

MEDICAID MANAGEMENT INFORMATION SYSTEM

PROVIDER MANUAL FOR PHARMACIES



Published By:

**Medical Services Division
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250**

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STATE DIRECTORY
ADDRESSES AND TELEPHONE NUMBERS

PHARMACY PROGRAM INQUIRIES

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Administrator, Pharmacy Services
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Bismarck ND 58505-0250
1-701-328-4023

**POS STATE NETWORK
COMMUNICATIONS INQUIRIES**

ITD Support Center (Computer Files)
(See Page 20)
600 E Boulevard Ave
Bismarck ND 58505
1-701-328-4470
1-877-328-4470

PRIOR APPROVAL FORMS

<http://www.hidndmedicaid.com>

**TO OBTAIN MEDCAID FORMS - REFER
TO WEB PAGE:**

<http://www.nd.gov/eforms/>

CSHS INQUIRIES & TO OBTAIN FORMS:

Children's Special Health Services
ND Department of Human Services
600 E Boulevard Ave
Bismarck ND 58505-0269
1-701-328-2436

VERIFY

Patient Eligibility
Verification System
1-700-328-2891
1-800-428-4140

MEDICAID POS

Provider Relations
Medical Services
ND Department of Human Services
1-701-328-4030

**POS SWITCH COMPANIES NETWORK
INQUIRIES** (See Page 20)

NDC Help Desk 1-800-388-2316
Timeshare Help Desk 1-800-333-3672
Envoy Help Desk 1-800-333-6869

**PHARMACY ADJUSTMENTS (FORM SFN
640) MAIL TO:**

Medical Services Division
ND Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

VR INQUIRIES & TO OBTAIN FORMS

Regional Vocational Rehabilitation Office
- Bismarck - Devils Lake
- Dickinson - Fargo
- Grand Forks - Jamestown
- Minot - Williston

Forms may also be obtained by calling 1-701-328-4033.

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Healthy Steps Eligibility	Jaci Edison	328-2374
Healthy Steps Eligibility	Leann Bayman	328-4892
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Medical Claims Processing Specialist - Pharmacy claims	Vivian Holzer	328-4086
Medical Claims Processing Specialist Sterilization Claims, & Provider Relations Backup	Michelle Adams	328-4046
Medical Claims Specialist - Currently on the MMIS System Replacement Project (Northbrook)	Cherie Kraft	328-5426
Medical Coding Specialist - Certified	Barbara Koch, LPN, CPC	328-1044
Medical Coding Specialist - Certified	Sara Regner	328-4825
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Program Administrator, Home & Community Based Services (HCBS)	Tess Frohlich	328-4630
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Program Specialist - Electronic Billing (a.k.a. EDI) & HIPAA Claims	Tammy Henderson	328-2325
Program Specialist - QS, Buy-In, QMB, Cost Effective Ins., & provides TEC3 Assistance on recipient eligibility	Pat French	328-4121
Provider Enrollment and Provider Forms Ordering	Rhonda Rud	328-4033
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QSP Auditor, HCBS	Marella Krein	328-4579
QSP Provider Enrollment, HCBS	Theresa Wolf	328-4621
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Supervisor, Claims Processing	Juli Johnson	328-1622
TPL (Third Party Liability) Analyst	Bev Locken	328-3507

INTRODUCTION

On September 1, 1978 the State of North Dakota began operation of the Medicaid Management Information System (MMIS). The MMIS is an automated claims processing system which began with an Optical Character Reader for claims entry. Eventually the system allowed electronic billing of claims using magnetic tape, computer diskettes and electronic mailbox.

In January 1988 the Technical Eligibility Computer System Medicaid Enhancement (TME) program began operation and provided for computerized transmission of recipient eligibility data from the County Social Service Board (CSSB) offices to the state agency. The TME system eliminated the need for counties to authorize and supply claim forms to providers and also established direct access by providers to the State eligibility files for verification of recipient eligibility status. This patient eligibility verification system is a computer synthesized voice response system known as VERIFY.

The Pharmacy Point-of-Sale (POS) system began statewide operation on July 1, 1996. Prospective Drug Utilization Review (ProDUR) audits are performed on all drug claims submitted through the POS system. The ProDUR information provided to pharmacists is based on the patient's medical diagnosis and prescription history. Pharmacists are required to evaluate any ProDUR information that is returned with a claim and intervene appropriately.

All Medicaid claims as well as Vocational Rehabilitation (VR) Services and Children's Special Health Services (CSHS), previously known as Crippled Children Services are processed by MMIS. However, VR and CSHS eligibility is not available on the VERIFY system. Eligibility for those recipients must be determined by contacting the regional VR office and/or the state CSHS office.

This billing manual is designed to aid providers in billing the North Dakota Medicaid, VR and CSHS programs. Included are general items of interest to providers, specific claim form billing instructions and procedures to follow when requesting adjustments to payments. We hope you find this manual helpful in meeting the requirements of our claims processing system. Should you have any questions, please contact us. Addresses and telephone number of appropriate departments and staff are listed in the State Directory of this manual.

Out of State Pharmacies: Effective September 3, 2002, ND Medicaid pharmacy services made the proper programming changes to allow pharmacy services to become in-line with medical services. ND Medicaid-Medical Services has required that services available in-state must be provided in-state and exceptions require prior authorization. There will be no change in pharmacy services for provider pharmacies located in North Dakota and the three bordering states (MT, SD, MN). However, pharmacies that are physically located outside of this four state area will be required to file a prior authorization to justify the reason that the service is not available in-state.

DRUG UTILIZATION REVIEW (DUR) REQUIREMENTS

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that all state Medicaid programs include a retrospective and prospective drug utilization review (DUR) program for all covered outpatient pharmaceuticals as well as patient counseling. The primary goal of drug utilization review is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use. The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The Medicaid DUR program includes: retrospective DUR, prospective DUR, and the State DUR Board, as well as patient counseling.

Retrospective DUR

The retrospective DUR program involves reviews by a panel of actively practicing physicians and pharmacists of patient drug history profiles generated from Medicaid paid claims data. The reviews are based upon predetermined standards consistent with the following:

1. American Medical Association Drug Evaluations
2. United States Pharmacopeia-Drug Information
3. American Hospital Formulary Service Drug Information

The retrospective review of the patient drug history profiles by the panel of reviewers includes evaluation for:

1. Therapeutic appropriateness
2. Over and under utilization
3. Appropriate use of generic products
4. Therapeutic duplication
5. Drug-disease contraindications
6. Drug-drug interactions
7. Incorrect dosage or duration of therapy
8. Clinical abuse/misuse

Prospective Drug Utilization Review (ProDUR)

The ProDUR program requires the pharmacy provider to screen for drug therapy problems at point-of-sale or distribution, before each prescription is filled or dispensed. In compliance with OBRA 1990 DUR requirements, pharmacy providers must screen each prescription for certain therapeutic problems using standards consistent with OBRA 1990 requirements. The pharmacy provider's prospective DUR program must be based upon predetermined standards, consistent with the compendia and literature previously listed under the "Retrospective DUR" section. OBRA requires:

1. A pharmacist using his/her professional judgment shall review the patient record and each prescription drug order presented for dispensing for purposes of promoting therapeutic appropriateness by identifying the following, when possible:
 - a. over or under utilization
 - b. therapeutic duplication
 - c. drug-disease contraindications, where diagnosis is provided by the prescriber
 - d. drug-drug contraindications
 - e. incorrect drug dosage or duration of drug treatment
 - f. drug allergies
 - g. clinical abuse/misuse

2. Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the prescriber.

Computerized pharmacy providers must use a prospective DUR software database which screens for the therapeutic problems listed in paragraph 1., a - g, above. It is not necessary that these databases include patient-specific diagnoses or allergy information.

Point-of-Sale (POS) providers may receive additional ProDUR information provided by the North Dakota POS system. These audits are supplemental to those required by law to be performed by the pharmacy provider and not in lieu of those audits. North Dakota Medicaid ProDUR audits are based on information from the current claim, from claim history for the same and different pharmacies, and from the patient's diagnostic history on medical claims. The medical, clinical, and pharmaceutical information used in POS ProDUR audits is supplied by First Data Bank. The following audits are performed:

<u>Audit</u>	<u>NCPDP Code</u>
a. Early Refill (Same drug, same pharmacy)	ER
b. Drug Drug Interactions	DD
c. Duplicate Therapy Same Drug (Same drug, same or different pharmacy)	ID
d. Therapeutic Duplication	TD
e. Medical Disease Diagnosed Contraindicated	MC
f. Drug Disease Contraindicated	DC
g. Adult High Dose	HD
h. Geriatric High Dose	HD
i. Pediatric High Dose	HD
j. Adult Low Dose	LD
k. Geriatric Low Dose	LD
l. Pediatric Low Dose	LD

m.	Additive Toxicity	AT
n.	Iatrogenic Side Effect (Inferred)	IC

DUR OVERRIDE CODES - one from each column are needed to override an alert

<u>CONFLICT CODES</u>	<u>INTERVENTION CODES</u>	<u>OUTCOME CODES</u>
ER Early refill	M0 Prescriber consulted	1A Filled, false positive
DD Drug-Drug Interaction	P0 Patient consulted	1B Filled Rx as is
ID Duplicate Therapy, Same Drug	R0 Pharmacist consulted	1C Filled with different dose
TD Therapeutic Duplication	00 No intervention	1D Filled with different directions
MC Medical Disease (Diagnosed) Contraindicated	Blank Not specified	1E Filled with different drug
DC Drug Disease Contraindicated		1F Filled with different quantity
HD Adult, Geriatric, or Pediatric High Dose		1G Filled with prescriber approval
LD Adult, Geriatric or Pediatric Low Dose		2A Prescription not filled
AT Additive Toxicity		2B Prescription not filled directions clarified
IC Iatrogenic Side Effect (Inferred)		

Pharmacists billing via POS are required to evaluate any ProDUR Information that is returned with a claim and intervene appropriately. Additional information regarding DUR audit processing logic is available by request.

TABLET SPLITTING: Pharmacies may receive an additional payment of \$0.15 per pill as an incentive to split the following tablets. Using NCPDP version 5.1, enter a Unit Dose Indicator of 4.

- Sertraline 100 mg tablets (for 50 mg doses)
- Mirtazapine 30 mg tablets (for 15 mg doses)
- Paroxetine 20 mg tablets (for 10 mg doses)
- Citalopram 20 or 40 mg tablets (for 10 and 20 mg doses, respectively)
- Escitalopram 20 mg tablets (for 10 mg doses)

One Dispensing Fee Per Month: May use when appropriate (unit of use products, liquids, creams, antibiotics, etc.) – NCPDP 5.1 - Submission Clarification Code of 5.

DRUG COVERAGE

A. GENERAL STATEMENT

Federal law requires that the department cover all drug products made by manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid (CMS), except for those drugs in the non-covered services categories listed.

Accordingly, if a drug is covered, the following criteria must apply:

1. The drug must not be limited or excluded, as specified in the List of Non-Covered Services below, and
2. Additionally, the pharmacist should determine if the drug is DESI (http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp); those drugs with a DESI code of 2 or 3 are covered; those drugs with a DESI code of 4, 5, or 6 are non-covered.
3. Compounds must be submitted as a compound via NCPDP version 5.1 standards. The claim will be paid if a payable ingredient is included in the compound and all NDC's submitted are valid and not discontinued.
4. For medical supplies, i.e., hearing aid batteries, etc., see the current Durable Medical Equipment manual. Also see the Department of Human Services, Medical Services, web page.

B. NON-COVERED SERVICES, GENERAL INFORMATION

The following are not covered by the Medicaid program:

1. Drugs determined to be less-than-effective (DESI - http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp) by the FDA and drugs identified as identical, related and similar (IRS) to DESI.
2. Drugs made by manufacturers which have a labeler code not included in a rebate agreement with CMS.
3. Drugs which are limited or excluded by the state or federal law. These include:
 - Agents when used for anorexia or weight gain
 - Agents when used to promote fertility
 - Agents when used for cosmetic purposes or hair growth/removal
 - Drugs dispensed after their expiration date
 - Cost of shipping or delivering a drug
 - Drugs which are experimental or investigational

- Drugs used for erectile dysfunction
4. The following drugs, when provided for Medicaid recipients in nursing facilities, are part of the per diem.
 - OTC drugs, even if prescribed
 - Nursing stock drugs and durable medical equipment (i.e. saline, sodium chloride for inhalation and trach therapy)
 - Vitamin and mineral products

C. LIST OF LIMITED COVERAGE DRUG CATEGORIES

Legend or OTC drug coverage is limited in the following categories:

1. AGENTS WHEN USED FOR THE SYMPTOMATIC RELIEF OF COUGH AND COLDS:

Coverage: Legend, non-DESI drugs classified in First Data Bank as Therapeutic Code Generic 50.

2. AGENTS WHEN USED TO PROMOTE SMOKING CESSATION:

Coverage: Patients will be limited to a 90 day supply of therapy for patches, gum, lozenges, and bupropion, every two years. Combination therapy with these medications is allowed. Chantix is limited to the initial 12 weeks of therapy with an additional 12 weeks allowed if the patient has continuously quit for a minimum of one month (since day 56 of therapy). The Chantix regimen will be allowed once every two years.

3. AGENTS (ORLISTAT) when used for weight loss or lipid management

Coverage: Orlistat is covered, by prior authorization, with dietitian evaluation, for recipients with a body mass index of 40 or greater (height and weight must be supplied). Updates on progress are required semi-annually with coverage terminated if no progress is shown (specifically 5% weight loss in 6 months) or coverage continuing as long as progress is made until the BMI falls below 30.

4. NON-PRESCRIPTION DRUGS:

Coverage: Analgesics, antacids, “anti-ulcer” medication including histamine antagonists, iron supplements, non-sedating anti-histamines, and artificial tears. These products must have valid NDC numbers and be included in a CMS rebate agreement.

5. Some medications may require Prior Authorization as a condition of coverage. For a current list of medications, please refer to the website at <http://www.hidndmedicaid.com/>.

6. Medicare Part D recipients

Medicaid will cover the following per our limits and requirements for full benefit dual eligibles if their Part D plan does not cover the medication:

- Benzodiazepines
- Barbiturates
- Aspirin
- Acetaminophen
- Certain prescription vitamins
- Non-prescription drugs listed in #4 above provided all prescription alternatives have failed
- Numbers 1 & 3 above

REIMBURSEMENT OF DRUGS

Per CMS regulations, actual payment remains the lower of:

1. The usual and customary charge to the general public
2. Average Wholesale Price (AWP), per Blue Book, minus 10% plus the professional fee
3. Wholesale Acquisition Cost (WAC) plus 12.5% plus the professional fee
4. Federal Upper Limit (FUL) – (http://www.cms.hhs.gov/Reimbursement/05_FederalUpperLimits.asp) plus the professional fee.
5. State Maximum Allowable Cost (MAC) for drugs with generic equivalents plus the professional fee. <http://nddrug.rxexplorer.com/>
6. State maximum allowable cost plus dispensing fee for some other medications (e.g. specialty drugs).

Non-legend drugs are reimbursed at EAC (1-4 above) plus 1.5 times the EAC up to a maximum of the current legend drug-dispensing fee (\$4.60).

The professional fee is \$4.60 for brand and \$5.60 for generic.

PHARMACY SERVICES PROGRAM REQUIREMENTS

1. Federal Upper Limit (FUL) (http://www.cms.hhs.gov/Reimbursement/05_FederalUpperLimits.asp) or Maximum Allowable Cost (MAC) <http://nddrug.rxexplorer.com/>) program.
2. DESI (Drug Efficacy Study Investigation - http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp) or less than effective drugs.
3. Manufacturer/Labeler Drug Rebate agreement.
4. Prospective/Retrospective Drug Utilization Review.
5. A professional fee (dispensing fee) is payable once per month per drug for all maintenance medication.
6. The quantity of medication dispensed shall not exceed a 34 day supply unless another insurance is the primary payer and pays a portion of the claim, then the primary insurance rules apply, or if the medication is packaged as a standard or its duration is a standard beyond 34 days.

7. Provider numbers (pharmacy and Prescriber) must be NPIs

RECIPIENT LIABILITY

Pharmacies billing via the Point-of-Sale (POS) System will be advised of any recipient liability (R/L) due the pharmacy as the POS claim is paid. Recipient liability is also known as “excess income” or “spend down.” Recipient liability is immediately updated by each POS claim. Part D recipients also eligible for Medicaid cannot have their claims sent to Medicaid via POS. You must bill them for the amount the Part D plan states and the recipient will have to bring their receipt to their county worker.

Pharmacies using paper claims or other electronic billing may also want to know whether a recipient is likely to have recipient liability (R/L). This information is available by calling the patient eligibility verification system, VERIFY, located in the State Office at:

Local calls:	1-701-328-2891
Toll-Free:	1-800-428-4140

Refer to VERIFY Operational Steps section for further information.

If all the recipient liability has been applied to paid claims at the time of the call, VERIFY will indicate there is no recipient liability for that month. Therefore, VERIFY may indicate \$500 of recipient liability on 02-01-2003 but no recipient liability on 02-20-2003, if it has all been applied to claims with February dates of service.

For POS claims, at the time the prescription is transmitted on-line, real time to the state any recipient liability remaining is applied immediately to that claim and is due and payable at that time. The weekly remittance advice will reflect that transaction.

For paper claims, any recipient liability remaining at the time of the weekly checkwrite is applied weekly for all claims in order of date of service and is reported back to the pharmacy on the remittance advice.

Pharmacy claims for persons residing in long term care facilities are not held until recipient liability is met. Rather, the patient’s entire liability is accrued against the facility charge, which is received much later in the month. In rare cases, the facility charge will be insufficient to satisfy recipient liability. When this happens, the state will recoup payments from the pharmacy which will then have to bill the patient or family for any previously paid claims. Payment recoupment will be by claim adjustment by state staff and will be reflected on a remittance advice.

If a recipient does not pick up an ordered prescription that has recipient liability by the end of the next business day, you must reverse the claim to ensure that the recipient liability is applied to other services received by the recipient. If the recipient comes to pick up the prescription later during the month, simply rebill and if there is recipient liability remaining, the claim will adjudicate as such.

THIRD PARTY LIABILITY

If other insurance or other responsible party (third party liability, including court ordered insurance) has been identified through the patient, the county, the patient eligibility verification system (VERIFY), or the Point-of-Sale (POS) system, the pharmacy must collect from the other source of payment prior to billing Medicaid. Following is the current policy for pharmacy claims with TPL:

1. If there is no insurance payment indicated on the claim and there is TPL indicated on the state system, the claim will be denied.
2. If there is an insurance payment indicated on the claim and there is no TPL in the state system, the claim will go to pay and will be returned to you with an EOB Code of 235 - "Insurance not on state system. Send carrier name and policy number to state TPL unit." This gives the provider the chance to inform the state of other insurance for recipients without penalizing you for indicating payment. Either call or FAX the insurance information to the state using telephone number 701-328-3507 or FAX number 701-328-1544.
3. If there is any insurance payment indicated on the claim and there is one TPL policy in the state system, the claim will automatically go to pay.
4. If there is an insurance payment indicated on the claim of less than 50% and there is more than one TPL policy in the state system, the claim will be captured for manual review by state staff and either paid or denied appropriately.
5. If there is an insurance payment indicated on the claim of more than 50% and there is more than one TPL policy in the state system, the claim will automatically go to pay.
6. If the total amount of the claim is less than \$100.00 per month and the third party coverage is for major medical insurance, then a pharmacy may bill Medical Services directly by POS or hard copy without first billing the insurance company.

The amount of other insurance paid by the third party is indicated by NCPDP version 5.1 fields 431-DV (other insurance payment amount) and 433-DX (patient pay amount – equals copay due from patient per primary insurance(s)).

If the pharmacy has been unable to collect benefits from the insurance company or other responsible party after a reasonable period of time, the pharmacy may bill Medical Services directly. An explanation of efforts made to collect other TPL must accompany their request, and if accepted by the state, a prior authorization will be entered which will allow the pharmacy to bill Medicaid electronically. The prior authorization would have to be renewed yearly.

COORDINATED SERVICES PROGRAM

(Formerly Lock-In Program)

When a recipient is placed on the Coordinated Services Program (CSP) by this state agency, that recipient is limited to services provided by a primary CSP physician, pharmacy, and/or dentist.

Coordinated Services Program status is made available to providers by notices mailed to practitioners in the recipient's service area to inform them of a recipient's CSP status and the name(s) of the CSP provider(s). Their CSP status is also included on the Point-of-Sale system and the patient eligibility verification system, VERIFY.

Therefore, the only claims payable for a CSP patient are those prescribed by the primary CSP physician or billed by the primary CSP pharmacy. Other claims will be denied. The only exceptions are prescriptions written by a referred physician or in cases of emergency or after-hours clinic visits. In these situations the pharmacist may resubmit the claim using the NCPDP emergency override indicator. Contact your software vendor since pharmacy systems may vary as to how this value is recorded on the claim.

Prescriptions not ordered by the CSP/referred prescriber or dispensed by the CSP pharmacy will be monitored by the S/URS unit after payment if the emergency override indicator is used.

REFERRAL

If the prescription is not from the CSP prescriber or a referred prescriber, the pharmacist must contact the CSP physician to verify the referral and authorize continued dispensing. It is inappropriate to simply change the prescribing physician to the CSP physician if there is no referral. The CSP physician should be advised to send a copy of the CSP referral to the state office. When a referral is verified, the pharmacist may override the denial using the emergency override indicator, and dispense up to a 30-day supply.

EMERGENCY ROOM OR AFTER-HOURS CLINIC

If a pharmacist determines that a medical emergency requires immediate dispensing of the drug, then the pharmacist may resubmit the claim using the emergency override indicator. The department will allow **a four day supply** for most prescriptions from a prescriber for a CSP recipient who was seen at an emergency room or an after-hours clinic. Also, the department will allow a single course of therapy for antibiotics and single unit-of-use products, such as inhalers will be allowed with larger days supply from a prescriber for a CSP recipient who was seen at an emergency room or an after-hours clinic. Any additional supply must be authorized by the CSP prescriber.

GENERAL TIPS FOR BILLING

1. Always bill your usual and customary charge to the general public for each prescription. All discounts are to be reduced from the usual and customary charges before billing Medicaid.
2. Metric decimal quantities should be used per NCPDP guidelines.
3. Be certain to use current NDCs when billing. NDCs may become obsolete or change from time to time but are payable for two years from their obsolete date as identified by the state's drug file source, First Data Bank. Incorrect NDCs will be denied. In addition, all claims submitted without an NDC where an NDC number has been assigned will be denied. This includes DME and compounded items.
4. All services require a prescription order from a licensed prescriber.
5. All initial claims must be submitted within one year from the date of dispensing of the prescription. All adjustments must be submitted within one year of the remittance advice date of the paid prescription.
6. When tracing a claim that has been unpaid and no word has been received within a reasonable period (generally 30 days), rebill the claim by any method. If the claim is unpaid and payable, payment will be made. If the claim was previously paid, then you will be advised accordingly that the claim is a duplicate.

INSTRUCTIONS FOR POINT-OF-SALE (POS) BILLING

North Dakota Medicaid has the capability of accepting Point-of-Sale (POS) pharmacy claims. Pharmacies submitting via POS must submit claims in the National Council for Prescription Drug Programs (NCPDP) version 5.1.

Claims submitted via POS are processed in real time and may be paid, denied, or captured. Paid or captured claims may also be reversed by the submitting pharmacy. The following are characteristics unique to POS billing:

1. Eligibility - POS billing confirms the patient's Medicaid eligibility on the date the prescription is dispensed. It is not required to make a separate call to the patient eligibility verification system (VERIFY) because the POS system uses the same source of information as VERIFY. If the patient is ineligible on the dispensing date, the claim will be denied.
2. Recipient Liability - For those recipients having a liability, sometimes referred to as "excess income" or "spend down", the POS system determines the amount of liability for each claim and reports that amount to the pharmacist at the time of dispensing.
3. Third Party Liability - (See the Third Party Liability section, page 13, for further information.)
4. Prospective Drug Utilization Review (ProDUR) - ProDUR audits are based on information from the current claim, from claim history for the same and different pharmacies, and from the patient's diagnostic history on medical claims. Pharmacists are required to evaluate any ProDUR information that is returned with a claim and intervene appropriately. For more information, see section entitled Prospective Drug Utilization Review (ProDUR).
5. Reversals - Pharmacists may retract any claim that has been paid or captured by submitting an NCPDP reversal transaction. Reversals may be used in many circumstances. Following are some examples:
 - a. A prescription is not picked up by the patient.
 - b. Prospective Drug Utilization Review (ProDUR) information provided by the system as a claim was paid results in a prescription not being dispensed or being modified. If modified, the new claim may be submitted at any time after the reversal.
 - c. An error was made when submitting the claim. A corrected claim may be submitted and processed at any time after the reversal. Generally, a reversal and resubmission can be used in place of the pharmacy hard-copy adjustment form SFN 640.
 - d. Credits for restocking unused medications for long term care patients are processed by submitting a reversal for the original claim and then rebilling

via POS for the amount of product actually used. See section entitled Long Term Care Credits for a detailed description of the LTC Credit process. This is not supported with version 5.1; therefore, simply reverse the original claim and rebill with the correct amount of product. Please contact ND Medicaid if the entire quantity was returned.

6. Denied claims - If a claim has been DENIED for any reason, you may REBILL via POS if you think it should be payable, making any needed claim corrections. Examples:
 - a. A claim is denied because the Medicaid ID number is invalid, correct the number and resubmit.
 - b. A claim is denied because the patient is not eligible. If the patient later establishes eligibility for the dispensing date, resubmit the claim via POS within one year from the date of the original prescription.
7. Adding NDC Numbers to the Pharmacy's Vendor System - Each computer vendor company has its own specifications to follow when manually adding a new product to the drug file. Check with the vendor since some companies require input of hyphens/spaces in the NDC number and some do not. Vendors have programmed their software to correspond to the state's specifications and hyphens/spaces may or may not be automatically added or subtracted.
8. Beginning or Modifying Point-of-Sale Billing - Pharmacies that are contemplating utilizing Point-of-Sale (POS) billing or making vendor system changes should contact Medical Services prior to implementation to obtain the vendor software system specifications and testing instructions. Contact:

Brendan K. Joyce, PharmD, R.Ph.
Administrator of Pharmacy Services
Division of Medical Services
ND Department of Human Services
600 E. Boulevard Ave-Dept 325
Bismarck, ND 58505-0250
Phone: 1-701-328-4023
e-mail: bjoyce@nd.gov
9. POS System Availability - The North Dakota Medicaid POS system is scheduled to be available 24 hours a day, seven days a week except for maintenance. Regular maintenance of the state's computer system is scheduled Wednesday mornings from 4:00 AM through 7:00 AM. Additional maintenance is scheduled every other Sunday from approximately 7:00 AM to 3:00 PM.
10. All POS claims must be submitted by 12:00 Noon Monday to be included in the Monday night checkwrite.
11. Network Processing Difficulties - The POS system is accessed via one of the pharmacy claims networks connected with North Dakota Medicaid. At times the

switch network system may be out of service or unable to exchange information with the state's system. If the condition persists, please contact the network's help desk directly for assistance. The switch companies and their telephone numbers are:

NDC Help Desk	1-800-388-2316
Timeshare Help Desk	1-800-333-3672
Envoy Help Desk	1-800-333-6869

12. State Processing Difficulties - If the network returns information that state files are out of service, specific messages you may see are as follows:

- POS Suspense File is out of service
- Recipient Master Files are out of service
- Drug Pricing File is out of service
- Provider Master File is out of service
- Other Master Files are out of service
- Data field problem in Drug File
- NDPOS Not Responding (T33)

If one of these conditions persists more than 20 minutes, record the message you received and contact:

ITD Support Center
600 E. Boulevard Ave
Bismarck, ND 58505
1-701-328-4470
1-877-328-4470

ADJUSTMENTS TO PAYMENTS

DENIED POS CLAIM

If a claim has been DENIED for any reason and you think it is payable, you may REBILL via POS, making any needed claim corrections. Examples include:

- a. A claim is denied because the Medicaid ID number is invalid. Correct the number and resubmit.
- b. A claim is denied because the patient is not eligible. If the patient later establishes eligibility for the dispensing date, resubmit the claim via POS within the one year filing limit.

ADJUSTMENTS

If you feel an error has been made in payment as shown on your remittance advice, you may correct the error in one of the following ways:

- a. Reverse and re-bill with the necessary corrections.
- b. Use the Adjustment Request form SFN 640 to request an adjustment. Please follow the instructions on the following pages for completing the Adjustment Request.
- c. Call the Medicaid state office Provider Relations staff at 1-701-328-4030, 1-701-328-4031 or 1-800-755-2604 for a telephone correction to a previously paid or denied claim. The correction will be made on line and the corrected payment will be reflected on your next check.

REFUNDS

If you discover that you have been overpaid by Medicaid or CSHS, please identify the error by writing to the appropriate address above. Refunds may be handled in one of three ways at the provider's option:

1. Send a copy of your remittance advice, circling the amount of overpayment. Complete an Adjustment Request Form (SFN 640) explaining why you have been overpaid. The amount of overpayment will be reduced from a subsequent payment.
2. Reverse and re-bill with the necessary corrections.

PHARMACY REQUEST FOR AN ADJUSTMENT

INSTRUCTIONS - FORM SFN 640

The Provider Adjustment Request Form SFN 640 is to be used by a pharmacy that does not have on-line capabilities when requesting an adjustment to a previously submitted claim. Information supplied on the form should be as complete as possible, so that the problem claim can quickly be identified and a solution determined. Normally, such data may be obtained from either the pharmacy's copy of the claim in question or the Remittance Advice (R/A). You may submit up to 4 claims per adjustment.

When completing the form, enter the information as printed on the Remittance Advice. If you believe this information is incorrect, and has necessitated a payment adjustment, explain in Block 19 (Explanation/ Remarks).

Forms must be legible to be processed, if not they will be returned.

Block (1) Reason for Request

Check the reason(s) that define(s) why the adjustment request is being submitted. Possible reasons include:

- a. Underpayment: Payment for services rendered was less than the proper amount.
- b. No Payment: After waiting a reasonable period of time (generally 30 days) and the pharmacy still has received no payment or explanation for a claim that was submitted.
- c. Overpayment: Payment for services rendered was more than the proper amount.
- d. Corrected Billing: Additional billing information is furnished with the adjustment request.
- e. Other: Include brief statement of explanation.

Block (2) Provider's Name and Address

The pharmacy's name and address should be entered in this block.

Block (3) Provider Number

The pharmacy provider number assigned by the North Dakota Medicaid program should be entered in this block.

Block (4) Recipient Identification

- a. I.D. No. - The Medicaid Identification Number of the patient.
- b. Patient's Name - The recipient's correct name as it appears on the eligibility status notice provided by the department.
- c. Case No. - Not required.
- d. Birth date.

Block (5) Recipient's Residence

Indicate place of residence for date of service of the adjustment. One entry only.

Block (6) Remittance Advice (R/A) Date

If an R/A has been issued on the claim in question, place its date of issue in this block. Obtain the R/A date from the upper left hand corner of the R/A above the provider number.

Block (7) Authorization Number

No entry is required.

Block (8) Prescribing Doctor's (Prescriber) Name

The prescriber's full name or the prescriber's Medicaid provider number from the claim form or R/A should be entered in this block.

Block (9) Control Number (from Remittance Advice

The 13 digit control number of the claim in question, from the R/A, should be entered in this field.

ALL INFORMATION ON BLOCKS 10 THROUGH 17 MUST COME FROM THE R/A.

Block (10) Date of Service

Indicate in this block the exact date on which the prescription being adjusted was dispensed.

Block (11) Rx. No.

Enter the prescription number for the service in question.

Block (12) Rx. Date

Enter the date the prescription was originally dispensed.

Block (13) Drug name, Conc. & Mfg.

Enter the drug name, concentration and manufacturer in this block. Be complete. If the drug cannot be identified, the adjustment will be returned.

Block (14) NDC (National Drug Code) Number

The NDC of the prescription in question should be entered in this column.

Block (15) Quantity (metric)

Enter the metric quantity of the prescription dispensed in this block.

Block (16) Bill Amount

The amount claimed by the provider on the original claim as due for the prescription dispensed.

Block (17) Paid Amount

The amount which was actually paid for a service in question. Obtained from the R/A only.

Block (18) State Use Only

Leave blank. For internal office use only.

Block (19) Explanation/Remarks

Describe in this block the nature of the problem or condition that you feel should be reviewed as a possible adjustment. Include all information you believe will be helpful in determining the correct solution. Too much information is always better than too little.

Block (20) - Mail To:

No pharmacy entry is required in this block. However, this block does contain the address to which the adjustment request should be sent for finalization. Do not enclose Pharmacy Adjustment Requests in the same mailing envelope with other type of documents.

Block (21) Provider Signature

The name of the person responsible for completing the adjustment request and the date of the request and telephone number must be entered in this block.

SFN 640 pharmacy adjustment form is located at:

<http://www.state.nd.us/eforms/Doc/sfn00640.pdf>

LONG TERM CARE CREDIT

Pursuant to State Medicaid Director Letter #06-005, any drug products that are unused due to a discontinued prescription or to the discharge or death of the patient must be restocked by the dispensing pharmacy and credited to the Medicaid program (returns must comply with the North Dakota State Board of Pharmacy rules).

The credit may be made by reversing the original transaction and then re-submitting with the adjusted actual units utilized. If desired, a paper form could be submitted to the Department. A sample LTC credit form is located on the next page.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

PHARMACY REQUEST FOR A CREDIT

INSTRUCTIONS: Use this form for medications returned from a long-term care facility and only unit dose packaging approved by ND Board of Pharmacy

1. Internal Control Number _____
(13 digits from Remittance Advice)
2. Recipient Identification Number _____
(9 digits)
3. Date of Service _____
4. Prescription Number _____
5. Quantity Used _____
6. Days Supply _____
7. Provider Number _____
(5 digits)
8. Reason Code _____

Code Chart: 51 Patient passed away
52 Physician changed order
53 Medication on hold
54 Medication discontinued
55 Patient discharged
56 Patient allergic reaction
57 Other

MEDICARE PART B COVERED ITEMS

Certain items of durable medical equipment, supplies and drugs are payable by MEDICARE on behalf of recipients who are eligible for both Medicare and Medicaid. These items include:

- Ostomy & Urologic Supplies
- Wheelchairs
- Crutches
- Canes
- Oxygen Equipment
- Braces (Orthopedic)
- Lumbosacral Supports
- Corsets (Orthopedic)
- Prostheses
- Medically necessary Durable Medical Equipment from a licensed prescriber for use in the home (Purchase & Rental)
- Diabetic supplies, including BG monitors, GB strips, and lancets
- Medicare Part B covered drugs

Billing is accomplished in two steps:

1. First, bill Medicare on CMS 1500 forms or electronically. The North Dakota Pharmaceutical Association may maintain a supply of CMS 1500 forms. Please contact them for information on these forms.
2. When the claim has been processed by Medicare, it should automatically cross over to Medicaid for consideration of payment of any deductible and coinsurance amounts that are due.
3. Medicaid will then reimburse for any deductible amount due from the recipient plus any coinsurance amount due, if any, up to the Medicaid allowable payment, for each item.
4. If you have not received payment within 60 days of billing Medicare, please bill the department on a CMS 1500 form. When billing Medicaid, attach a Medicare "Explanation of Benefits" form to the CMS 1500 form and mail to:

Medical Services
ND Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Billing instructions for the CMS-1500 form can be found at the following web site:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/nd-medicaid-cms-1500-claim-form-billing-instructions.pdf>

DESI - DRUG EFFICACY STUDY IMPLEMENTATION - PROGRAM or Less-Than-Effective-Drug Program

Effective October 1, 1982, federal financial participation (FFP) was terminated under Medicaid for drugs that the FDA determined to be less than effective (LTE). In reviewing these LTE and identical, related and similar (IRS) drugs, the Secretary of Health and Human Services determined there was not a compelling justification for their medical efficacy; therefore, they are not covered or payable.

The active ingredient and the route of administration are the major controlling factors regarding the FDA's less-than-effective-drug determinations.

The DESI indicators are now reported to the state quarterly on a drug rebate tape from CMS and may change for any particular drug from quarter to quarter. CMS defines the DESI/IRS drugs as a code 2, 3, 4, 5 or 6 and those definitions are as follows:

Code 2 - DESI/IRS Drugs are determined to be safe and effective

Code 3 - DESI/IRS Drugs are under review

Code 4 - DESI/IRS LTE Drugs for some indications

Code 5 - DESI/IRS LTE Drugs for all indications

Code 6 - DESI/IRS LTE Drugs withdrawn from the market

The North Dakota Medicaid program pays for the Code 2 and 3 drugs. The Code 4, 5 and 6 drugs are considered DESI/IRS less-than-effective-drugs and are non-payable.

See the following link for information –

http://www.cms.hhs.gov/medicaiddrugrebateprogram/12_lteirsdrugs.asp

COMPOUNDED ITEMS

Compounds must be submitted using NCPDP version 5.1 standards. If at least one component of the compound is payable and all NDC numbers are on the First DataBank drug file and not discontinued, the claim will pay at EAC for each ingredient plus a maximum of \$10.00 compounding/dispensing fee.

No hard copy claims are allowed for compounds - the only functionality is for NCPDP version 5.1 standards.

DURABLE MEDICAL EQUIPMENT (DME)

The Non-Covered Equipment and Supply List is included as Attachment A of this manual.

Covered diabetic supplies (strips, lancets, machines, syringes) are reimbursable using NDC numbers. Insulin is to be billed as any other legend drug using the correct NDC number.

Any items for which the charge is more than \$300.00 per month, sale or rental, requires prior authorization using the Request for Prior Approval, Form SFN 1115 which is obtained from Medical Services.

Please note that nutritional supplements need to be prior authorized in all situations where payment is requested: Food supplementation prior authorization guidelines are contained in the manual at: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/dme/dme-manual.pdf>.

SFN 1115 Durable Medical Equipment Prior Authorization form is located at: <http://www.state.nd.us/eforms/Doc/sfn01115.pdf>

Refer to Attachment A of this manual.

ROUTINE DRUGS, SUPPLIES & DME FOR LONG TERM CARE FACILITIES

Some supplies or equipment cannot be billed separately through independent suppliers for residents in long term care. These supplies become part of the cost of care in the facility.

The only exceptions are found in Section II of Attachment B which lists insulin, IV/SQ Meds, IV solutions with medication admixed, and legend drugs. These are allowed for separate payment.

Refer to Attachment B of this manual.

FEDERAL UPPER LIMIT (FUL) / MAXIMUM ALLOWABLE COST (MAC) PROGRAM

CMS establishes a specific federal upper limit (FUL) for multiple source drugs. A multiple source drug is a drug marketed by two or more manufacturers or labelers or by the same manufacturer under two different names.

The Maximum Allowable Cost (MAC) - <http://nddrug.rxexplorer.com/> list is obtained by the Department of Human Services and updated weekly or as needed. Rates are based on market conditions.

The payment rate for MAC or FUL drugs does not apply if a licensed prescriber certifies in his/her own handwriting, on the face of the prescription, that a specific brand is medically necessary for a particular patient AND a prior authorization is obtained from ND Medicaid AND the pharmacy submits the claim with the proper DAW 1 indicator. The handwritten phrases "Medically Necessary," "Brand Necessary," "Dispense as Written," or "Brand Medically Necessary" are acceptable. A check-off box or abbreviation is not acceptable for North Dakota Medicaid prescriptions.

See the following web link for information -

FUL - http://www.cms.hhs.gov/Reimbursement/05_FederalUpperLimits.asp

MAC - <http://nddrug.rxexplorer.com/>

MANUFACTURER/LABELER DRUG REBATE AGREEMENT PROGRAM

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that pharmaceutical manufacturers have a rebate agreement in effect with CMS for their pharmaceuticals to be reimbursed by Medicaid programs.

Some pharmaceutical manufacturers have more than one labeler code. Therefore, if a manufacturer wants all products to be reimbursable, the company must include all labeler codes in their rebate agreement with CMS. Then only pharmaceuticals with a labeler code included in a rebate agreement are covered by Medicaid.

The labeler code which is the first 5 digits of the NDC number identifies the manufacturer of the product and Medicaid uses this labeler code to determine if the pharmaceutical is rebateable and payable. The labeler code is the controlling factor rather than the manufacturer's name, and for that reason a numeric listing by labeler code is furnished to pharmacies on a quarterly basis.

Manufacturer rebate payments to the state are based on prescription claims payment data identified by NDC number. To assure that the appropriate manufacturer is billed for the rebate, accurate records must be maintained by pharmacies. The actual NDC number on the package from which the medication is dispensed must be utilized on all pharmacy claims submitted for payment.

Inaccurate records may result in:

- The Medicaid agency billing the wrong manufacturer
- Disputes between the state and the manufacturer in the amount of rebate due
- An audit of the records of pharmacy providers which may result in false claims charges and reversals of payments

Additionally, failure to correctly reflect the actual NDC number dispensed may negatively impact revenues generated for the state. Therefore, it is imperative that pharmacists take care to correctly identify the specific NDC number of the pharmaceutical dispensed.

VERIFY OPERATIONAL STEPS

FOR ALL VOICE RESPONSES

1. Dial (701) 328-2891 or
1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS # (Receive Message)
3. Enter PATIENT ID NUMBER and PRESS # (Receive Message)
4. Enter DATE OF SERVICE and PRESS # (Receive Message)
5. Enter "2" if no more inquiries and to end call

OR,

Enter "1" for additional inquiries and repeat 3 and 4 above.

FOR SPEED DIALING

1. Dial (701) 328-2891 or
1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS #, PATIENT ID NUMBER and PRESS #, DATE
OF SERVICE and PRESS # (Receive Message)
3. Enter "2" if no more inquiries and to end call

OR,

Enter "1" for additional inquiries and repeat 2 above using PATIENT ID and PRESS # and
DATE OF SERVICE and PRESS #

TO REPEAT INFORMATION

1. Enter "*" to repeat current message
2. Enter "1" for Eligibility and Recipient Liability
3. Enter "2" for Coordinated Services Program (Lock-In) and Primary Care Physician (PCP)
4. Enter "3" for Co-Payment
5. Enter "4" for Third Party Liability (TPL)
6. Enter "5" for Vision
7. Enter "6" for ALL Menu items

FOR CURRENT DATE, PRESS # KEY, INSTEAD OF 8-DIGIT DATE

ATTACHMENT A

NON-COVERED EQUIPMENT AND SUPPLY LIST – DURABLE MEDICAL EQUIPMENT AND SUPPLY PROGRAM

Reimbursement is limited to only the most economical and medically necessary DME delivered in the most appropriate and cost effective manner. An item is not reimbursable if there is another item that is equally safe, effective, and substantially less costly.

Generally, DMEs are not useful to a person in the absence of illness or injury. The item must be appropriate for use in the home or residence. Items that are beneficial primarily in allowing leisure, recreational, or daily living activities are not reimbursable.

The following is a list of some generic categories/items specifically **determined not reimbursable** by State Plan (general) Medicaid: (not all inclusive)

A. Adaptive Equipment for Daily Living, including, but not limited to: special eating utensils, plates, appliances.

- Alarms or environmental controls – telephone, door, appliance, computer television

- Belts – personal, transfer, walking

- Hip boards

- Injectors, hypodermic jet pressure

- Jar openers

- Magnifying lenses

- Mediplanners

- Pivot machine

- Plate guards

- Plates

- Reachers

- Scooters – 2, 3 and 4 wheel

- Tongs, eating utensils

- Walker skis

- Walking sticks

- Wheelchair – second or third chair, manual or electric, regardless of purchaser

- Wheelchair modifications to accommodate vehicles

- Wheelchair puller

Whirlpools

Writing guides

B. Building Modifications, including, but not limited to: wheelchair ramps, widening of doorways, ceiling/wall mounted equipment.

Building modifications – remodeling residences, ramps, rails

Compasses

Elevators and stair lifts

C. Automobile Modifications, including, but not limited to: lifts, controls, restraints, seats, compasses.

Automobile or vehicle modifications

D. Environmental Control Device, including, but not limited to: switches, controls, telephone, air filter/conditioner/purifier.

Air filters, air conditioners, air purifiers except for oxygen related equipment

Battery clubs – hearing aid

Car Seats

Control units for environmental equipment

Dehumidifiers – room, central

Humidifiers – except oxygen related

Telephones – including telephone lights and alarms

Vaporizers

E. Exercise Equipment, including, but not limited to:

Bicycles – exercise

Dumbbells

Equipment – including in-home physical therapy items, pulleys, ropes, weights, and balls

Treadmill

Weight machines

Wrist/hand strengthening

F. Miscellaneous Items:

Beds – except for hospital and short term restorative specialty beds

Blood pressure equipment – except for transplant patients or other medical exceptions by prior approval

Chairs – seat lift, laminectomy

Compression stockings and lymphadema equipment

Masks except oxygen administration and burn

Pump, breast – except manual

Scales

Standing Frames

G. Personal care items, including but not limited to: shampoo, soap, toiletries, lotions, ted hose, panty hose

Cloths – disposable, wash, wipes

Deodorants

Food blenders and processors

Gloves

Hot packs

Ice packs, collar, etc

Lamps – except bilirubin, SADD

Leg bag drainage system for electric wheelchair

Mattresses – except hospital bed

Monitor – home uterine

Nylon aid

Pads – heat, cold

Paper – toilet, facial tissues

Personal need, over the counter items – razors, tweezers, toothbrushes (electric and non-electric) and toothpaste, toothettes, cotton swabs, lotions, creams and occasional use products, sanitary products, nursing pads, tampons, napkins, shoe horns, wedges, foam toe pads and all other non-custom shoe or foot items

Shoes – tennis shoes or non-customized shoes – includes extra depth and extra width shoes unless required for customized orthotic

Tables – including over the bed

Toys

Water bottles

Water Pics

H. Medical Alert Bracelets

I. Convenience or Comfort Items (for the individual or caregivers benefit)

Bottles – hot water, nursing

Button aids

Carafes

Diapers for persons under 4 years of age

Disinfectants – room, nebulizers

Elastic laces

Emesis basins

Massage devices

Sock nylon aids

Sponges, bath

Swim plugs, headbands

J. Institutional equipment

Medical supplies used by home health (other than those pre-authorized)

Paraffin baths

Psoriasis Lamps

K. Educational equipment

Books, pamphlets, brochures

CDs, tapes, videos

Computers and printers – expect assistive communication devices

ATTACHMENT B

ROUTINE DRUGS, SUPPLIES AND DURABLE MEDICAL EQUIPMENT FOR NURSING FACILITIES, ICF/MR FACILITIES, AND SWING BED FACILITIES

Routine drugs, supplies and durable medical equipment that ARE to be provided as part of the care for Medicaid recipients in nursing facilities, swing beds, and ICF/MR facilities are identified in this section. Legend drugs except DESI drugs are allowed for separate payment to pharmacies for drugs provided to all residents of facilities.

- Part I -** Identifies those items that are to be provided by the facility; are includable as allowable costs on the Cost Reporting Form of a nursing facility or ICF/MR; and will not be paid if separately billed to the department by a pharmacy or other DME supplier. The listed items are non-payable outside the rate even if they are prescribed by a licensed physician.
- Part II -** Identifies items that will be allowed for separate payment to pharmacies if billed to the department on SFN 634 or CMS 1500 by a participating pharmacy with a prescription from a licensed physician. If these items are provided by a facility, payment is considered to be included as part of the daily rate and the facility cannot bill separately for these items.
- Part III -** Identifies items provided to nursing facility or swing bed recipients that will be allowed for separate payment if prescribed by a licensed physician; billed by a participating DME supplier or pharmacy; and prior approved when necessary. All items costing or with an estimated cumulative rental or combination costs of \$300 or more require prior approval. If these items are provided by a facility, payment is considered to be included as part of the daily rate and the facility cannot bill separately for these items.
- Part IV -** Identifies items provided to ICF/MR recipients that will be allowed for separate payment if prescribed by a licensed physician; billed by a participating DME supplier or pharmacy; and prior approved when necessary. All items costing or with an estimated cumulative rental or combination costs of \$300 or more require prior approval. If these items are provided by a facility, payment is considered to be included as part of the daily rate and the facility cannot bill separately for these items.

ITEMS TO BE SUPPLIED BY FACILITY AND NOT PAYABLE TO PHARMACIES OR OTHER SUPPLIERS

- A. **Over-the counter (non-legend) items, including but not limited to:**
 - Aspirin, Acetaminophen
 - Antacids
 - Antidiarrheals
 - Antihistamines
 - Hemorrhoidal Preparations
 - Laxatives
 - Liniments
 - Lotions/Creams
 - Vitamins

- B. **Personal items, including but not limited to:**
 - Artificial Sweetener
 - Breath Freshener
 - Cleansing, Antibacterial Solution
 - Denture Cream, Denture Adhesive
 - Deodorant
 - Mouthwash
 - Razor Blades
 - Salt Substitute
 - Shampoo
 - Soap
 - Talcum Powder
 - Tissue
 - Toothpaste, Tooth powder, Toothbrush

- C. **Supplies and Durable Medical Equipment (DME), including but not limited to:**
 - Ace Bandage
 - Aerochamber/Inhalaid
 - Alcohol (rubbing), Antiseptic, Hydrogen Peroxide
 - Ambu Bag
 - Apnea Monitors
 - Band-Aids
 - Bandages
 - Bedrails, Footboard
 - BIPAP, CIPAP Machines
 - Blood Glucose Monitoring Device, test strips and supplies
 - Blood Stool Tester
 - Catheter, Tubing, Bag & Irrigating Syringe
 - Clinistix, Ketostix, Dextrostix
 - Clinitest, Diastix, Ketodiastix, etc.
 - Commode Chair

Communication Device (excluded for ICF/MR)
Compression Stockings
Cotton
Cradle
Crutches, Cane
Deodorizer
Dressings, Vigilon, Duoderm, Bioclusive
Enemas, equipment and disposable
Examination Equipment
Finger Cot
Fleece Pad, Sheep Skin
Foam Pad
Gastric Feeding Tube, Sets, Bags
Gauze, Gauze pads, 4 x 4's
Geriatric Chair
Gloves
Hearing-Aid or Larynx Batteries
Heating Pad
Hot Water Bottle
Humidifier
Ice Bag
Incontinence Pads & Briefs, Sanitary Napkins, Disposable Diapers
IPPB Equipment
IV Tray or Subcutaneous Tray and Tubing
Lubricants, e.g., Vaseline, K-Y Jelly
Needles, reusable and disposable
Nebulizer
Oxygen, Oxygen Mask, Oxygen Cannula, Oxygen Catheter, Oxygen
Concentrator, Cart, Stand, Regulator, etc. (excluded for ICF/MR)
Ostomy Supplies and Related Items
Pump, Parenteral and Enteral
Q-Tips, Applicators
Restraints
Roho Cushion
Seating Systems non-customized
Sodium Chloride for Irrigation/Inhalation
Specialized beds or mattresses costing less than \$25 per day
Suction Machine and Supplies
Sun Lamp
Supplemental Nutritional Formulas, e.g., Ensure, Infant Formula
Suppositories, Glycerin
Suture Tray
Syringes, all types
Tape, e.g., Micropore, Surgical
Telfa
Tes-Tape

Thermometer

Toilet Riser

Tracheostomy Supplies

Trapeze Bar

Underpad

Vaporizer

Walker

Wheelchair (excluded for ICF/MR)

D. Vaccines for mass immunizations, including but not limited to:

Influenza Vaccines

Pneumonia Vaccines

ITEMS THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO PHARMACIES

1. Insulin
2. IV and SQ Medications
3. IV Solutions (if medication admixed)
4. Legend Drugs, except Influenza and Pneumonia Vaccines (See Part I, D)

ITEMS PROVIDED TO NURSING FACILITY OR SWING BED RESIDENTS THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO DME SUPPLIERS OR PHARMACIES

All items costing \$300 or more, or with an estimated cumulative rental or combination costs of \$300 or more, require prior approval, and must have a prescription by a licensed physician.

1. Custom Seating Systems
2. Custom Shoes (if diagnostic criteria is met)
3. Hearing Aids
4. Orthotics
5. Prosthetics
6. Repair of recipient owned equipment
7. Specialized beds or mattresses costing \$25 or more per day
8. Vacuum Assisted Wound Closure

ITEMS PROVIDED TO ICF/MR RESIDENTS THAT WILL BE ALLOWED FOR SEPARATE PAYMENT TO DME SUPPLIERS OR PHARMACIES

All items costing \$300 or more, or with an estimated cumulative rental or combination costs of \$300 or more, require prior approval, and must have a prescription by a licensed physician.

1. Custom Seating Systems
2. Custom Shoes (if diagnostic criteria is met)
3. Communication Devices
4. Hearing Aids
5. Orthotics
6. Oxygen concentrators and supplies
7. Prosthetics
8. Repair of recipient owned equipment
9. Specialized beds or mattresses costing \$25.00 or more per day
10. Vacuum Assisted Wound Closure
11. Wheelchairs and Accessories (per DME guidelines, limitations, or restrictions)