation, and employee roster shall be furnished to the Division of Medicaid, the Office of the

Attorney General, or the Office of the Inspector General (OIG) upon request and at no cost to the requesting agency.

If pharmacy records do not substantiate services, which have been paid for under the Medicaid program, the pharmacy is required to refund to the Mississippi Medicaid Program any money received within 30 days. If a refund is not received within 30 days, a sum equal to the amount paid for such services may be deducted from any future payments that may be due the provider; or DOM may choose to require immediate payment plus interest.

Records must be in an auditable form, which includes the requirements that the prescriptions are filed in numerical order and easily retrievable.

A pharmacy provider who knowingly or willfully makes or causes to be made false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the pharmacy provider as a provider of Medicaid services.

DRUG LIMITS

Beneficiaries are entitled to five prescriptions per month, of which, no more than two may be non-preferred/brand products. This includes refills. Long term care residents, defined as beneficiaries residing in nursing facilities (NH), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or psychiatric residential treatment facilities (PRFT), are exempt from this limit. Refer to Pharmacy Billing section of the Pharmacy Services' Provider Reference Guide for additional information regarding billing specifics.

PRESCRIPTION BENEFITS

Description	Prescription Benefits
Regular Beneficiaries	Full Prescription Benefits
Long-Term Care Beneficiaries	Full Prescription Benefits
Dually Eligible – Qualified Medicare Beneficiary (QMB)	Medicare Part D
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Children under 21	Full Prescription Benefits
Family Planning Beneficiaries	Limited Prescription Benefits
Dually Eligible – Specified Low Income Medicare Beneficiary (SLMB)	Medicare Part D
K- Baby (newborns without a Medicaid ID number)	Full Prescription Benefits

DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES

Most durable medical equipment (DME) and/or medical supplies are traditionally not covered through the Pharmacy program. Pharmacies that wish to provide DME and/or medical supplies must be enrolled as a Medicaid DME provider.

In order for DOM to reimburse for DME/medical supplies in the pharmacy venue, the pharmacy must be enrolled as a MS Medicaid DME provider. All DME items and/or medical supplies must be filed on a CMS 1500 claim form.

FRAUD

Refer to the CMS 1500 section of the Billing Manual for addition instruction(s). Refer to Title 23, Part 209 of the MS Administrative Code for more information.

GENERIC MANDATES FOR PRESCRIPTION DRUGS

The only exceptions to the generic mandate are:

- Observed allergy to a component of the generic drug,

- An attributable adverse event, or

- Drugs generally accepted as narrow therapeutic index (NTI) drugs.

In the absence of a specific request for the brand name drug from the prescriber to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent.

Please note that some generic drugs may be classified as non-preferred by the MS Division of

Medicaid (DOM) and require prior authorization. This occurs when a branded drug is less expensive to DOM due to the federal and/or supplemental rebates. In such cases, the dispensing pharmacy is required to bill the branded agent rather than the generic agent.

The prescriber must indicate the following on a written or faxed prescription:

- Brand name medically necessary, and/or

- Dispense as written, and/or

- Do not substitute.

DOM recognizes some drugs as narrow therapeutic index (NTI) drugs in which the generic mandate does not apply. Claims must be submitted with a DAW equal to "7". MS Medicaid considers the following five drugs as NTI drugs:

- Coumadin®

- Dilantin®

- Lanoxin®

- Synthroid®

- Tegretol®

The prescriber must indicate one of the following on a written or faxed prescription in order for the pharmacist to submit the DAW 7:

- Brand name medically necessary, **or**

- Dispense as written, **or**

- Do not substitute.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

All point of sale or POS transactions submitted to MS Division of Medicaid must be HIPAA compliant. Data must be encoded to comply with NCPDP D.0 format.

HOSPICE DRUG COVERAGE

Medicaid beneficiaries enrolled in Hospice Services are covered under a per diem rate which includes all services for that beneficiary. For those beneficiaries receiving Medicaid Hospice Services, all palliative therapy, or drugs used to treat beneficiary's terminal illness, is to be billed to the Hospice provider. Medicaid will only pay for drugs used for an indication not directly related to the beneficiary's terminal illness that are within the applicable Medicaid prescription service limits. Since plans of care are specific for beneficiaries, it is the responsibility of the dispensing pharmacy to bill the Hospice provider or Medicaid appropriately. The dispensing pharmacy must retain documentation regarding Hospice Service drug coverage for beneficiaries which is easily retrievable for auditing purposes.

All Medicaid policies and procedures such as prior authorization requirements and limits are still applicable. Pharmacy providers must maintain the explanation of benefits (EOB) from other

insurance companies or payers, i.e., Hospice. These records must be available to Medicaid upon request.

HOW TO BILL A NON-COVERED HOSPICE DRUG

Pharmacy may override electronically by entering a "3" in the "Other Coverage Code" field. It is the responsibility of the pharmacy to have documentation and proof that Hospice was billed first and that they received a denial of 'drug not covered' in case of an audit.

WHEN HOSPICE IS NO LONGER IN EFFECT

Hospice Providers must submit a disenrollment form (DOM-1166) for Medicaid beneficiaries who are no longer receiving care by that Hospice Provider. Hospice disenrollment forms and submission directions can be found at http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/.

For additional information regarding Hospice refer to the Title 23, Part 205 and the Hospice Provider Reference manual at http://www.medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-205.pdf.

IDENTIFICATION OF PRESCRIBERS

As required by federal regulation, effective January 1, 2008, pharmacies must use the National Provider Identification (NPI) to identify the prescriber on prescription claims. Pharmacy claims must use a valid prescribing provider type and national provider identification (NPI) number for an individual and not a building, i.e., clinic or hospital. A 'prescriber' must be a person and not a building. Valid provider types are physicians, doctors of osteopathy, podiatrists, dentists, optometrists, nurse midwives, nurse practitioners and physician assistants.

The pharmacy is responsible for maintaining accurate and current prescriber identification information and access must be made available to all pharmacy employees. Accurate prescriber identification of the prescription issuer is required. Non-compliance may result in termination of POS privileges and/or recovery of false claims.

A current Prescribing Provider's List is available by accessing the DOM website at http://www.medicaid.ms.gov and clicking on "Pharmacy Information" in the third column or by contacting the fiscal agent.

IMMUNIZATIONS IN THE PHARMACY VENUE

In the MS Medicaid Pharmacy program, the following immunizations are covered services for the fee for services Medicaid Beneficiaries:

- Influenza and pneumonia immunizations for Medicaid beneficiaries ages 19 and older who are not residents of long-term care facilities.

- For the dually eligible, refer to Title 23: Medicaid, Part 224 Immunizations of the Administrative Code, which may be found at http://www.medicaid.ms.gov/providers/administrative-code/, for billing instructions.

- Zoster immunizations for Medicaid only beneficiaries ages 60 and older.

  o For the dually eligible, bill the beneficiary's Medicare Part D plan.

As with other pharmacy services, a hard copy prescription must be on file. Immunizations provided from a credentialed pharmacist will count against the service limits and co-payments are applicable. MS Medicaid reimburses for the drug's ingredient cost and pays a dispensing fee for immunizations administered in the pharmacy venue. No administration fee is paid for immunizations administered in the pharmacy venue.

All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC). For additional information regarding immunizations and Medicaid policies, refer to Title 23: Medicaid, Part 224 Immunizations of the Administrative Code, which may be found at http://www.medicaid.ms.gov/providers/administrative-code/.

INCARCERATED BENEFICIARIES

The MS Medicaid Program is prohibited by federal regulations 42 C.F.R. §§ 435.1009 and 435.1010 from paying for services for Medicaid beneficiaries who, on the date of service, are incarcerated in a correctional or holding facility for individuals who are prisoners, including juvenile correctional facilities, are detained pending disposition of charges, or are held under court order as material witnesses.

If medications are requested for incarcerated Medicaid beneficiary, the medications cannot be billed to the Medicaid pharmacy program and are subject to recoupment. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

LOCK IN

Beneficiaries can be locked into a specific pharmacy provider, and/or prescriber(s), which means they can only receive their prescriptions from an assigned provider. If they attempt to have their prescriptions written or filled at a provider other than the one assigned, their claims will deny. The MS Division of Medicaid's Bureau of Program Integrity administers this program and can be reached at 1-800-880-5920 or 601-576-4162.

LONG-TERM CARE FACILITY

DOM defines 'long-term care facility' as a nursing home, intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID), or psychiatric residential treatment facility (PRTF). Long-term care (LTC) residents may receive prescriptions, if the medication orders, signed by the prescribing provider, are documented in the individual patient record at the LTC. The pharmacist must maintain all transcribed documentation in his/her own prescription files. The patient's place of residence must be identified by placement of the facility's name on the front of the prescription documentation at the pharmacy. DOM reimburses claims for prescriptions for NF residents when the prescribing provider's authorization is indicated in the patient's chart and he/she authorizes prescriptions by initialing his/her medication orders. Pharmacists are advised to periodically check with the LTC consulting pharmacist to assure that the prescribing provider's orders are being reviewed. Maintenance medication dispensed for LTC residents from patient chart instructions should generally be prescribed in one-month quantities, except as required for titration or short-term treatment.

Prior authorization requirements for specific drugs and/or class of drugs exist for LTC residents as do for the general population. The cost of any drug supplied to residents in opposition to Medicaid policy and/or prior authorization requirements are not allowable on the facilities' cost reports.

Section 1902(a) (23) of the Social Security Act guarantees beneficiaries the ability to obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them to that beneficiary. Participation in any package plan for medical care, such as those furnished by an LTC facility, must be strictly voluntary.

A resident of a long-term care facility defined as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or psychiatric residential treatment facility is allowed freedom of choice of pharmacy providers for drugs covered by the Medicaid drug program. The freedom of choice is limited to pharmacies that meet labeling and packaging requirements established by the Board of Pharmacy.

Consequently, once a beneficiary chooses a particular provider or LTC facility, he or she has clearly exercised freedom of choice with respect to all items of medical care included within the scope of that care, including all services provided or arranged for by the LTC facility which are reimbursed through the LTC rate. For those services, the State should not pay for care other than from the LTC provider or LTC arranged providers, because such payments would be redundant.

Although the individual retains freedom of choice for services that are not reimbursed through the LTC facility, there may be restrictions imposed by the LTC facility as a condition of residency. While the State should not withhold payment to providers other than those approved by the LTC facility for care actually rendered, the LTC facility may refuse to permit such care under its own rules (if, as discussed below, those rules are consistent with NF certification requirements). By choosing the LTC facility, the individual voluntarily accepted those restrictions. The individual's freedom of choice would only be violated if those restrictions were imposed by the State.

Violations of a beneficiary's freedom of choice of provider may be reported by contacting the MS State Department of Health's Health and Care Facility Complaints' Hotline at 1-800-227- 7308.

All providers participating in the Medicaid program are required to maintain records that disclose pharmacy services that have been rendered and billed under the program and, on request, make premises and such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records should be retained and maintained in an auditable manner a minimum of five years in order to comply with all State and Federal regulations and laws.

Long-term care beneficiaries are exempt from the monthly prescription drug limits. The dispensing fee for all drugs dispensed to a beneficiary in LTC is $3.91 per day.

LOST/STOLEN MEDICATIONS

If a beneficiary's medication is lost or stolen, DOM allows the beneficiary to have a prescription refilled in some situations with an override from the Pharmacy PA unit if monthly service limits have not been exhausted. If you have questions, contact the Pharmacy PA unit.

MAX DAILY DOSE

The maximum daily dose sets a drug utilization review (DUR) edit for "high dose, if the daily dose exceeds the maximum daily dose on the drug file. If a beneficiary's medical condition requires a higher dose, DOM allows the beneficiary to have the higher unit dose with prior approval, which is handled by Pharmacy PA Unit.

MAXIMUM ALLOWABLE COST (MAC)

The Centers for Medicare and Medicaid Services (CMS) has established federal upper limits (FUL) or maximum allowable cost (MAC) on certain multiple source drugs to ensure that the Federal government acts as a prudent buyer of drugs. The FUL list includes those drugs where the Food and Drug Administration (FDA) has determined there are sufficient generic equivalents and where national drug pricing compendia (e.g., First Data Bank, Medical Economics and MediSpan) demonstrate there are sufficient drug suppliers listing the drug for sale nationally as set forth in 42 CFR § 447.332. This is an aggregate upper limit.

The most current FUL drug listing can be found at the following website:
http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits.html

Medicaid cannot exceed the FUL or MAC set on these drugs regardless of the provider. DOM may not routinely cover all drugs listed on the FUL drug listing.

DOM has the authority to establish upper payment limits for other multi-source products.

MEDICARE COVERED DRUGS

Beneficiaries eligible for both Medicare and Medicaid are known as dually eligible beneficiaries. Medicare is the primary payer for the dually eligible beneficiary. Dual eligible beneficiaries have prescription drug coverage through Medicare Part C or Part D if enrolled in a Medicare Advantage Plan.

In accordance with federal guidelines, Medicaid is not responsible for covering pharmacy benefits or pharmacy benefits for the full dual eligible, except for drugs in the Medicare Part D excluded drug categories. Coverage is limited to drugs covered for other Medicaid eligible beneficiaries in the following classes:

- Over the counter drugs (OTCs).

- Cough and cold preparations.

- Prescription vitamins.

- Qualified Medicare Beneficiaries (QMB) are not eligible to receive pharmacy benefits through the Medicaid program.

- Medicare cost-sharing groups (QMB, SLMB, QI) who enroll in Part D benchmark plans have no premium or deductible charges with Part D.

Medicaid does provide coverage of deductible and co-insurance amounts for Medicare Part B covered drugs and other Medicare covered services with the exception of those covered under Part D.

MEDICARE PART B DRUGS

Refer to Part 209 Chapter 1 Rule 1.4 regarding billing of Medicare Part B drugs and associated crossover payments for dually eligible Medicare and Medicaid beneficiaries.

Beneficiaries with Medicare Part B services are allowed minimal prescription drug coverage. DME pharmacy providers may submit Medicare crossover claims to Medicaid using a CMS-

1500 claim form. Refer to the CMS-1500 section of the Billing Manual for further instructions. DOM does not process any Medicare Part B claims via pharmacy point of sale or POS.

MEDICARE PART D DRUGS

Medicare Part D is the portion of Medicare that covers prescription drugs. Any Medicaid beneficiary eligible for Medicare Part A and/or B is eligible for Medicare Part D and must enroll for coverage.

Medicare Part D payment is considered payment in full and should not be submitted to Medicaid for additional payment. Medicaid is always the payer of last resort.

For drugs and drug classes not covered by Medicare Part D, Medicaid offers limited coverage for the true or full dually eligible.

BILLING INFORMATION

Claims submitted through the pharmacy point-of-sale (POS) system for Medicare covered drugs will be denied for dually eligible beneficiaries.

NON-COVERED PHARMACY SERVICES

For detailed information regarding non-covered pharmacy drugs and/or drug categories, please refer to the MS Administrative Code, Title 23, Part 214 Pharmacy Services, Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted.

DOM does not cover drugs in therapeutic classes covered by Medicare Part D for dual eligible individuals entitled to receive Medicare benefits under Part A, Part B and/or Part C. Failure to receive prior authorization for a Part C or Part D drug is not a reason for Medicaid to reimburse for a Part C or Part D drug.

DOM covers to the same extent it covers for all Medicaid beneficiaries under Section 1927 (d) of the Social Security Act, for the CMS standard excluded or otherwise restricted drugs or classes of drugs, or their medical uses with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR, §

423.104(f)(1)(ii)(A) to full benefit dual eligible beneficiaries under the Medicare Part D Prescription Drug Benefit.

OVER THE COUNTER (OTC) DRUGS

DOM covers selected over-the-counter (OTC) drugs pursuant to a legal prescription in writing or verbal order. Only those OTC products manufactured by companies who participate in the Federal Drug Rebate Program are covered. Prescribing of these OTC drugs is strongly encouraged whenever appropriate. OTC drug prescriptions are included in the monthly drug benefit limit. DOM may not cover all available package sizes.

Charges to Medicaid shall be no more than what is charged to the general public for retail sale, otherwise known as shelf price. DOM reimbursement to providers may be based on the unit price represented by the largest package size if significant cost savings would be realized.

Effective January 1, 2014, over the counter drugs (OTCs) can no longer be billed to MS Medicaid as a point of service (POS) claim for beneficiaries residing in LTC facilities, i.e. NH (nursing

homes), ICFIDD (intermediate care facilities for individuals with intellectual disabilities), and PRTFs (psychiatric residential treatment facilities. For these beneficiary populations, DOM's OTC formulary items are now considered 'stock items' and are to be included in the facility's cost report. This excludes OTC insulin, Pseudoephedrine and Pseudoephedrine combination products listed on the OTC formulary, and Guaifenesin/codeine listed on the OTC formulary.

The Over-the-Counter (OTC) Drug List is subject to change. Refer to the Pharmacy Services page on the DOM website at www.medicaid.ms.gov for a current listing of over the counter drugs covered by the Division of Medicaid.

PAPER CLAIMS

Should be submitted to the following address:

MS Medicaid Program
P.O. Box 23076
Jackson, MS 39225

Refer paper claim questions to Xerox, formerly ACS, at 1-800-884-3222.

PHARMACY BILLING

HOUR EMERGENCY SUPPLY

According to Title XIX of the Social Security Act, in emergency situations, DOM will allow payment for a 72-hour supply of drugs requiring prior authorization (PA). A 72-hour emergency supply of drugs may be provided to beneficiaries while waiting for the acknowledgement of a PA. The pharmacy will be reimbursed for this product even if the prescription is changed to an alternative medication or the PA is denied. 72-Hour Emergency Supply prescriptions should be submitted through the pharmacy's point of sale (POS) system.

The emergency fill will apply to non-preferred drugs on the Preferred Drug List and any drug affected by a clinical or therapeutic edit requiring prior authorization. Emergency supplies should be reserved for situations when all the following conditions are met:

- If the beneficiary's monthly prescription benefit limit has not been met,

- When a medication is needed without delay,

- If the prescribing provider cannot be reached and/or is unable to request the PA, and

- No more than two (2) emergency fills per drug per month have been dispensed. The 72-hour emergency fill functionality should not be used for:

- Routine and continuous overrides, or

- If the drug is not subject to a prior authorization and/or the claim meets the prior authorization criteria.

If the drug is approved for PA, then the emergency supply quantity should be reversed, and the entire quantity should submitted. DOM will only reimburse for one dispensing fee and only one copayment, where applicable, may be collected.

For billing directions regarding point of sale (POS) billing of a 72 Hour Emergency Supply, refer to the Pharmacy Services' page on the DOM website at www.medicaid.ms.gov.

If the drug is approved for PA, the emergency supply should be submitted as part of the original fill. The dispensing fee and beneficiary co-pay may not be collected until the remainder of the drug is dispensed.

CYCLE BILLING - AUTOMATIC REFILL

DOM does not allow prescriptions to be automatically refilled for MS Medicaid beneficiaries. The refill of a prescription must be initiated by the beneficiary and/or beneficiary's responsible party.

31 AND 90 DAY SUPPLY

Beneficiaries are limited to a maximum of a 31-day supply based on the daily dosage for all prescriptions, with some exceptions. Refer to the MS Administrative Code Title 23 Medicaid, Part 214 Pharmacy Services, Chapter 1 General Pharmacy, Rule 1.6.F.

MS Medicaid allows a 90 day supply on a limited number of maintenance medications. For the current 90 Day Maintenance List, go to http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/. The 90 Day Maintenance list is subject to revisions.

DECIMAL UNITS/POINTS

DOM's Pharmacy Point of Sale (POS) accepts quantity amounts including decimal units. Pharmacy claims are to be submitted using the actual unit(s) dispensed, including any decimal increments. Decimal units should not be rounded up or down since this practice may result in under or over payments and/or create rebate disputes for the State of Mississippi.

DISPENSING FEE

The dispensing fee is $3.91 for branded products and $4.91 for generic products. The dispensing fee for beneficiaries residing in a Long Term Care (LTC) facility is $3.91 for all drugs.

LTC pharmacies are limited to one dispensing fee per drug, defined as same chemical entity and strength, per month.

DISPENSING NATIONAL DRUG CODE (NDC) REQUIREMENTS

The National Drug Code, or NDC Number, is a unique number identifying drug products and is issued by the US Food and Drug Administration (FDA). NDC numbers are comprised of three components:

- The first component identifies the drug manufacturer ("Labeler No."),

- The second component identifies the product ("Product No."), and

- The third component identifies the package size ("Pkg.").

It is the responsibility of the pharmacy provider to bill the correct/appropriate NDC number for the product on each claim. The NDC number must be for the drug and package size actually dispensed and must include all eleven (11) digits for the NDC to be correct. This requirement is for all products, regardless of legend or over the counter (OTC) status.

Most drugs distributed by re-packagers are not covered by Medicaid because the re-packager does not participate in the federal rebate program with the Centers for Medicare and Medicaid Services (CMS). A pharmacy may not dispense a re-packager's drug and then bill Medicaid using the original manufacturer's NDC number.

Medicaid has the authority to recoup monies when an audit determines that the incorrect NDC number was billed.

SUSPENDED CLAIMS

Mississippi Medicaid does not suspend any pharmacy POS claims. Claims pay or deny. Exceptions are some claims entered through the web portal. See the **Web Portal Section** for specific information.

TIMELY FILING LIMITS

Providers must submit claims within 365 days.

THIRD PARTY LIABILITY

Pharmacy providers are required to bill prescription claims to private third party insurance carriers for those beneficiaries covered by both Medicaid and other third party insurance.

Pharmacy providers must keep explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request.

Remember, Medicaid is always the payer of last resort. If a beneficiary tells the provider that his/her insurance policy is no longer in effect, that the policy never existed, or that the policy is for

something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Recovery.

Upon receipt of this information, the patient's statement will be researched and, if necessary, the third party resource file will be updated.

Mississippi Medicaid Electronic Procedure for Billing Other Insurance A. Beneficiaries whose data on file with Medicaid indicates other third party coverage:

1. Pharmacy sends electronic claim to fiscal agent and it is rejected with NCPDP Reject Code "41" which will display the message, "Submit Bill to Other Processor or Primary Payer". The text of the rejection message (NCPDP Field # 504-F4) will also state the Third Party payer information including name, address and telephone number.

2. Pharmacy sends claim to Third Party Payer.

    a. Third Party Payer *pays 100%* of the Medicaid allowable charge- Claim may be resubmitted to Medicaid but no payment will result.

    b. Third Party Payer *pays less than 100%* of the Medicaid allowable- Claim should be resubmitted to Medicaid.

3. Enter the total amount paid by Third Party Payer in the "TPL Amount Paid" field (NCPDP Field # 431-DV – "Other Payer Amount Paid").

4. Enter "02" in "Other Coverage Code" Field (#308-C8- Other Coverage Exists- Payment Collected).

5. Submit claim to Medicaid fiscal agent for the full usual and customary amount.

    DO NOT SUBMIT COPAY AMOUNT ONLY.

6. Resulting payment will be Medicaid allowable minus TPL Amount Paid.

7. Third Party Payer sends back a *$0.00 Paid* Amount* (Rejection or Denial) *Valid Values for "Other Payer Reject Codes" (Field # 472- 6E) received from other insurance are:

    a. 40= Pharmacy Not Contracted with Plan on Date of Service

    b. 65= Patient is Not Covered

    c. 67= Filled Before Coverage Effective

    d. 68= Filled After Coverage Expired

e. 69= Filled After Coverage Terminated

f. 70= Product/Service Not Covered

g. 73= Refills are Not Covered

h. 76= Plan Limitations Exceeded

8. Enter $0.00 in the 'TPL Amount Paid' Field 431-DV

9. In Field #"**308-C8**,'**Other Coverage Code' one of the following** applicable values **should** be entered *(this field is optional when Field #308-C8 'Other Coverage Code' = 01, 03 or 04)*:

a. **01** = **No Other Coverage Exists** (Ex: Claim denies due to coverage expired)

b. **03 = Other Coverage Exists**-Claim Not Covered (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)

c. **04** = **Other Coverage Exists**-Payment Not Collected 05 = Managed Care Plan Denial-Not an acceptable value

d. **06 = Other Coverage Denied**- Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber are out of the insurance company's network.

e. **07 = Other Coverage Exists**- Not in Effect on Date of Service

f. **08 = Billing for Copay**-Not an acceptable value iii.

10. Submit claim to Medicaid fiscal agent.

11. Claim will pay Medicaid Allowable.

Beneficiaries whose data on file indicates no other coverage but provider is aware of other insurance coverage.

• Follow steps under "a" above.

• Provider must report the beneficiary's other insurance to Medicaid: Call Bureau of Recovery, Division of Medicaid at 601-359-6095, or (preferably) FAX information to: 1-601-359-6294.

Report insurance coverage via the form on the DOM website at:
http://www.medicaid.ms.gov/providers/provider-resources/.

Refer to directions posted on Pharmacy Services webpage regarding billing other insurance at: http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/.

PHARMACY DISEASE MANAGEMENT

Pharmacy Disease Management services are those provided by specially credentialed pharmacists for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anticoagulation therapy, or other disease states as defined by the Mississippi State Board of Pharmacy. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes. The process provides cost-effective, high-quality health care for beneficiaries referred by their physicians. The referring physician requests pharmacy disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the pharmacy disease management services performed by the pharmacist cannot duplicate those provided by the physician.

The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. The pharmacist is to evaluate the patient and consults with the physician concerning the suggested/prescribed drug therapy. After the drug therapy review with the physician, the pharmacist counsels the patient concerning such topics as compliance and provides the patient with educational and informational materials specific to the disease or drug. The pharmacist is to function in an educational capacity to ensure the patient understanding and compliance with the proper usage of all drugs prescribed by the physician. The involvement with the patient and the education of the patient about lifestyle changes and improved drug regimen compliance are aimed at improving overall health and the reduction and/or avoidance of costly hospitalizations and emergency care.

The State Pharmacy Act in its Disease Management Protocol requires communication with the referring physician. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

The primary components of this service are as follows:

- Patient evaluation,

- Compliance assessment,

- Drug therapy review,

- Disease state management according to clinical practice guidelines, and

- Patient/caregiver education.

The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with and education of the beneficiary, for example a partitioned booth or a private room.

A copy of the pharmacy care records, including the documentation for services, is shared with the patient's physician and remains on file in the pharmacist's facility available for audit by DOM.

To provide this service, a pharmacist must be a registered pharmacist with the Mississippi Board of Pharmacy who has completed a disease specific certification program approved by the Mississippi Board of Pharmacy practicing within the scope as defined by state law. All disease management pharmacists must renew their specific disease management certifications as required by the Board of Pharmacy.

The pharmacist applying to become a pharmacy disease management provider must complete an enrollment packet and Mississippi Medicaid provider agreement form. The enrollment application must include proof of Mississippi Pharmacist registration and National Institute for Standards in Pharmacists Credentialing certification in the pharmacy disease management areas for which reimbursement is sought. Mississippi Medicaid Pharmacy Disease Management Provider Agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than 30 miles from the borders of Mississippi. Only the individual pharmacist may enroll as a pharmacy disease management provider. Businesses such as partnerships and corporations do not qualify. Enrollment packets can be obtained from Medicaid's fiscal agent.

Pharmacists credentialed to provide pharmacy disease management services may receive reimbursement using only the individual Medicaid pharmacy disease management provider number.

Pharmacies with multiple individual pharmacy disease management providers may apply for group services under one group provider number. Each pharmacist in the group is still required to have his/her own individual provider number. This number must be entered on the claim in the servicing provider field. An enrollment packet must be completed and a group number must be received for the servicing location.

Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the CPT code 99402. An encounter must be at least 15 minutes and average 30 minutes. The number of encounters is limited to 12 per beneficiary per fiscal year.

Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services. Neither OBRA-mandated counseling nor JCAHO- mandated institutional discharge counseling qualify as a pharmacy disease management service.

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. All claims will be filed to the beneficiary's Medicaid ID number. 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.

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 (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, e.g., in alphabetical order, for a minimum of five years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

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

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

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

- Copies of all laboratory data provided, &

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

PHARMACY

The Division of Medicaid (DOM) recognizes the definitions of these terms as set forth by the Mississippi State Board of Pharmacy. A pharmacy eligible to participate in the Mississippi Medicaid program must be licensed in the state of MS to dispense pharmaceuticals and adhere to all state and federal guidelines as well as to DOM policy. Pharmacies are required to file a copy of their current MS Board of Pharmacy permit with DOM. Failure to do so may result in the withholding of payments and/or enrollment termination.

Listed below are the pharmacy provider categories for the Mississippi Medicaid program:

RETAIL PHARMACY

Pharmacies that hold either a Community Pharmacy or Non-Resident Pharmacy permit and participation in the Mississippi Medicaid program requires the pharmacy to be a community. A pharmacist must be on premises to dispense drugs to the general public. A prospective drug

utilization review of beneficiary records is required prior to dispensing prescriptions. An opportunity for face-to-face counseling must be provided to beneficiaries or to their representatives (guardians, relatives, etc.). DOM will not reimburse a retail pharmacy provider for dispensing of prescriptions where a personal provider/beneficiary relationship does not exist.

Pharmacies located out-of-state or non-resident pharmacies, which provide medications to MS Medicaid beneficiaries, including, but not limited to mailing and/or shipping, must be licensed by the state in which they are located and hold a current permit by the MS Board of Pharmacy.

CLOSED-DOOR PHARMACY

Pharmacies hold a Specialty Community Pharmacy permit and participation in the Mississippi Medicaid program is limited to dispensing infusion therapy drugs or dispensing drugs to beneficiaries in an institutional setting (ex: a nursing home or similar long term care facility). A pharmacist must be on the premises to dispense drugs. Prospective drug utilization review of beneficiary records is required prior to dispensing prescriptions. Face-to-face counseling is not required if the beneficiary is a resident of a long term care facility or the dispensed drugs are administered by a physician, nurse, or similarly authorized health professional. If the medication is shipped to the beneficiary, then phone counseling will be available.

INSTITUTIONAL PHARMACY

Pharmacies that hold an Institutional I or II Pharmacy permit are limited to the dispensing of drugs to beneficiaries in an institutional setting (ex: a nursing home or similar long term care facility). These pharmacies are on-site, may have limited hours, and may dispense to outpatient beneficiaries. Prospective drug utilization review of beneficiary records is required prior to dispensing prescriptions. Face-to-face counseling is not required if the beneficiary is a resident of a long term care facility or the dispensed drugs are administered by a physician, nurse, or similarly authorized health professional.

Permit holders who dispense drugs outside of the specified required criteria listed above are not eligible to be a Mississippi Medicaid provider of pharmacy services.

Medicaid Pharmacy Provider Agreements will not be initiated or maintained with pharmacy wholesalers or with holders of only a Drug Room Permit, Retail, Closed-door, or Institutional Pharmacy physically located more than thirty (30) miles from the state borders of Mississippi.

Exceptions to the thirty (30) mile limit may be made if the servicing pharmacy provider is:

- Located outside of the thirty (30) mile limit, and is the source of a drug not obtainable from any pharmacy provider within the thirty (30) mile limit, or

- 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) that is located outside of the thirty (30) mile radius, or

- Providing drugs to a Mississippi Medicaid beneficiary receiving specialized care and services (e.g. transplant) in a facility located outside the thirty (30) mile limit.

PROVIDER REIMBURSEMENT

DOM reimburses pharmacy providers only for prescriptions that are received via hand delivery by a beneficiary or his/her representative, received 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 (ex: nurse).

DISPENSING PHYSICIANS

DOM does not enroll dispensing physicians for reimbursement as a pharmacy provider type.

CHANGE OF OWNERSHIP LIABILITY

When a participating pharmacy changes ownership and the new owner desires to participate or continue participation in the Mississippi Medicaid program, the new owner, upon consummation of the transaction effecting the change of ownership, shall, as a condition of participation, assume liability for any and all amounts that may become due to the program as a result of audit. The new owner further agrees that such amounts may be withheld from the payment of claims submitted when determined, provided, however, that the assumption of liability by the new owner shall not be in any way construed as relieving the previous owner of his/her liability to DOM.

When there is a change in ownership or federal identification number of a provider, the new owner shall immediately notify the fiscal agent and request a new provider application and agreement to obtain a new provider number. After completion of a new provider application and agreement, and in accordance with enrollment procedures, the fiscal agent will assign a new provider number. No payment will be made until the provider number is assigned.

Providers with questions about remittance advice statements, check inquiries, billing medical supplies, publications, and beneficiary eligibility can call the Provider Inquiry Unit: 800-884-3222 or 601-206-3000.

Providers can also utilize the Mississippi Medicaid Web Portal for the most current information. Providers can enroll online, check claim status, check eligibility, and check policy through the web portal. Once registered as a provider, pharmacies can also submit claims (CMS 1500 claims, 72 Hour Emergency, Retro-eligibility and TPN claims) online, through the Envision web portal. The web portal is a one-stop shop for Medicaid providers. The Web Portal address is: https://msmedicaid.acs-inc.com

Contact Information for Pharmacy Providers			
		Telephone	Fax
Xerox, formerly Affiliated Computer System (ACS)	Fiscal Agent	800-844-3222 or 601-206-3000	601-206-3059
Automated Voice Response System (AVRS)	Eligibility	866-597-2675 or 601-206-3090	
Division of Medicaid (DOM)	Pharmacy Services	800-421-2408 or 601-359-5253	601-359-9555
Pharmacy Prior Authorization Unit	Prior Authorizations	877-537-0722	877-537-0720
Pharmacy Helpdesk		866-759-4108	866-209-4520

CLAIM PAYMENTS TO PROVIDERS

Providers who wish to inquire about their reimbursement should contact AVRS at 866-597-2675 or 601-206-3090.

PREFERRED DRUG LIST

The Preferred Drug List (PDL) is a list of drugs, which have been 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 is the responsibility of the Executive Director of the Division of Medicaid. The Division of Medicaid (DOM) recommends that prescribers use the drugs on the PDL list.

The preferred drug list contains a wide range of generic and preferred brand name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Drugs on the PDL are as effective as non-preferred drugs, but offer economic benefits for beneficiaries and the State of Mississippi. PDL addresses drugs dispensed in the pharmacy or point of sale (POS) venue only. It is not applicable to drugs provided and billed by physician offices.

The Mississippi Medicaid Preferred Drug List is subject to change. It is updated at least annually and as needed. New to the market drugs in classes which are included on the PDL are considered non-preferred until reviewed. Refer to the Pharmacy Services page on the DOM website at www.medicaid.ms.gov for a current listing of prescription drugs on the PDL.

PREFERRED DRUG LIST EXCEPTIONS

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

PDL exception request will be reviewed and a determination notice provided within 24 hours from receipt of request by telephone or other telecommunications device. The prescriber must initiate the PDL exception request for non-preferred PDL drugs that require prior authorization. PDL exception and/or PA forms will be signed by the prescriber. The form must remain in the patient's chart and will be subject to audit by the Division of Medical Services or its authorized representatives.

In emergency situations, the Division will allow payment for a 72-hour supply of drugs that are to be authorized.

Refer to the Pharmacy Services page on the DOM website @ www.medicaid.ms.gov for a Preferred Drug List Exception Request Form.

PRESCRIPTION REQUIREMENTS

TELEPHONE, ELECTRONIC AND/OR FAXED PRESCRIPTIONS

All prescriptions must be from a provider licensed under state law. Prescriptions may be electronically transmitted (e-prescribed), telephoned or faxed from the prescriber in accordance with federal and/or state laws and regulations. E-prescribed and telephoned prescriptions are to be transcribed to a hard copy document including all required information including the name or initials of the pharmacist dispensing the prescription and the name of the individual electronically or orally transmitting the order. It is the provider's responsibility to ensure the integrity of the prescription.

All covered outpatient drugs must be prescriber by a practitioner qualified under state law and within the scope of his and/or her practice, and in accordance with federal and state guidelines.

PRESCRIPTIONS FOR NEWBORNS

Prescriptions for a newborn must clearly indicate "NEWBORN" on the prescription. This will assure the pharmacist that he/she can file a claim. Pharmacists must use the baby's name, baby's date of birth, the mother's ID number, and the infant exception code (K) when filing a claim for these prescriptions.

PRESCRIPTION DOCUMENTATION REQUIREMENTS

All written prescriptions must contain, but not limited to, the following components and information:

- Beneficiary's name,

- Beneficiary's address if the prescription is for a controlled substance,

- Date of issuance of prescription,

- Name of prescribed drug and quantity to be dispensed but no more than a 31-day supply,

- Specific directions for its use in order for the pharmacist to dispense medications within the framework of rules and regulations of DOM regarding prescribed drugs,

- Prescriber's signature,

- Authorized refills, if applicable,

- Prescriber's name and DEA number,

- Prescriber's address if the prescription is for a controlled substance,

- Date filled and serial number of prescription.

PRIOR AUTHORIZATION

PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION

The MS Division of Medicaid requires prior authorizations for reimbursement of pharmacy claims under certain circumstances. The prior authorization process is designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid beneficiaries. The Mississippi Division of Medicaid requires prior authorization for reimbursement of Synagis.

In addition, clinical edits, as well as limits placed on drugs based on age, gender, quantity and dosage, as approved by Drug Utilization Review (DUR) Board and/or Pharmacy and Therapeutics Committee may require PA. There is a maximum approval limit of one year.

PRIOR AUTHORIZATION PROCESS

Processes related to prior authorization for prescription drugs must be handled according to the procedures set forth by the Pharmacy Bureau PA Unit. Prior authorization forms are located on the Pharmacy Services' webpage at http://www.medicaid.ms.gov/resources/forms/ and select Pharmacy Services.

The prescriber must initiate the prior authorization (PA) for prescription drugs that require PA. The PA request form will be completed by the prescriber. A copy of the PA form must remain in the patient's chart and will be subject to audit by the Division of Medical Services or its authorized representatives.

In an emergency, for those drugs for which a 72 hour supply can be dispensed, a pharmacy may dispense up to a three-day supply of a drug that requires clinical criteria. This provision applies only in an emergency.

Refer to the Pharmacy Services' webpage for information regarding prior authorization and forms as well as the current DOM Preferred Drug List or PDL.

REFILL TOO SOON (EARLY REFILL)

The refill-too-soon or early refill logic is set up to allow a beneficiary the opportunity to get their prescriptions filled no more than 25% early for regular legend drugs and no more than 15% early for controlled drugs.

- DUR overrides do not stop the early refill edits from posting.

- Early refill requests are handled by the Pharmacy PA unit.

REIMBURSEMENT

EAC (Estimated Acquisition Cost) is defined as the Division's estimate of the price generally paid by pharmacies for pharmaceutical products. EAC may be based on the Average Wholesale Price (AWP) or the Wholesale Acquisition Cost (WAC) or the State Maximum Allowable Cost (SMAC).

Usual and customary charge for prescription drugs is the price charged to the general public. DOM 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 beneficiaries who purchase or receive their prescriptions through a third party payer such as Blue Cross and Blue Shield, Aetna, etc.

Medicaid does not cover delivery charges.

PARTICIPATING FEDERALLY QUALIFIED HEALTH CENTER (FQHC) PROVIDERS

In reference to billing of Discounted Drugs, the Veterans Health Care Act of 1992 Title VI-Drug Pricing Agreements changed the way that drugs are billed to Medicaid by Federally Qualified Health Center (FQHC) in-house pharmacies. The Act requires that State Medicaid Agencies not request rebates on drugs that have already been discounted in price by the manufacturer at the time of purchase. The effective date of the applicable Section of the Act is December 1, 1992.

All drugs, as defined by the Act, purchased by an in-house pharmacy of an FQHC at a discounted price are to be reported on the cost report and be reimbursed through the core services encounter rate and not billed through the Pharmacy Program.

PHARMACIES PARTICIPATING IN THE 340B PROGRAM

Pharmacies participating in the program established by Section 340B of the Public Health Services Act must notify DOM regarding their participation. Said participants must also be listed on the HRSA website, www.hrsa.gov/opa/. Providers are required to complete the required certification forms and supply three recent and comprehensive invoices annually.

Drugs with discounts generated from participation in this program are ineligible for federal drug rebates and pharmacy claims from 340b providers are not submitted to manufacturers for drug rebates. Pharmacies participating in this program must submit actual acquisition costs when billing the Medicaid program. Submission of additional invoices may be required for auditing. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by DOM. As manufacturer price changes occur, providers must ensure that their billings are updated accordingly.

For the current DOM Pharmacy Reimbursement methodology visit the DOM website at http://www.medicaid.ms.gov/providers/pharmacy/.

RETURN OF UNUSED LONG TERM CARE MEDICATIONS

The Division of Medicaid will not reimburse for medications in tamper-resistant packages prescribed for a resident in a long-term care (LTC) facility but not dispensed to the resident. Such medication must be returned to the dispensing pharmacy and not billed to Medicaid. A medication is considered to be dispensed when it leaves the dispensing pharmacy and is delivered to the long-term care institutional facility. Return of unused medications in the long term care facility venue must be in compliance with the MS State Board of Pharmacy regulations and state and federal guidelines.

Medication is considered to be dispensed when it leaves the dispensing pharmacy and is delivered to the institutional facility. Medications prescribed to a LTC facility resident are considered not dispensed if:

- The medication was discontinued prior to delivery,

- The resident expired prior to medication being delivered,

- The resident was in the hospital (on discharge status from the LTC facility) at time of delivery,
- The medication dosage was changed prior to delivery, or

- The resident had excess medications remaining from a previous cycle with a documented explanation by the Director of Nurses

Any such medication subject to return must be intact with no doses removed from the blister package (unit dose). Medications dispensed and placed in bulk packaged and accepted by a responsible party at the long term care facility cannot be returned to the dispensing pharmacy for any reason. All medication subject to return must be returned to the dispensing pharmacy within five (5) days. No controlled substances may be returned.

The LTC facility must have written procedures regarding returning medications not dispensed to the resident to the dispensing pharmacy. The dispensing pharmacy must approve, in writing, the LTC facilities return procedures to ensure that any returned medications have been properly stored and have not been tampered with. The dispensing pharmacy must maintain those procedures in its files. Written procedures must be available from both the LTC facility and the pharmacy upon request by DOM.

The provider pharmacy must implement approved procedures which ensure that any returned medication has been properly stored, has not been tampered with, and the integrity of the medications remains intact. Documentation of the aforementioned criteria must comply with the MS Board of Pharmacy's regulations.

The record of adjustment may be a copy of the void/adjustment form or a documented note in the pharmacy's billing computer as to the date of adjustment.

RETURN TO STOCK/CLAIMS REVERSALS

Notwithstanding any other Division of Medicaid regulation, and for purposes of billing for prescribed drugs, the date of service means the date a prescription is filled. If the drug has not been received by the beneficiary or the beneficiary's representative within fifteen (15) calendar days from the date the prescription is filled, the pharmacy must reverse the claim and refund the payment to the DOM. The date of service/ the date the prescription is filled are considered as day1. The pharmacy must retain a record of the reversal on file for audit purposes.

DOM cannot adjust pharmacy claims submitted by point of sale (POS). To correct information submitted on a pharmacy POS claim, the pharmacy must reverse and resubmit the claim with the correct information. For assistance with claim reversals, please contact DOM's fiscal agent or Xerox at 1-800-884-3222.

SUSPENDED CLAIMS

DOM does not suspend any pharmacy POS claims. Claims either pay or deny. Exceptions are some claims entered through the web portal. Please refer to the **Web Portal** Section for specific information regarding this.

TAMPER RESISTANT PRESCRIPTION PAD/PAPER

All non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by Medicaid. The tamper-resistant prescription pads/paper requirement applies to all outpatient drugs, including over-the-counter drugs. Tamper–resistant prescription pad/paper is more difficult to erase, alter, or fraudulently reproduce. This type of hard copy prescription pad/paper includes features that resist duplication and changes. The intent of this policy is to reduce forged, unauthorized and altered prescriptions and to deter drug abuse.

This mandate applies whether DOM is the primary or secondary payer of the prescription being filled. This new provision impacts all DOM prescribers: physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs.

A prescription must contain at least one feature in all three categories in order to be considered "tamper-resistant."

CATEGORY 1- COPY RESISTANCE:

One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. Examples may include but are not limited to:

- "Void" or "Illegal" pantograph with or without reverse "RX"

- Security back print (artificial watermark)

- Special paper watermarking

CATEGORY 2- ERASURE/MODIFICATION RESISTANCE:

One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. Examples may include but are not limited to:

- To Prevent Erasure

  o Erasure revealing background

  o Toner receptor coating/Toner lock c. Chemically reactive paper

- To Prevent Modifications

  o Quantity check off boxes and refill indicator

  o Quantity Border/ refill Border and Fill (Computer generated prescriptions on paper only)

Note: While only one feature from Category 2 is required, DOM recommends that one feature of erasure and one feature of modification resistance be used.

CATEGORY 3- COUNTERFEIT RESISTANCE:

One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. Examples may include but are not limited to:

- Security features and descriptions listed on prescriptions

- Thermo chromic ink

For additional information regarding industry-recognized features refer to the DOM website at www.medicaid.ms.gov under Pharmacy Services.

Note that computer generated prescriptions are not exempt from the CMS mandate.

Pharmacies presented with a prescription written on a non-tamper resistant prescription pad/paper may satisfy the federal requirement by calling the provider's office and verbally confirming the prescription with the physician or prescriber. The pharmacy should document through notations on the hard copy of the prescription, or electronically, that such communication and confirmation has taken place. Documentation should include the following:

- Date

- Time

- Person who verified the prescription

- Beneficiary's name

- Beneficiary' age

- Drug information (name, strength, quantity, number of refills)

- Verification that all medications were ordered if more than one medication is specified

Emergency fills with a non-compliant written prescription are allowed as long as the prescriber provides a verbal, faxed, electronic or compliant written prescription within 72 hours.

EXEMPTIONS

Exemptions to this mandate include:

- Prescriptions presented by other modes of transmission, e.g., facsimile, electronic or e- prescribed, and telephone

- Refills for which the original prescription was filled prior to April 1, 2008

- 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

- Transfer of a prescription between two 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

A prescription order written on a tamper resistant prescription pad/paper does not automatically make the prescription compliant or valid. The pharmacist must ensure the validity of any prescription received and comply with federal and state statutes, laws and regulations when dispensing. Prescribing providers are required to comply with federal and state statutes and laws.

A uniform layout, format, or style is not required. Prescribing providers who prescribe for Medicaid beneficiaries are responsible for ordering the pads. Prescribers may choose to customize the layout and use the pads for non-Medicaid beneficiaries.

TOBACCO CESSATION

TOBACCO CESSATION MEDICATIONS

The following types of tobacco cessation medications are covered in the Mississippi Medicaid program:

- Over-the-counter nicotine products,

- Legend or prescription nicotine replacement products,

- Bupropion Hydrochloride, and

- Varenicline Tartrate.

A physician's prescription is required for all legend and over-the-counter tobacco cessation medications. Each prescription will count toward the monthly drug limit.

DOM authorizes benefits for tobacco cessation medications for the purpose of supporting beneficiaries who are trying to quit tobacco use with the temporary assistance of nicotine replacement therapy. It is expected that utilization of these products will be in accordance with medical standards of practice, FDA guidelines, and manufacturers' recommendations which generally limit product use to approximately 12 weeks. DOM will monitor the beneficiary's utilization of tobacco cessation products for over utilization or misuse, and in instances where there are patterns suggesting over utilization or misuse, the prescribing physician(s) will be contacted for justification of medical necessity.

TOBACCO CESSATION COUNSELING

To maximize the effectiveness of tobacco cessation medications, several telephone and on-line help centers are available for beneficiary use in conjunction with cessation medication.

Resource	Program Description	Contact Information
MS Tobacco Quitline	A telephone counseling, information, and tip line that is available for anyone interested in kicking the habit. Tobacco Quitline Hours are 8:00 am - 8:00 pm M-F	1-800-784-8669 (1-800-QUIT-NOW) www.quitlinems.com http://www.cancer.org/healthy/stayawayfromtobacco/quit-for-life
American Cancer Society's Quit For Life®	Tobacco cessation program that links callers with trained counselors. Participants are matched with a quit coach who helps develop a personalized quit plan, provides guidance in choosing medicines and give ongoing follow-up support.	1-800-227-2345 (1-800-ACS-2345)
National Cancer Institute	Get information and advice about quitting smoking through a confidential online text chat with an information specialist from NCI's Cancer Information Service - Monday through Friday, 8:00 a.m. to 11:00 p.m. Eastern Time at LiveHelp	1-877-44U-QUIT (1-877-448-7848) http://livehelp.gov/smokefree Monday-Friday 9:00AM-11:00 PM EST

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American Lung Association: Freedom From Smoking Online	Tobacco cessation program that allows caller to chat or email the Quitter INYOU program.	1-800-LUNG-USA
Nicotine Anonymous	Non-Profit 12 Step Fellowship of volunteers helping each other live nicotine-free lives. Nicotine Anonymous welcomes all those seeking freedom from nicotine addiction, including those using cessation programs and nicotine withdrawal aids. The primary purpose of Nicotine Anonymous is to help all those who would like to cease using tobacco and nicotine products in any form.	http://www.nicotine-anonymous.org

TOTAL PARENTERAL NUTRITION

Medicaid may reimburse for certain total parental nutritional (TPN) solutions if it is a combination of two or more drugs that satisfies the following criteria:

- At least one drug is covered in the Mississippi Medicaid program,

- The finished product is not otherwise commercially available, and/or

- The finished product is being prepared to treat a specific beneficiary's condition.

Medicaid will not reimburse for those drugs not typically covered in the Mississippi Medicaid program as defined in Part 214 Pharmacy Services of the Administrative Code. Therefore, any drugs in the combination not covered will not be reimbursed.

TPN solutions include those used for hyperalimentation, intradialitic parenteral nutrition, and intraperitoneal nutrition. Each has specific requirements that must be met for reimbursement.

HYPERALIMENTATION

In order for hyperalimentation to be covered through the Mississippi Medicaid Pharmacy program, all of the following must apply

- Documentation from the prescriber must be clear and precise to verify that the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.

- Records must include documentation that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the patient must be intravenously infused with nutrients.

- Infusions must be vital to the nutritional stability of the patient and not supplemental to deficient diet.

- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted to DOM.

INTRADIALYTIC PARENTERAL NUTRITION (IDPN) AND INTRAPERITONEAL NUTRITION (IPN)

IDPN and IPN are methods of administration of certain types of hyperalimentation for dialysis treatments.

These nutritional solutions are not covered for the beneficiary with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to, but not limited to the following:

- A swallowing disorder,

- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder,

- A psychological disorder, such as depression, impairing food intake,

- A metabolic disorder inducing anorexia, such as cancer,

- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease,

- A side effect of a medication, or

- Renal failure and/or dialysis.

In order for IDPN or IPN solutions to be covered through the Mississippi Medicaid Pharmacy program, all of the following must apply:

- The prescribing provider must submit clear and precise documentation to DOM to verify that the beneficiary suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight to sustain life.

- Records should document that the beneficiary cannot be maintained on oral or enteral feedings and that, due to severe pathology of the alimentary tract, the patient must be maintained with IDPN or IPN.

- Infusions must be vital to the nutritional stability of the beneficiary and not supplemental to a deficient diet or deficiencies caused by dialysis.

- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly evident in the documentation.

BILLING REQUIREMENTS

Claims for TPN (hyperalimentation, IDPN, and IPN) solutions must be submitted as follows:

- The initial claim must include a medical necessity statement from the prescribing provider that identifies whether the needed solution is for hyperalimentation, IDPN, or IPN and provides information by which DOM can determine that the above criteria have been satisfied.

- Claims are to be billed via the web portal on a paper Mississippi Medicaid Pharmacy Claim form and sent to DOM. Please write "TPN" on the top of each claim for identification purposes only.

- Claims are to be billed monthly for up to a 31 day supply.

- Claims should list the actual NDC number(s) with the corresponding quantities of each ingredient used beginning with the most costly ingredient.

- The provider should bill for the number of milliliters of TPN that was dispensed to the beneficiary during the billing period.

- To receive the compounding fee, enter a C on the claim following the NDC for each ingredient.

- The maximum dispensing fee shall not exceed $30.00 per liter.

- The quantity for those non-covered NDCs will not be included in the total liter quantity to determine the dispensing fee.

The pharmacist is responsible for maintaining the documentation in the pharmacy file.
For dually eligible beneficiaries having both Medicare and Medicaid, Mississippi Medicaid will not cover these TPNs if Medicare denies the therapy based on Medicare's coverage criteria. Such claims should not be submitted to DOM.

UTILIZATION REVIEW

The Medicaid Drug Utilization Review (DUR) Program promotes patient safety through state-administered utilization management tools and systems that interface with the Medicaid Management Information systems (MMIS) Medicaid DUR is a two-phase process that is conducted by state Medicaid agencies. In the first phase (prospective DUR) the state's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. The second phase (retrospective DUR) involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

The pharmacist assumes professional responsibility in dispensing drugs to eligible beneficiaries under the Medicaid Program. He or she may refuse to dispense any prescription that appears to be improperly executed or, in his or her professional judgment, is unsafe as presented. He or she may refuse to dispense drugs to known addicts or to persons known to "shop" for physicians or pharmacies in an effort to obtain more drugs than one physician would authorize.

PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)

Prospective Drug Utilization Review (ProDUR) alerts provide for a review of drug therapy at the point of sale where each prescription is filled to allow the pharmacist to make sound professional judgment decisions concerning any potential drug therapy problems. The pharmacist may override the ProDUR alert, after professional consideration of the information, if an override is necessary for the health and well-being of the beneficiary. All information pertaining to ProDUR overrides is retained on file with Medicaid.

Pharmacists may process claims that contain prospective Pro-DUR message by using standard NCPDP DUR outcome and/or intervention codes which can be located on the DOM Payer Sheet at http://www.medicaid.ms.gov/providers/billing-manual/. ProDUR is a function of Medicaid's claims processor.

RETROSPECTIVE DRUG UTILIZATION REVIEW (DUR)

Retrospective Drug Utilization Review (DUR) is required in order to identify patterns of abuse, misuse, inappropriate and/or medical unnecessary drug care among Medicaid providers or beneficiaries. The focus of drug utilization review is to enhance and improve the quality of drug care and beneficiary outcomes by encouraging optimal drug care for MS Medicaid beneficiaries.

The MS DOM Drug Utilization Review (DUR) Board was established in order to comply with federal regulations contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The DUR Board is comprised of twelve members, six practicing physicians and six practicing pharmacists. Board members are active MS Medicaid providers and in good standing with their respective regulatory boards. Members are gubernatorial appointees, serve three year terms, may be reappointed and receive no honorariums.

The DUR Board meets quarterly to discuss the methods to assure appropriate use of drugs in the MS Medicaid beneficiary population and reviews utilization of drugs therapy, and evaluates the long term success of the treatments. The DUR Board meetings are public meetings, conform to the MS Public Meetings Act, and the public may attend. Meeting agendas, minutes and other information about the DUR are available on the DOM's Pharmacy Services' webpage at http://www.medicaid.ms.gov/providers/pharmacy/drug-utilization-review-dur-board/.

DOM contracts with a third party vendor to assist the agency with the federal mandate of DUR retrospective drug review. RDUR is a function of MS-DUR, a faction of the University of Mississippi, School of Pharmacy's Center of Pharmaceutical Marketing and Management.

VACATION SUPPLY

DOM does not allow for a vacation supply.

WEB ADDRESSES

MS Division of Medicaid	http://www.medicaid.ms.gov/
GHS, Goold Health Services, PDL and supplemental rebate vendor	http://www.ghsinc.com/
MS-DUR	http://www.pharmacy.olemiss.edu/cpmm/msdur.html
Xerox, formerly ACS, fiscal agent	https://msmedicaid.acs-inc.com/msenvision/

WEB PORTAL CLAIMS ENTRY

DOM allows certain claims to be submitted for reimbursement through the web portal at https://msmedicaid.acs-inc.com/msenvision/index.do.

- 72 hour emergency fill claims

- Disputed Reimbursement pharmacy claims

- Regular POS pharmacy claims in emergency situations

- Retroactive eligibility claims older than 12 months

- TPN- Total Parenteral Nutrition claims