

# PROVIDER MANUAL FOR PHARMACIES



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## ND MEDICAID REFERENCE SHEET

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Provider Call Center / Eligibility Verify Line	1-877-328-7098
Medical Services	1-800-755-2604
Sanford Health Plan (Medicaid Expansion)	1-855-305-5060
Medicaid Fraud	1-701-328-4024
Third Party Liability	1-701-328-2347

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

### CONFLICT CODES

**ER** Early refill

### INTERVENTION CODES

**M0** Prescriber consulted  
**P0** Patient consulted  
**R0** Pharmacist consulted other source

### OUTCOME CODES

**1B** Filled Rx as is  
**1C** Filled with different dose  
**1D** Filled with different directions  
**1F** Filled with different quantity  
**1G** Filled with prescriber approval

### **COORDINATED SERVICES PROGRAM (LOCK-IN) EMERGENCY OVERRIDE CODE = Level of Service of 03**

**TABLET SPLITTING:** Pharmacies may receive an additional payment of \$0.15 per pill as an incentive to split the following tablets. Using NCPDP version D.0, enter a Unit Dose Indicator of 3.

- 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 D.0 Submission Clarification Code of 5.



## STATE DIRECTORY

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### Addresses and Telephone Numbers

#### **PHARMACY PROGRAM INQUIRIES**

Brendan Joyce, PharmD, R.Ph.  
Administrator, Pharmacy Services  
Medical Services Division  
ND Department of Human Services  
600 E Boulevard Ave-Dept 325  
Bismarck ND 58505-0250  
1-701-328-4023

#### **POS STATE NETWORK COMMUNICATIONS INQUIRIES**

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

#### **THIRD PARTY LIABILITY INQUIRIES**

medicaidtpl@nd.gov

#### **PROVIDER ENROLLMENT INQUIRIES**

dhsenrollment@nd.gov

#### **PROVIDER RELATIONS INQUIRIES**

mmisinfo@nd.gov

#### **MEDICAID FRAUD INQUIRIES**

medicaidfraud@nd.gov

#### **PRIOR APPROVAL FORMS / PREFERRED DRUG LIST / PRIOR AUTHORIZATION INQUIRIES**

<http://www.hidesigns.com/ndmedicaid/>  
ndpa@hidinc.com

#### **CSHS INQUIRIES**

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

#### **AIDS DRUG ASSISTANCE PROGRAM (ADAP) INQUIRIES**

Ryan White Part B Coordinator  
2635 E. Main Ave.  
Bismarck, ND 58506-5520  
Phone: (701) 328-2379 | Fax: (701) 328-0338

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

RelayHealth Help Desk 1-800-401-5973  
eRx Network Help Desk 1-866-379-6389



## INTRODUCTION

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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 Children's Special Health Services (CSHS), AIDS Drug Assistance Program (ADAP), Aid to the Blind, Russell Silver Program, and some county jail claims are processed by the ND Medicaid pharmacy system.

This billing manual is designed to aid providers in billing for these claims. Included are general items of interest to providers. We hope you find this manual helpful. Should you have any questions, please contact us. Addresses, emails, and telephone numbers of appropriate departments and staff are listed in the State Directory of this manual. Further detail on claims processing requirements are located in our payer sheet on our website <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-pharmacy.html>.

**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**

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The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) 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 of patient drug history profiles generated from Medicaid paid claims data. The reviews are based upon predetermined standards consistent with subsection 1927 of the Social Security Act.

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

1. Therapeutic appropriateness
2. Overutilization and underutilization
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 90 DUR requirements, pharmacy providers must screen each prescription for certain therapeutic problems using the OBRA 90 defined standards. The pharmacy provider's prospective DUR program must be based upon predetermined standards, consistent with subsection 1927 of the Social Security Act. 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. Overutilization or underutilization
  - 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.

Pharmacies must use a prospective DUR software database which screens for the therapeutic problems listed in paragraph 1. a - g, above.

Pharmacies may receive additional ProDUR information in the response transaction. These are supplemental to those required by law to be performed by the pharmacy provider but 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 Databank. 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**

**CONFLICT CODES**

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**INTERVENTION CODES**

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**P0** Patient consulted  
**R0** Pharmacist consulted other source

**OUTCOME CODES**

**1B** Filled Rx as is  
**1C** Filled with different dose  
**1D** Filled with different directions  
**1F** Filled with different quantity  
**1G** Filled with prescriber approval

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 NDPDP version D.0, enter a Unit Dose Indicator of 3.

- 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.) – NDPDP D.0 Submission Clarification Code of 5.





## DRUG COVERAGE

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### 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. The drug must not have a Covered Outpatient Drug (COD) status of 5 or 6 (this replaced the DESI rating).
3. Compounds must be submitted as a compound via NCPDP version D.0 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 at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>. Also see the Department of Human Services, Medical Services web page at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html>.

### NON-COVERED SERVICES, GENERAL INFORMATION

The following are not covered by the Medicaid program:

1. Drugs determined to be less-than-effective (COD status of 5 or 6)
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 and therefore cannot be billed through a pharmacy claim.
- 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

## **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-COD status 5 or 6 drugs classified in First Databank as Therapeutic Code Generic 50.

2. AGENTS WHEN USED TO PROMOTE SMOKING CESSATION:

Coverage: Please visit our prior authorization website for current coverage requirements and criteria: <http://www.hidesigns.com/ndmedicaid>.

3. NON-PRESCRIPTION DRUGS:

Coverage: Analgesics, antacids, histamine-2 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.

4. SOME MEDICATIONS may require Prior Authorization as a condition of coverage. For a current list of medications, please refer to the website at [www.hidesigns.com/ndmedicaid](http://www.hidesigns.com/ndmedicaid).

5. 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:

- Aspirin
- Acetaminophen
- Certain prescription vitamins
- Non-prescription drugs listed in #4 above provided all prescription alternatives have failed



## REIMBURSEMENT OF DRUGS

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Effective 10/1/2016, for prescribed drugs that are covered by North Dakota Medicaid, including specific North Dakota Medicaid covered non-legend drugs that are prescribed by an authorized prescriber and legend drugs prescribed by an authorized prescriber, North Dakota Medicaid will reimburse at the following lesser of methodology (in all instances, the professional dispensing fee will be \$12.46):

1. The usual and customary charge to the public, or
2. North Dakota Medicaid's established Maximum Allowable Cost (MAC) for that drug plus the professional dispensing fee (ND Medicaid's MAC is acquisition cost based and includes all types of medications, including specialty and hemophilia products), or
3. The current National Average Drug Acquisition Cost (NADAC for that drug plus the professional dispensing fee, or if there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee; In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.
4. For 340B purchased drugs, the lesser of logic will include the 340B MAC pricing (ceiling price) plus the professional dispensing fee.
  - a. Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee.
  - b. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.
5. All Indian Health Service, Tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing (one encounter rate per person/facility per day).
6. For Federal Supply Schedule purchased drugs, their provider agreements will require them to bill at no more than their actual acquisition cost plus the professional dispensing fee.
7. Drugs not distributed by a retail community pharmacy (such as a long-term care facility) will be reimbursed as outlined in items 1-6 above and 8-13 below in this section.

8. Drugs not distributed by a retail community pharmacy and distributed primarily through the mail (such as specialty drugs) will be reimbursed as outlined in items 1-7 above and 9-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.
9. Clotting factors from Specialty Pharmacy, Hemophilia Treatment Centers (HTC), Center of Excellence will be reimbursed as outlined in items 1-8 above and 10-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.
10. Drugs acquired at Nominal Price (outside of 340B or FSS) will be reimbursed at no more than the actual acquisition plus the professional dispensing fee while also using the logic as outlined in items 1-9 above and 11-13 below in this section.
11. All of the logic as outlined in items 1-10 above in this section (with the exception of the professional dispensing fee being included in the calculations) will apply to Physician Administered Drugs (no professional dispensing fee will be paid for Physician Administered Drugs).
12. Investigational drugs are paid at invoice pricing which includes the cost of the drug, the international regulatory, shipping and handling fee, and next day delivery service.
13. A fee of fifteen cents per pill will be added to the dispensing fee for the service of pill splitting. Pill splitting is entirely voluntary for the patient and the pharmacist. Pill splitting will only be permitted under the following circumstances: when Medical Services determines it is cost effective, the pill is scored for ease of splitting, and the pharmacy staff splits the pill. This fee will only be allowed for medications that have been evaluated by the state for cost-effectiveness and entered into the Point-of-Sale system.

## **PHARMACY SERVICES PROGRAM REQUIREMENTS**

1. Federal Upper Limit (FUL) (<https://www.medicaid.gov/medicaid/prescription-drugs/federal-upper-limits/index.html>) or Maximum Allowable Cost (MAC) (<http://nddrug.rxexplorer.com/>) program.
2. Covered Outpatient Drug (COD) Status 5 and 6 drugs (replaced DESI to identify less than effective drugs): <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/data/index.html>.
3. Manufacturer/Labeler Drug Rebate agreement [www.medicaid.gov](http://www.medicaid.gov).
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

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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 the patient for the amount the Part D plan states and the recipient will have to bring their receipt to their county worker.

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.

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

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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. State staff will review these claims, contact the patient, and enter the insurance into the system.
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 denied.
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.

The amount of other insurance paid by the third party is indicated by NCPDP version D.0 fields 431-DV (other insurance payment amount) and 352-NQ (patient pay amount – equals copay due from patient per primary insurance(s)).

If the primary insurance denies a prescription, all options with the primary insurance must be exhausted (appeal for formulary coverage, prior authorization, changing medications to a formulary medication, etc.). If a pharmacy submits a claim (with false information populated in 431-DV or 352-NQ) that was denied by the primary insurance to Medicaid for payment, that will be considered fraud. Field 352-NQ cannot be populated unless the primary insurance actually processed the claim as a paid claim. For questions regarding Third Party Liability, please call our TPL help desk at 701-328-2347 or e-mail at [medicaidtpl@nd.gov](mailto:medicaidtpl@nd.gov).





## **COORDINATED SERVICES PROGRAM (CSP)**

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

Coordinated Services Program status is made available by notices mailed to providers 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 prescriber 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 prescriber to verify the referral and authorize continued dispensing. It is inappropriate to simply change the prescriber to the CSP prescriber if there is no referral. The CSP prescriber should be advised to send a copy of the CSP referral to the state office. When a referral is verified, the pharmacy will be able to bill for prescriptions written by the referred to provider.

### **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. For a single course of therapy for antibiotics and single unit-of-use products, such as inhalers, the department will allow a 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

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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. The NDC dispensed is the NDC that must be billed to ND Medicaid.
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.
7. Automatic refills and automatic shipments are not allowed. Medicaid does not pay for any prescription (original or refill) based on a provider's auto-refill policy. Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a member or their responsible party may be subject to recovery. Any pharmacy provider who pursues a policy that includes filling prescriptions on a regular date or any type of cyclical procedure may be subject to audit, claim recovery or possible suspension or termination of their provider agreement.



## INSTRUCTIONS FOR POINT-OF-SALE (POS) BILLING

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North Dakota Medicaid only accepts electronic claims or claims that the provider enters through our web portal at [mmis.nd.gov](http://mmis.nd.gov). Pharmacies submitting via POS must submit claims in the National Council for Prescription Drug Programs (NCPDP) version D.0.

All claims submitted are processed in real time and will be either paid or denied. Paid 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 on page 15 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 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.
  - d. Processing credits for restocking unused medications for long term care patients is not supported with version D.0. Therefore, reverse the original claim and then rebill via POS for the amount of product actually used.
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. 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.
8. 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:

RelayHealth Help Desk	1-800-401-5973
eRx Help Desk	1-866-379-6389

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**

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### **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.
- c. Call the Medicaid state office Provider Relations staff at 1-701-328-4030 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 on Page 3 of this Manual. Refunds will be handled the same as adjustments (above).



## **LONG TERM CARE CREDIT**

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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.



## **AUTOMATIC REFILLS AND SHIPMENTS**

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Automatic refills and automatic shipments are not allowed. Medicaid does not pay for any prescription (original or refill) based on a provider's auto-refill policy.

Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

Any prescriptions filled without a request from a member or their responsible party may be subject to recovery. Any pharmacy provider who pursues a policy that includes filling prescriptions on a regular date or any type of cyclical procedure may be subject to audit, claim recovery or possible suspension or termination of their provider agreement.

## MEDICARE PART B COVERED ITEMS

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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





## **DRUG EFFICACY STUDY IMPLEMENTATION (DESI) PROGRAM**

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



## COMPOUNDED ITEMS

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Compounds must be submitted using NCPDP version D.0 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 as outlined in the REIMBURSEMENT OF DRUGS section.

No hard copy claims are allowed for compounds - the only functionality is for NCPDP version D.0 standards. Also, ND Medicaid must calculate the reimbursement amount total for all ingredients, so field 442 E7 must be equal to the sum of the multiple iterations of field 448 ED (field 442 E7 has to be the final quantity of what is dispensed while 448 ED values have to be the quantity dispensed for each individual ingredient of the compound).



## DURABLE MEDICAL EQUIPMENT (DME)

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*For those pharmacies dispensing Durable Medical Equipment (DME), you are required to comply with everything in the DHS [DME Manual](#).*

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

Covered diabetic supplies (strips, lancets, machines, syringes, pen needles) are reimbursable using NDC numbers billed as a POS claims, provided the primary insurance also allows POS billing. Medicare Part B claims are not payable through POS.

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/dhs/services/medicalserv/medicaid/docs/dme/dme-manual.pdf>

SFN 1115 Durable Medical Equipment Prior Authorization form is located at:  
<http://www.nd.gov/eforms/Doc/sfn01115.pdf>. Refer to Attachment A of this manual.



## **ROUTINE DRUGS, SUPPLIES & DME FOR LONG TERM CARE FACILITIES**

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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 medications, IV solutions with medication admixed, and legend drugs. These are allowed for separate payment.

Refer to Appendix B of this manual.



## MANUFACTURER/LABELER DRUG REBATE AGREEMENT PROGRAM

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OBRA 90 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.



## AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

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The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- ▽ Member Inquiry
- ▽ Payment Inquiry
- ▽ Service Authorization Inquiry
- ▽ Claims Status

### AVRS Access Telephone Numbers (available 24/7)

**Toll Free: 877-328-7098**

**Local: 701-328-7098**

Providers are granted access to the Automated Voice Response System (AVRS) by entering the new ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One PIN number is assigned to each Medicaid ID number.

Touch Tone Phone Entry	Function
*	Repeat the options
<b>9 (nine)</b>	Return to main menu
<b>0 (zero)</b>	Transfer to Provider Call Center (M-F 8am – 5pm CT) –or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVR system at any point to speak with a Provider Call Center customer service representative. The call center is available during regular business hours from 8am to 5pm Central Time, Monday through Friday, and observes the same holidays as the State of North Dakota. Providers may also elect to leave a voicemail message at any time when the call center is not available. Except during heavy call times, provider voice mail messages will be responded to in the order received on the following business day during regular business hours.

AVRS Options	Secondary Selections
<b>Option 1:</b> <b>Member</b> <b>Inquiry</b>	Callers may select any of the following options: <ul style="list-style-type: none"> <li>▪ Eligibility/Recipient Liability</li> <li>▪ Primary Care Provider (PCP)</li> <li>▪ Coordinated Services Program (CSP) enrollment</li> <li>▪ Third Party Liability (TPL)</li> <li>▪ Vision</li> <li>▪ Dental</li> <li>▪ Service Authorizations</li> </ul>
<b>Option 2:</b> <b>Payment</b>	Remittance Advice payment information is available for the specific time frame entered.

**CSHS**

CSHS eligibility information is not available on AVRS. Eligibility for CSHS recipients must be determined by contacting the state CSHS office.

**WOMEN’S WAY**

**Women’s Way** is a breast and cervical cancer early detection program available to eligible North Dakota women. Women who are in active treatment and a ND Medicaid eligible through the Women’s Way coverage group are entitled to full ND Medicaid coverage, including dental. Women’s Way eligibility information is not available on the AVRS system. Women’s Way recipient identification numbers begin with WW0000000. Questions on Women’s Way eligibility can be directed to Provider Relations at 701-328-4030.

**HEALTHY STEPS**

Healthy Steps eligibility and benefit information is available by calling Blue Cross Blue Sheild of North Dakota at 1-800-342-4718.



## APPENDIX A - NON-COVERED EQUIPMENT AND SUPPLY LIST – DURABLE MEDICAL EQUIPMENT AND SUPPLY PROGRAM

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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 lymphademaal 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



## **APPENDIX B - ROUTINE DRUGS, SUPPLIES AND DURABLE MEDICAL EQUIPMENT FOR NURSING FACILITIES, ICF/MR FACILITIES, AND SWING BED FACILITIES**

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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**

1. Over-the counter (non-legend) items, including but not limited to:

- Aspirin, Acetaminophen
- Antacids
- Antidiarrheals
- Antihistamines
- Hemorrhoidal Preparations
- Laxatives
- Liniments
- Lotions/Creams
- Vitamins

2. 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

3. 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, Ketodiasix, 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)

4. 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)