

# **Louisiana Medicaid Program Provider Manual**

## **Chapter 37**

### **Pharmacy Benefits Management Services**



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: UPDATE LOG**

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**UPDATE LOG**

**HOW TO USE THE UPDATE LOG**

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Introduction

Periodically letters and remittance advices (RAs) are sent to providers regarding policy revisions or additions. Providers should maintain these communications until updates to the Chapter are issued.

It is very important that the provider read and maintain the updated material as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

If a letter or RA is missed, write or call the Medicaid fiscal intermediary help desk. In addition these correspondences are available online at [www.lamedicaid.com](http://www.lamedicaid.com)

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Explanation of the  
Update Log

The provider can use the update log to determine receipt of all correspondences issued by the Louisiana Medicaid Pharmacy Benefits Management Section.

Update No. is a sequential numbering of revisions.

Revised Date is the date that the update was issued.

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UPDATE NO.	REVISED
37-001 New Manual	12/01/2005
37-002 Policy Changes (Sections 37.5.2, 37.5.3, 37.6.3, and 37.7.6)	05/01/2006
37-003 Policy Change (Section 37.6.3)	08/20/06
37-004 Policy Changes	08/15/07
37-005 Policy Changes	11/01/08
37-006 Policy Changes (Section 37.5.6 and 37.9.9)	05/01/09
37-007 Policy Changes (Sections 37.5.7 and 37.5.8)	06/17/09
37-008 Policy Changes (Sections 37.5.7, 37.5.8, 37.8.3 and 37.9.5)	10/01/09
37-009 Policy Changes (Sections 37.2.1, 37.5.3, 37.5.8, 37.14	11/20/09
37-010 Policy Changes (Sections 37.4.2, 37.5.7, 37.5.8, 37.9.5, and 37.22.8	02/19/10
37-011 Policy Changes (Sections 37.2.1, 37.5.3, 37.5.6, 37.5.7, 37.5.8, 37.6.5, 37.8.5, 37.9.2, 37.9.5, 37.13, 37.14,	12/15/10
37-012 Policy Changes (Sections 37.5.7, 37.5.8, 37.9.5)	04/01/11
37-013 Policy Changes (Sections 37.8, 37.9, 37.14, 37.20)	01/01/12

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: INTRODUCTION TO THE CHAPTER**

**INTRODUCTION TO THE CHAPTER**

**Overview**

Introduction

Chapter 37 explains covered pharmacy services and limits, who is eligible to receive these services, provider qualifications and enrollment, how to file claims, Medicaid reimbursement, and other relative Medicaid pharmacy program policies and procedures.

The purpose of the Pharmacy Benefits Management Services Chapter is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Louisiana Medicaid recipients.

The following introduces the format used to prepare the Pharmacy Benefits Management Chapter and tells the reader how to use the Chapter.

In This Section

This Section contains:

TOPIC	PAGE
Characteristics of the Chapter	ii
Chapter Updates	iii

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: INTRODUCTION TO THE CHAPTER**

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**CHARACTERISTICS OF THE CHAPTER**

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Format	The format used in this Chapter represents a concise and consistent way of displaying complex, technical material.
Numbering System	<p>The header on each page designates the title of the Chapter and Section. The major subject areas are numbered with the Chapter number and Section number (Example: 37.1.1).</p> <p>Pages are numbered consecutively by Section. Page numbers follow the Section numbers found at the bottom of each page. (Example: 1-1)</p>
Issue Date	The month, day and year that the Section is issued will appear at the top right corner of each page.
Revised Date	<p>The month, day and year that any revised material is issued will appear under the Issue Date at the top right corner of each page.</p> <p>The provider can check this date to ensure that the material being used is the most current and up to date.</p>
Introduction	Each Section will include a brief summary of the material contained within.
Topic Roster	Each Section contains a topic roster, which lists the major subject areas covered in the Section and gives the page number where the subject can be found. This topic roster serves as a table of contents within each Section.
Label	<p>Labels or names are located in the left margin of each information block. They describe the content or function of the block.</p> <p>Labels provide key subject matter identification which facilitates scanning and locating information quickly within a Section of this Chapter.</p>
Information Block	<p>One of the major features of the format is the information block, which replaces the traditional paragraph. Blocks are separated by horizontal lines.</p> <p>The block consists of one or more paragraphs or diagrams about a portion of a subject. Each block is identified or named with a label.</p>

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: INTRODUCTION TO THE CHAPTER**

**CHARACTERISTICS OF THE CHAPTER, continued**

Note

**Note:** is used most frequently to refer the user to material located elsewhere in the Chapter that is pertinent to the subject being addressed within the information block.

**Note:** Also refers the user to other documents or policies contained in other Chapters of the Louisiana Medicaid Program Provider Manual.

White Space

The “white space” format style throughout the Chapter is characteristic of the Chapter format style. It enhances readability and allows space for writing notes during training and for on-the-job reference.

**CHAPTER UPDATES**

How Changes Are  
Updated

The Chapter will be updated as policy is added or revised.

All changes will be updated on the website.

Update Log

The Update Log serves as a reference for the provider to be sure that each update has been received.

An “Update No.” will be indicated in the first column on the update log. The second column is titled the “Revised Date” and indicates the date that the update was issued.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.1 GENERAL PROGRAM INFORMATION**

**37.1 GENERAL PROGRAM INFORMATION**

**Overview**

Introduction

This Section presents an overview of the Louisiana Medicaid Program and its legal authority, organization and administration.

**Note:** Additional General Information is provided in Chapter 1 of the Louisiana Medicaid Program Provider Manual.

In This Section

This Section contains:

TOPIC	PAGE
Background	1-2
Legal Authority	1-2
Medicaid Program	1-2
Louisiana Medicaid Pharmacy Benefits Management Section	1-3
Medicaid Management Information System (MMIS)	1-4

### **37.1.1 BACKGROUND**

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Medicaid is a joint federal and state governments funded program enacted by Title XIX of amendments to the Federal Social Security Act in 1965. The program was implemented in Louisiana in 1966.

The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), set the guidelines for a state's participation in Medicaid and monitors the services covered by the program.

In Louisiana, the program is designed to provide certain healthcare benefits for those categorically needy and medically needy recipients who are in need of medical services.

Medicaid reimburses Louisiana Medicaid enrolled health professionals and other qualified providers from state and federal funds for medically necessary services and/or supplies performed and/or delivered to Medicaid recipients.

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### **37.1.2 LEGAL AUTHORITY**

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The Medicaid program is authorized by Title XIX of the Federal Social Security Act and Title 42 of the Code of Federal Regulations. The Louisiana Medicaid program is authorized by La. R.S. 36:251 et seq.

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### **37.1.3 MEDICAID PROGRAM**

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The Department of Health and Hospitals (the Department), Bureau of Health Services Financing (BHSF, the Bureau or Medicaid) is responsible for administering the program in compliance with state and federal laws, regulations and guidelines.

Responsibilities include the following functions:

- Administering the program including developing policies, regulations and procedures relative to the program;
- Determining the services covered by the program and setting the reimbursement methodologies and rates within state and federal regulations and guidelines;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.1 GENERAL PROGRAM INFORMATION**

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**37.1.3 MEDICAID PROGRAM, continued**

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- Determining service limits within state and federal regulations and guidelines;
  - Determining categories of assistance to be covered within state and federal laws and regulations;
  - Determining eligibility of applicants, maintaining the recipient eligibility file and issuing Medicaid cards to program eligibles;
  - Enrolling providers who want to participate in the program; and
  - Operating the Medicaid Management Information System (MMIS) and processing claims from providers through a fiscal intermediary contract.
- 

**37.1.4 LOUISIANA MEDICAID PHARMACY BENEFITS MANAGEMENT  
SECTION**

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The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) Section within the Bureau is responsible for the development, implementation and administration of the Medicaid pharmacy program. The LMPBM is the first state-owned and administered Pharmacy Benefit Management (PBM) System in the nation. The LMPBM Section is charged with the responsibility of assuring quality pharmacy services while developing efficiencies in operation, service and cost.

The LMPBM Section is responsible for the daily operational activities for pharmacy prescription services, including total parenteral nutrition (TPN). Prescription services are one of the largest service and expenditure areas under the Medicaid program.

The pharmacy program covers all Food and Drug Administration (FDA) approved legend drugs that meet the OBRA '90 and OBRA '93 criteria with a few exceptions. The LMPBM Section determines the reimbursement methodology for both the drug ingredient cost and the maximum allowable overhead cost (dispensing fee) for covered drugs.

The LMPBM Section consists of the following components:

- Policy;
- Program development and implementation;
- Network development;
- Program coverage;
- Preferred drug list development and implementation and prior authorization for certain drug categories;



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.1 GENERAL PROGRAM INFORMATION**

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**37.1.4 LOUISIANA MEDICAID PHARMACY BENEFITS MANAGEMENT  
SECTION, continued**

- 
- Federal upper limit and state maximum allowable cost limits for multiple source drugs;
  - Claims management,
  - Clinical interventions, including pharmaceutical care management;
  - Pre- and post-payment drug utilization review;
  - Electronic Prescribing;
  - Federal and state supplemental pharmaceutical manufacturer rebates;
  - Pharmacy provider desk and field audits,
  - Disease and outcomes management;
  - Recipient lock-in program;
  - Provider help desk;
  - Recipient help desk;
  - Provider relations; and
  - Provider education for prescribers and pharmacists on peer-based prescribing and dispensing practices.

Program staff in the Section administers contracts for functions essential to the administration of the LMPBM program.

The LMPBM Section initiates policy development, implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and Medicare/Medicaid pharmacy claim crossovers. The Section approves all new drugs added to program coverage and establishes any limitations on reimbursement or coverage in accordance with the federally approved reimbursement methodology. The Section directs an extensive network of over 1200 pharmacy providers. This Section is also responsible for the integrity of several subsystems including the drug file component of reference subsystem, the Drug Utilization Review subsystem and the drug portion of the Surveillance and Utilization Review subsystem.

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**37.1.5 MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)**

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The Medicaid Management Information System (MMIS) is a claims processing and information system designed to manage the Medicaid program's expenditures through effective claims processing and utilization control.

The Department contracts with a fiscal intermediary who operates the federally approved MMIS consistent with CMS and Department requirements.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.1 GENERAL PROGRAM INFORMATION**

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**37.1.5 MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS),**  
continued

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The fiscal intermediary is contracted to provide the following pharmacy related services:

- Pharmacy claim processing through an on-line real-time Point of Sale (POS) system;
  - Coordination of the federally mandated Omnibus Budget Reconciliation Act of 1990 Drug Utilization Review (DUR) Board activities;
  - Retrospective Drug Utilization Review (LADUR);
  - Prospective Drug Utilization Review (UniDUR);
  - Disease State Management Initiatives (DSM);
  - Educational brochures - Disease state specific-(Prescriber & Pharmacy);
  - Educational brochures - Disease state specific-(Recipient);
  - Educational Articles - "Provider Update" newsletter;
  - Lock-In Program;
  - Drug Utilization Review Board (DURB) coordination;
  - Surveillance Utilization Review (SUR) post payment services review;
  - Louisiana Pharmacy Federal and State Supplemental Rebate Information Management System (LAPRIMS);
  - Operation of the legislatively mandated Prescribing Practitioner and Pharmacy Peer-based Profiling Program;
  - Preferred Drug List and Prior Authorization System;
  - Monthly Prescription Limit System; and
  - Electronic Data Inquiry/Clinical Drug Inquiry System (e-CDI).
-

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2 PHARMACY PROVIDER ENROLLMENT AND PARTICIPATION  
GUIDELINES**

**Overview**

**Introduction**

This Section describes pharmacy provider qualifications, enrollment, the provider record, how the provider can make changes to the provider record, IRS reporting, provider rights and responsibilities, record keeping requirements, billing agents, and Point of Sale enrollment.

**Note:** Providers should refer to Chapters 3 and 4 of the Louisiana Medicaid Program Provider Manual for additional information on Provider Enrollment and Requirements, including General Standards for Participation.

**In This Section**

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Provider Rights and Responsibilities	2-3
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**

**PARTICIPATION GUIDELINES**

**37.2.1 PROVIDER QUALIFICATIONS**

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To receive Medicaid reimbursement, a provider must be enrolled in Louisiana Medicaid and meet the provider qualifications at the time the service is rendered.

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Pharmacy Definition      A Pharmacy is a facility licensed in accordance with the La. R.S. 37:§1164 (36): “Pharmacy means any place located within this state where drugs are dispensed and pharmacy primary care is provided, and any place outside of this state where drugs are dispensed and pharmacy primary care is provided to residents of this state.”

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Provider Qualifications      The Medicaid program reimburses pharmacies, not individual pharmacists, for the provision of prescribed drugs.

To enroll in Medicaid, the pharmacy must have a community pharmacy or institutional pharmacy permit issued by the Louisiana Board of Pharmacy as defined by the Board’s regulations at LAC, 46:LIIL, §1301 and §1701.

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Administering Pharmacists      Pharmacists who have the Authority to Administer authorized by the Louisiana Board of Pharmacy may administer the influenza vaccine. These pharmacists who have this authority are required to obtain a Medicaid pharmacist provider number in order for the enrolled pharmacies to be reimbursed for the administration of this vaccine.

**Note:** Refer to Section 37.14 medication Administration for detailed information.

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Dispensing Physicians      Payment will be made for medications dispensed by a physician on a continuous basis only if the physician meets all of the following conditions:

- Is permitted with the Louisiana Board of Medical Examiners as a dispensing physician;
- When his/her main office is more than five miles from a facility which dispenses drugs; and
- Enrolls in the Medicaid program as a pharmacy provider and complies with all other requirements of the prescribed drug services program.

Under the above circumstances, vendor payment (when the treating physician dispenses his own medications and bills under his own name or the name of his own clinic or hospital) will be made on the same basis as to pharmacy providers.

**Note:** Refer to Section 37.6 Reimbursement for Services for detailed information.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**

**PARTICIPATION GUIDELINES**

**37.2.2 PROVIDER RIGHTS AND RESPONSIBILITIES**

Right to Refuse Services A provider is not required to provide services to every recipient who requests services. A provider can limit the number of Medicaid recipients that the provider serves, and accept or reject recipients according to the pharmacy's policies, except for the reasons described below:

- A provider cannot deny services to a recipient solely due to race, creed, color, national origin, disabling condition, or disability in accordance with the federal anti-discrimination laws;
- A provider cannot deny services to a recipient due solely to the presence of third party insurance coverage or the recipient's inability to pay a Medicaid co-payment.

Medical Assistance  
Program Integrity  
Law (MAPIL)

The Louisiana Medical Assistance Program Integrity Law, La. R.S. 46:437.1-46:440.3 imposes terms and conditions on Medicaid providers. The following is an outline of some of the terms and conditions and is not all inclusive:

- Comply with all federal and state laws and regulations;
- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- Have all necessary and required licenses or certificates;
- **Maintain and retain all records for a period of at least five (5) years;**
- Allow for inspection of all records by governmental authorities;
- Safeguard against disclosure of information in patient medical records;
- Bill other insurers and third parties prior to billing Medicaid;
- Report and refund any and all overpayments;
- Accept payment in full for Medicaid recipients providing allowances for co-pay authorized by Medicaid;
- Agree to be subject to claims review;
- The buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- Notification prior to any change in ownership;
- Inspection of facilities; and
- Posting of bond or letter of credit when required.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2.2 PROVIDER RIGHTS AND RESPONSIBILITIES, continued**

**Prescription  
Provider Fee**

A prescription fee shall be paid by each pharmacy and dispensing physician for each out-patient prescription (Medicaid and non-Medicaid) dispensed. The fee shall be \$.10 per prescription dispensed by a pharmacist or dispensing physician. When a prescription is filled outside of Louisiana but not shipped or delivered in any form or manner to a patient in the state, no provider fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana shall be subject to the \$.10 fee per prescription.

Medicaid enrolled pharmacy providers must comply with this requirement as a condition of participation in Louisiana's Medicaid program.

Activity reports, either manually or electronically produced, must be available upon request and on-site at the store. These reports must detail the number of prescriptions dispensed on which provider fees were paid, by month for any given month. Providers are assessed on a quarterly basis by DHH. This information must be readily available during an audit when requested by a representative of Medicaid.

**Dispensing Cost  
Survey**

As a condition of enrollment, all pharmacy providers must complete an overhead cost survey (commonly known as a dispensing cost survey). The purpose of this survey is to determine the cost of dispensing prescriptions in the State of Louisiana.

In addition, periodically, Medicaid conducts overhead cost surveys of all participating pharmacy providers to determine the accuracy of the maximum allowable overhead cost (dispensing fee). All providers are required to complete these surveys as well.

**Federal Anti-  
Discrimination Laws**

Providers must adhere to the following federal laws in order to maintain eligibility:

- Civil Rights Act of 1964, which prohibits discrimination on the basis of race, creed, color or national origin;
- Section 504 of the Rehabilitation Act of 1975, which prohibits discrimination on the basis of a disabling condition; and
- Americans with Disabilities Act of 1990, which assures equal access to services for persons with disabilities.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**

**PARTICIPATION GUIDELINES**

**37.2.2 PROVIDER RIGHTS AND RESPONSIBILITIES, continued**

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Solicitation	In accordance with La. R.S. 46:438.2, La. R.S. 46:438.4 and 42 U.S.C. 1320a-7b it is unlawful to:
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Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending obtaining, purchasing, leasing, or ordering any goods, facility, item, or service for which payment may be made, in whole or in part, under the Medicaid program.

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Confidentiality	All information about Medicaid recipients is confidential under federal law. Information cannot be released without the patient's written consent unless the provider is billing a third party or releasing the information to a billing agent. Billing agents must adhere to all federal and state confidentiality requirements.
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All medical and billing records must be made available to official representatives of the Medicaid program upon request; however, the requester must show identification.

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Health Insurance Portability and Accountability Act (HIPAA)	State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations <b>42 CFR 447.202</b> .
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The Louisiana Department of Health and Hospitals (DHH) is a covered entity under HIPAA. Therefore, DHH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to DHH contractors when acting on behalf of DHH. The federal HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose Protected Health Information (PHI) for treatment, payment, or health care operations. In addition, a "HIPAA Authorization" or "Opportunity to Agree or Object" by the individual is not required for uses and disclosures required by law.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2.3 RECORD KEEPING REQUIREMENTS**

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	<p>The provider must retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient. Records may be kept on paper, magnetic material, film, or other media.</p> <p>The records must be accessible, legible and comprehensible.</p>
Record Retention	<p>Providers must maintain and retain all records for a period of at least five years from the date of service.</p>
Types of Records That Must be Retained	<p>The following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):</p> <ul style="list-style-type: none"><li>• Medicaid claim forms and any documents that are attached;</li><li>• Professional records, such as patient treatment plans and patient records;</li><li>• Prior and post authorization, and service authorization information;</li><li>• Prescription records for Medicaid as well as those for all other patients (including Medicare, private pay and cash);</li><li>• Business records, such as accounting ledgers, financial statements, purchase/acquisition records, invoices, inventory records, check registers, canceled checks, sales records, etc.;</li><li>• Tax records, including purchase documentation; and</li><li>• Provider enrollment documentation.</li></ul>
Requirements for Prescription Record	<p>The Pharmacy must maintain a patient record for each recipient for whom new or refill prescriptions are dispensed. The record may be electronic or hard copy. The pharmacy's patient record system must provide for the immediate retrieval of the information necessary for the pharmacist to identify previously dispensed drugs when dispensing a new or refill prescription.</p> <p>Additionally, all records must be maintained in accordance with the Louisiana Board of Pharmacy regulations.</p>

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**  
**PARTICIPATION GUIDELINES**

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**37.2.3 RECORD KEEPING REQUIREMENTS, continued**

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**Right to Review  
Records**

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records.

The provider must send or make available, at his or her expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives.

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**Incomplete Records**

Providers who are not in compliance with the Medicaid documentation and record retention policies described in this Section may be subject to administrative sanctions and recoupment of Medicaid payments.

Medicaid payments for services lacking required documentation or appropriate signatures will be recouped.

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**37.2.4 PROHIBITION OF REASSIGNMENT OF PROVIDER CLAIMS**

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Medicaid payments cannot be reassigned to a factor. A factor is an individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a billing agent.

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**37.2.5 OUT-OF-STATE PROVIDERS**

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**Eligible Recipient  
Out-of-State**

Louisiana Medicaid will reimburse out-of-state services only under one of the following circumstances:

- Where an emergency arises from an accident or illness;
- Where the health of the individual would be endangered if he/she undertook travel to return to the State of Louisiana;
- Where the health of the individual would be endangered if the care and services are postponed until he/she returns to the state;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

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PARTICIPATION GUIDELINES**

**37.2.5 OUT-OF-STATE PROVIDERS, continued**

- 
- When it is general practice for residents of a particular locality to use medical resources in the medical marketing areas outside of the state; or
  - When the medical care and services or needed supplementary resources are not available within the state. Prior approval for these services is required.

These are the only circumstances in which an out-of-state pharmacy may be reimbursed for providing pharmacy services to Louisiana Medicaid recipients. The out-of-state pharmacy must obtain a provider enrollment number to secure reimbursement.

The out-of-state enrollment criteria does not apply to Medicare crossover claims. A provider must be enrolled as a Medicare provider in order to submit Medicare crossover claims. When enrolling in the Medicaid program, out-of-state pharmacies must indicate that crossover billing is requested. Some out-of-state providers will be allowed continuous Medicaid enrollment for Medicare crossover claims only.

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Recipients out of the  
Country

Medicaid does not reimburse for services provided to recipients when they are out of the United States.

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**37.2.6 PROVIDER ENROLLMENT**

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Medicaid  
Enrollment

Every pharmacy must submit a provider enrollment application and sign an agreement in order to provide Medicaid services.

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Medicaid  
Durable Medical  
Equipment/Supplies

A Pharmacy provider is enrolled to bill for pharmacy services and durable medical equipment/supplies with one provider number.

**Note:** Refer to Louisiana Medicaid Program Provider Manual Chapter 18 Durable Medical Equipment for detailed information.

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Medicare  
Enrollment

Pharmacies must contact the Medicare regional carrier to enroll as a Medicare provider. The carrier for DMERC Region C is Cigna. The provider may contact the National Supplier Clearinghouse at 866-238-9652.

**Note:** Refer to Section 37.7 Medicare Prescription Drug Coverage for detailed information.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**  
**PARTICIPATION GUIDELINES**

**37.2.7 ENROLLMENT PROCESS**

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The provider must submit a Medicaid enrollment package to the Medicaid fiscal intermediary. The fiscal intermediary will notify the provider in writing when the provider has been enrolled.

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Where to Obtain  
Enrollment  
Forms

Provider Enrollment forms can be obtained online at [www.lamedicaid.com](http://www.lamedicaid.com) or from the Medicaid fiscal intermediary. To obtain enrollment forms, the provider may call or write:

Molina  
225-216-6370  
**OR**  
Molina Provider Enrollment Unit  
P. O. Box 80159  
Baton Rouge, LA 70898-0159

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Enrollment Forms

To enroll in the Medicaid program, a provider must submit the following documents to the fiscal intermediary:

- Completed Form PE-50;
  - Copy of pre-printed IRS document showing Employer Identification Number (EIN) – CPO-545 or pre-printed Payment Coupon is acceptable – (W-9 forms are not acceptable.);
  - Completed Disclosure of Ownership and Control Interest Statement (CMS-1513) Form;
  - Completed Dispensing Cost Survey Forms;
  - Completed Point of Sale Forms POS-1, POS-2 and PE-50-PHCY;
  - Copy of Voided check – for account to which you wish to have your funds electronically deposited (deposit slips are not accepted); and
  - Copy of Pharmacy license from the State Board of Pharmacy. If requesting retroactive coverage, license must be submitted that covers the retroactive period of coverage.
- 

Accuracy of Information

All statements or documents submitted by the provider must be true and accurate. Filing of false information is sufficient cause for termination from participation or denial of an application for enrollment.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**  
**PARTICIPATION GUIDELINES**

**37.2.7 ENROLLMENT PROCESS, continued**

Effective Date of Enrollment	<p>Providers can request the desired date their new Medicaid provider number will become effective. The effective date entered will be considered in the enrollment process. All eligibility requirements must be met on the date requested for the date to be considered.</p> <p>Providers shall not bill until they receive confirmation from Medicaid that they are enrolled in Medicaid. Providers shall be in receipt of their Medicaid provider numbers and the effective date of enrollment prior to billing.</p>
Enrollment Application	<p>The provider enrollment application asks the applicant to provide certain information including: provider name, telephone number(s), address, applicable license number(s), tax ID number, category of service, specialty, all group affiliations, a list of all owners with five percent or more interest, and alternate addresses, if applicable.</p>
Licensure and Permits	<p>Prescribed drug services providers must submit complete and legible copies of the required licenses and permits with the enrollment applications.</p>
National Provider Identifier (NPI)	<p>As a requirement of Federal regulation, providers must have a National Provider Identifier (NPI) and utilize the NPI to identify themselves as a healthcare provider in the standard transaction.</p> <p>The NPI must be registered with Louisiana Medicaid prior to submission on a claim.</p>
Electronic Funds Transfer	<p>Providers must complete and submit Electronic Funds Transfer forms with the enrollment package. Medicaid requires all providers to receive reimbursement through electronic funds transfer.</p>
Tax ID Numbers	<p>Providers must submit legible documentation of their tax ID numbers to enroll in Medicaid.</p>
Termination	<p>A provider agreement can be terminated for any reason, at any time, by the provider or the state with 30 days written notice. All the conditions of the agreement remain in effect during the 30-day notice period and until termination is completed.</p>

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND**

**PARTICIPATION GUIDELINES**

**37.2.7 ENROLLMENT PROCESS, continued**

Termination,  
continued

Exceptions to the 30-day notice, including but not limited to, are:

- If the provider is required to be licensed or certified, the effective date of termination will be the date that the license or certification became invalid;
- If the provider is suspended, excluded or terminated from Medicare or any state's Medicaid program; or
- If the provider's business is closed, abandoned, or non-operational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational.

Reinstatement

To request reinstatement after a termination or suspension period, the provider must submit a new application, provider agreement, and other required forms to the fiscal agent. If the provider is enrolling under a different name or different tax ID number, the provider must furnish the prior name and tax ID number with the application.

**37.2.8 POINT OF SALE ENROLLMENT**

Point of Sale

Point of Sale (POS) claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed through the claims processing cycle in real-time; and a response indicating that the recipient is eligible or ineligible and that the claim is payable or rejected is returned to the pharmacy within seconds of submission.

Application Forms

To obtain authorization to submit claims via POS, the provider must complete, sign and send the following forms that are included in the provider enrollment packet:

- Medicaid Pharmacy Point of Sale Provider Certification;
- Medicaid Point of Sale Agreement; and
- Pharmacy Provider Enrollment Amendment Point of Sale Enrollment.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2.8 POINT OF SALE ENROLLMENT, continued**

Annual  
Re-certification

Providers must renew their POS Certifications annually. All applicable sections of this form must be completed in order for the recertification to be accepted by the Department. Recertification forms are mailed in October by the Department and are effective the following January.

**37.2.9 PROVIDER RECORD**

Provider Record

A provider record is created by the Medicaid fiscal intermediary for each provider from the information given on the initial enrollment application.

Provider ID Number

After the provider has been approved for enrollment in the Medicaid program, the fiscal intermediary assigns the provider a seven-digit provider number to identify the provider for billing and correspondence purposes. The provider must include the provider number on all correspondence to the fiscal intermediary or the Medicaid office.

**37.2.10 CHANGE OF ADDRESS PROCEDURES**

Medicaid Provider  
Change of Address

The provider must notify the Medicaid fiscal intermediary by telephone or in writing of any change of address. The notification must include the new business and mailing address(es), the physical location if different, the provider's previous address(es), and the effective date. The Provider Enrollment Unit can be contacted at 225-216-6370.

Medicaid correspondence is sent to the billing address listed on the provider record. Changes in addresses must be promptly reported.

**37.2.11 OTHER CHANGES TO PROVIDER RECORDS**

Requesting a Change  
Other Than an Address  
Change

Information in a provider's record can only be changed by the provider submitting a written, signed and dated request on letterhead stationery. The provider number must be included.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2.11 OTHER CHANGES TO PROVIDER RECORDS, continued**

Where to Send Request for Changes	Providers must send the letter to:  Molina Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159
Provider No Longer Accepts Medicaid	The provider must notify the Medicaid fiscal intermediary if the Medicaid pharmacy no longer accepts Medicaid for any reason, including closing the business.
Telephone Number	The provider must report changes in telephone numbers. Notice of a change in telephone number(s) must include the new telephone number(s), the provider's previous telephone number(s), and the effective date of the change.
Federal Tax ID/ Social Security Number	If a provider's federal tax identification/social security number changes, a new provider enrollment application must be completed.
Electronic Funds Transfer	If changing financial institutions or accounts, the provider must notify the fiscal intermediary Provider Enrollment Unit at least 60 days in advance. Failure to do so may result in lack of payment.

**37.2.12 CHANGE OF OWNERSHIP**

Name	The provider must contact the fiscal intermediary's Provider Enrollment Unit to report a name change.
Ownership	<p>The provider must notify the Medicaid fiscal intermediary immediately of a change in ownership. Failure to do so may result in departmental review.</p> <p>Upon completion of a new application and other required forms, the provider obtaining the new ownership will be assigned a new provider number.</p>

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.2 PHARMACY PROVIDER ENROLLMENT AND  
PARTICIPATION GUIDELINES**

**37.2.13 REPORTING TO THE IRS**

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Information Reported  
to the IRS

Federal law requires Medicaid to report to the Internal Revenue Service all payments made during the calendar year to any provider who received payment under a tax ID number.

**Note:** Refer to Section 37.2.11 Other Changes to Provider Records for information on reporting a change to a tax ID number

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IRS Form 1099

Medicaid reports payments to the IRS annually on Form 1099. A copy is also sent to each provider.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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## **37.3 MEDICAID RECIPIENT ELIGIBILITY**

### **Overview**

#### **Introduction**

This Section describes who can qualify for Medicaid benefits in Louisiana and the different eligibility groups and limitations.

Additionally, this Section informs providers of the processes used to verify Medicaid eligibility.

**Note:** Providers should refer to Chapter 2 of the Louisiana Medicaid Program Provider Manual for detailed information about recipient eligibility.

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#### **In This Section**

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.1 ELIGIBILITY DETERMINATION**

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Eligibility Requirements	To qualify for Medicaid, an individual must meet specific eligibility requirements, such as income, assets, age, citizenship or resident alien status, and Louisiana residency. The individual must have a social security number or proof of having applied for one.
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Who Determines Eligibility	Eligibility for Medicaid is determined by the Bureau of Health Services Financing (BHSF) Medicaid Program and by the federal Social Security Administration (SSA) for certain categories of elderly and disabled individuals.
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Eligibility Determined by SSA	The SSA determines eligibility for Supplemental Security Income (SSI). SSI recipients are automatically eligible for Louisiana Medicaid.
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Eligibility Periods	<p>Periods of Medicaid Coverage are not the same for all Medicaid eligibility programs. Depending on the Medicaid program, the recipient's eligibility may begin either on the first day of the month of application or on a specific day within the month and end before the last day of the month. Medicaid eligibility may be approved retroactively for up to three months prior to the date of application with some exceptions.</p> <p>Medicaid coverage will continue as long as a recipient meets all of the requirements for eligibility. A provider must verify a recipient's eligibility for the date of service prior to rendering the service.</p>
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**37.3.2 CLASSIFICATIONS OF ELIGIBLE RECIPIENTS**

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There are two main classifications for eligible recipients of Medicaid of Louisiana:

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<b>Categorically Needy</b>	Recipients classified as Categorically Needy must meet all requirements, including the financial income standard, and resource requirements of one of the cash assistance programs. The existing categorical programs are the Supplemental Security Income administered programs that provide assistance for the Aged, Blind or Disabled and the Low Income Families with Children program, which is based on the requirements for the Temporary Aid to Needy Families program administered by the Department of Social Services (DSS):
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Aged	Provides health assistance to individuals who are over 65 years of age and who meet the income and resource requirements of the program.
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Blind	Provides health assistance to individuals who are determined legally blind according to the SSI criteria and who meet the income and resource requirements of the program.
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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**37.3.2 CLASSIFICATIONS OF ELIGIBLE RECIPIENTS, continued**

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Disabled	Provides health assistance to individuals who are determined to meet the Social Security Disability criteria and who meet the income and resource requirements of the program.
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TANF	(Temporary Aid to Needy Families) provides health assistance to children and families who meet the income, resource and other eligibility criteria for the TANF program administered by DSS. This is the program that replaced the Aid to Families with Dependent Children program in the Welfare Reform legislation.
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LIFC	(Low Income Families with Children) provides health assistance to children (under age 19) and pregnant women who meet income and non-financial eligibility criteria. The requirements for this program are based on the requirements for the Temporary Aid to Needy Families program administered by DSS.
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Recipients are responsible for a co-payment for prescription drugs. However, children up to the age of twenty-one; pregnant women; institutionalized individuals; emergency services; and family planning services are exempt from co-payments.

Payment for all covered services or equipment billed to Medicaid shall be considered **payment in full**.

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<b>Medically Needy</b>	Medically Needy recipients must meet all of the requirements of the cash programs administered by SSI or the TANF program administered by DSS except income. These individuals have more income than is allowable under the cash programs, but qualify under the Medically Needy Program income standard, because of their need for medical services. Medically Needy recipients may be either Regular Medically Needy or Spend-Down Medically Needy.
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Regular Medically Needy	Regular Medically Needy recipients are those individuals or families who meet all LIFC (Low-Income Families with Children) related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES).
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With the exception of co-payments for prescription drugs, no payment can be accepted from a Regular Medically Needy recipient for covered services.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.2 CLASSIFICATIONS OF ELIGIBLE RECIPIENTS, continued**

**Spend Down Medically  
Needy**

Spend-down applicants may qualify for the Medically Needy Program on the basis that countable income has been spent or obligated to pay unpaid medical expenses. Spend-down medically needy eligibility begins on the exact date that medical expenses are incurred by these recipients, and countable income is reduced to the Medically Needy Income Standard allowing them to meet “spend-down” criteria. These recipients are responsible for a co-payment for some expenses.

Any provider who has medical bills from the exact date of the recipient’s spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from Medicaid. This form will notify the provider of the co-payment amount due by the recipient and the amount to be billed to Medicaid. *The provider must attach this form to the universal claim form and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under recipient liability. If services were provided on the date of spend-down but do not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

Medically Needy Recipients are identified on the MEVS and REVS system. MEVS and REVS denote the appropriate eligibility information based on the provider type of the inquiring provider. **RECIPIENTS ELIGIBLE THROUGH PROGRAMS OTHER THAN THE MEDICALLY NEEDY PROGRAM ARE NOT AFFECTED.**

Recipients with questions should contact Medicaid’s Eligibility Section at 888-342-6207. Providers with inquiries should call the fiscal intermediary Provider Relations at 800-473-2783 or 225-924-5040.

**Service restrictions apply to Medically Needy benefits and eligibility for service coverage should be verified.**

**37.3.3 ELIGIBILITY GROUPS**

**CHAMP**

(Child Health and Maternity Program) provides health assistance to children (under age 19) and pregnant women who meet income and non-financial eligibility criteria.

**Transitional Assistance**

Provides up to 12 months continued Medicaid coverage for families who lost Medicaid eligibility due to an increase in earnings or due to the loss of earned income deductions.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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**37.3.3 ELIGIBILITY GROUPS, continued**

<b>LaCHIP</b>	<p>(Louisiana Children's Health Insurance Program) provides health assistance to targeted low-income child (ren):</p> <ul style="list-style-type: none"><li>• Under the age of 19;</li><li>• Not eligible for Medicaid under any other eligibility group;</li><li>• Whose family income meets the specified cut off level; and</li><li>• Does not have other credible health insurance.</li></ul>
<b>LaCHIP Phase IV</b>	<p>The Phase IV LaCHIP Program is an expansion of the State Children's Health Insurance program (SCHIP). This program provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for Medicaid, including CHAMP PW benefits. Phase IV LaCHIP expands coverage to non-citizen pregnant women who are not qualified for other Medicaid programs due to citizenship status only.</p>
<b>LaChip Affordable Plan</b>	<p>LaCHIP Affordable Plan is a LaCHIP health insurance program for uninsured children in moderate income families whose income is too much to qualify for regular LaCHIP but whose gross income is below 250 percent of the Federal Poverty Level (FPL). The regular LaCHIP only covers uninsured children in families with countable income up to 200 percent of the FPL.</p>
<b>B/CC</b>	<p>(Breast and Cervical Cancer) provides full Medicaid coverage to uninsured women under age 65 who are identified through the Centers of Disease Control and Prevention's national Breast and Cervical Early Detection Program and in need of treatment for cervical and/or breast cancer, including pre-cancerous conditions.</p>
<b>LTC</b>	<p>(Long Term Care) provides Medicaid coverage to elderly and/or disabled individuals who are income and resource eligible and who need medical certification for services provided in a long term care facility or through home and community based services.</p>
<b>DAC</b>	<p>(Disabled Adult Children) provides Medicaid coverage to individuals over age 18, who became blind or disabled before age 22, and lost SSI eligibility on or after July 1, 1987, as the result of entitlement to or increase in RSDI.</p>
<b>DW/W</b>	<p>(Disabled Widows/Widowers) provides Medicaid coverage to widows/widowers with disabilities who would be eligible for SSI had there been no elimination of the reduction factor in 1984 and no subsequent COLA's</p>

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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**37.3.3 ELIGIBILITY GROUPS, continued**

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<b>EW/W</b>	(Early Widows/Widowers) provides Medicaid coverage to individuals who lose SSI eligibility because of the receipt of RSDI early widow/widower's benefits.
<b>Pickle</b>	Protects Medicaid coverage for two different groups of aged, blind, or disabled individuals who become ineligible for SSI or MSS as the result of a cost of living adjustment to RSDI benefits, or any other reason.
<b>SGA Disabled W/W/DS</b>	(Disabled widows/widowers and disabled surviving divorced spouses unable to perform any substantial gainful activity) protects Medicaid coverage for widow(er)'s who become ineligible for SSI due to the receipt of SSA Disabled Widow(er)'s Benefits so long as; they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefits were not counted as income, and they are not entitled to Part A Medicare.
<b>Section 4913 Children</b>	Provides for the continuation of Medicaid coverage for children with disabilities who lost SSI benefits because of the change in the definition of childhood disability. They are eligible if they received SSI benefits as of August 22, 1996, meet all other SSI eligibility factors, including income and resources, and meet the "pre 8/22/96" definition of childhood disability.
<b>TB</b>	(Tuberculosis) infected individuals not eligible for the full range of Medicaid services. Coverage is restricted to outpatient medical services directly related to diagnosis, confirmation and treatment of Tuberculosis.
<b>Emergency Services for Aliens</b>	These individuals must meet criteria for one of the other eligibility groups and are certified only for limited periods of eligibility via Form 18-EMS. Their days of eligibility only cover dates of service on which emergency (life threatening) services were rendered. Once a person's eligibility ceases, he/she must re-apply if coverage for new emergency services is needed.
<b>Presumptive Eligibility</b>	Pregnant women may have "Presumptive Eligibility (PE)" determined by a "qualified provider" such as some state hospitals, public health units, rural health clinics or Child and Maternal Health grantees. Presumptive eligibility begins on the date the qualified provider determines the pregnant woman is eligible. If the recipient does not file an application for Medicaid, eligibility ends the last day of the following month.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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**37.3.3 ELIGIBILITY GROUPS, continued**

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**Presumptive  
Eligibility,  
continued**

If a Medicaid application is filed, the woman will remain presumptively eligible until the eligibility on her application is determined. During this period, the “presumptively eligible” pregnant women will be eligible for ambulatory (outpatient) prenatal care including non-emergency transportation. Coverage may expire at any time if eligibility requirements are not met. MEVS and REVS eligibility verification responses will alert providers that the recipient may be eligible for outpatient ambulatory services only and that providers must inquire to verify eligibility. **Verification should be made by calling 800-834-3333.**

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**Newborn Eligibility**

Provides health assistance to a child born to a woman determined eligible for Medicaid benefits in any category (other than Presumptive Eligibility) on the date the child is born until its first birthday as long as the newborn resides in the home of the mother. If the mother is not eligible for Medicaid at the time of the child's birth then an application would have to be filed and the child would have to be found eligible for Medicaid under one of the existing Medicaid programs *for children*.

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**Take Charge**

Take Charge is a Section 1115 Demonstration Waiver to provide family planning services for women between the ages of 19-44 who have income up to 200% of the Federal Poverty Level. The waiver program, named “Take Charge” has a specified benefit package. Services will include yearly physical exams, laboratory tests, contraceptive counseling, medications and supplies (such as birth control pills, patches, injections, intrauterine devices, diaphragms, etc.). Voluntary sterilization procedures are also included. Services may be provided by any enrolled Medicaid provider(s) whose scope of practice permits the delivery of the services covered by the waiver program.

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**Program of All  
Inclusive Care for  
the Elderly  
(PACE)**

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community. PACE programs generally consist of an adult day health center where primary care physician services and other services are also available.

Pharmacy claims of PACE participants will be denied by Medicaid as these services are included in the reimbursement to the PACE provider. PACE providers will be responsible for reimbursing prescription services.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.3 ELIGIBILITY GROUPS, continued**

**Full Benefit  
Dual Eligibles  
(Medicare/Medicaid)**

The following describes the various categories of individuals who, collectively, are known as full benefit dual eligibles. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services which may include eligible Part B drugs. Effective January 2006, the Medicare Modernization Act provides for an outpatient drug benefit (Part D). Full benefit dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and Part D as well as eligible for some form of Medicaid benefit.

For those individuals with Medicaid benefits, Louisiana Medicaid will reimburse providers the coinsurance and/or deductible amounts submitted for Medicare Part B drugs that have been adjudicated by Medicare.

The following are full benefit dual eligible classifications as defined by Medicare and Medicaid.

**Note:** Refer to Section 37.7 Medicare Crossover Policy for detailed information.

**QMB Plus**

Qualified Medicare Beneficiaries (QMBs) with full Medicaid - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance, and provides full Medicaid benefits.

**SLMB Plus**

Specified Low-Income Medicare Beneficiaries (SLMBs) with full Medicaid – These individuals are entitled to Medicare Part A, have income of 100-120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

**Non QMB, SLMB,  
QDWI, or QI**

These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, Qualified Disabled and Working Individual (QDWI) or Qualified Individual (QI). Typically, these individuals need to spend down to qualify for Medicaid or fall into a special Medicaid eligibility group. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for services covered by both Medicare and Medicaid. Payment by Medicaid of Medicare Part B premiums is a State option.



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.3 ELIGIBILITY GROUPS, continued**

**Medicare Premium,  
Deductible and  
Coinsurance Eligible  
Only**

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The following qualify only for Medicaid payments of Medicare premiums, deductibles and coinsurance.

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**QMB Only**

QMBs without other Medicaid (QMB Only) These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare Providers.

For those individuals who are QMB only, Medicaid will pay a crossover claim only if the service is covered by Medicaid, otherwise the claim will deny as non-covered.

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**Medicare Premium  
Coverage Only**

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The following qualify only for Medicaid payments of Medicare premiums.

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**SLMB Only**

SLMBs without other Medicaid (SLMB Only) – These individuals are entitled to Medicare Part A, have income of 100-120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

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**QDWIs**

Qualified Disabled and Working Individuals (QDWIs) – These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

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**QIs**

Qualified Individuals (QIs) – These individuals are entitled to Medicare Part A, have income of 120%-135% FPL and resources that do not exceed twice the limit for SSI eligibility and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.4 PROOF OF ELIGIBILITY**

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Eligibility information for a recipient, including third party liability, primary care providers and any restrictions, including lock-in, may be obtained by accessing information through the Medicaid Eligibility Verification System (MEVS), or telephoning the Recipient Verification System (REVS) toll-free at 800-776-6323 or the local number at 225-216-7387.

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Medicaid Eligibility  
Verification System  
(MEVS)

MEVS is an electronic system used to verify Medicaid recipient eligibility information and can be accessed through [www.lamedicaid.com](http://www.lamedicaid.com). This system is available seven (7) days per week, 24 hours per day except for occasional short maintenance periods.

**Note:** Refer to Section 37.22 Louisiana Medicaid Website for detailed information.

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Recipient Eligibility  
Verification System  
(REVS)

REVS is a telephonic system used to verify Medicaid recipient eligibility. It is available seven (7) days a week, 24 hours per day except for short maintenance periods. This system is accessible through touch-tone telephone equipment using Molina toll-free telephone number at 800-776-6323 or 225-216-7387.

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Medicaid Identification  
Card

A plastic Health Network of Louisiana Eligibility card, with a unique identifying number, is issued to each eligible recipient by the Department of Health and Hospitals (DHH).

Take Charge program enrollees receive a pink identification card similar to a regular Medicaid card in appearance.

**Note:** Refer to Chapter 2 Generic Eligibility of the Louisiana Medicaid Program Provider Manual for detailed information and an example of a Medicaid identification card.

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Card Control Number

The sixteen-digit number on the front of the Medicaid identification card is the card control number and is used to bill for pharmacy services.

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Card Not Proof of  
Eligibility

Possession of a Medicaid identification card does not mean a recipient is eligible for Medicaid Services. Verification must be obtained through MEVS or REVS.

Also, some types of Medicaid eligibility, such as Presumptively Eligible Pregnant Women and Undocumented Aliens (eligible for emergency services only) do not receive plastic Medicaid cards. Their verification of eligibility is contained on the Notice of Eligibility Decision issued by the local Medicaid office.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

**37.3.4 PROOF OF ELIGIBILITY, continued**

Card Not Proof of  
Eligibility, continued

For Presumptive Eligibility recipients, call toll-free 800-776-6323 to verify eligibility or view the notice of issuance of Eligibility sent from the Bureau notifying them of their eligibility. Providers may call REVS at 800-776-6323 to verify eligibility.

Recipient Has Lost  
Identification  
Card

A replacement Medicaid card can be ordered by calling 800-834-3333 or by calling the LaCHIP hotline at 877-242-2447. Choose the “Replace Medicaid Card” option and provide the information required to obtain a replacement Medicaid card through the automated system.

If the recipient is not in possession of his or her identification card, the provider can still verify eligibility and, if the recipient is eligible, provide services.

**37.3.5 COMMUNITYCARE PROGRAM**

CommunityCARE is a primary care case management (PCCM) program. This program links Medicaid recipients with a physician, clinic, federally qualified health center, or rural health clinic that serves as the recipients primary care provider (PCP). The PCP provides basic care, referral, and after hours coverage of medical services for each recipient. The PCP receives a small monthly management fee for recipients assigned to him/her in addition to fee-for-service reimbursement for medical services rendered.

CommunityCARE recipients receive a Medicaid card issued for each eligible person in a household. Eligible recipients in a household may select or be assigned to a CommunityCARE provider. Only the provider shown in REVS or MEVS as the CommunityCARE PCP, is authorized to provide primary care services or make referrals for that recipient. **CommunityCARE recipients are not restricted for pharmacy services.**

The Community Care Hotline is available 8am to 5pm at 800-359-2122

All Medicaid recipients are enrolled in this program with the exception of the following list of recipient types who are exempt from CommunityCARE (List subject to change):

- Recipients who are 65 years or older;
- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes;
- Recipients with Medicare benefits, including dual eligibles;
- Medically Needy recipients;
- Foster children or children receiving adoption assistance;
- Office of Youth Development recipients (children in State custody);
- Recipients in the Medicaid “Lock-In” program;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.3 MEDICAID RECIPIENT ELIGIBILITY**

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**37.3.5 COMMUNITYCARE PROGRAM, continued**

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- Recipients who have other primary insurance;
- Recipients who have an eligibility period of less than 3 months;
- Recipients with retroactive eligibility (for the retroactive eligibility period only as CommunityCARE linkages may not be retroactive);
- Presumptively Eligible (PE) recipients (pregnant women only);
- BHSF case-by-case approved “Medically High Risk” exemptions;
- Recipients enrolled in Hospice; and
- Native American Indians residing in Jefferson Davis, St. Mary, LaSalle, and Avoyelles Parishes.

**Note:** Refer to Chapter 15 CommunityCARE of the Louisiana Medicaid Program Provider Manual for detailed information.

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**37.3.6 EPSDT RECIPIENTS**

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All eligible children under age 21 are covered in the Early Periodic Screening Diagnosis Treatment Program (EPSDT).

**Note:** Refer to Chapter 20 EPSDT of the Louisiana Medicaid Program Provider Manual for additional information.

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**37.3.7 LOCK-IN PROGRAM**

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Medicaid has developed a program to educate recipients who may be misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse or over-utilize pharmacy and physician benefits may be restricted to the use of one pharmacy and one physician, or one pharmacy provider (for pharmacy only Lock-In).

**Note:** Refer to Section 37.17 Lock-In for detailed information.

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**37.3.8 THIRD PARTY LIABILITY**

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Federal regulations and applicable state laws require that third-party resources are used before Medicaid is billed. *Third party* refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, that can be applied toward the Medicaid recipient’s medical and health expenses.

**37.3.8 THIRD PARTY LIABILITY, continued**

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Providers are able to coordinate benefits or “split-bill” pharmacy claims through the Medicaid Point of Sale system. Providers must bill recipients’ primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the recipient’s responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount.

**Note:** Refer to Section 37.8 Third Party Liability/Coordination of Benefits for further explanation of this process.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.4 PRESCRIBERS**

## **37.4 PRESCRIBERS**

### **Overview**

#### **Introduction**

This Section defines medical practitioners who are authorized to prescribe drugs covered by the Louisiana Medicaid Pharmacy Program.

In addition, this Section explains the requirement that all prescribers must have an individual Medicaid prescriber number, as a condition for prescription coverage by the program.

#### **In This Section**

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Prescriber Numbers	4-2
Prescribers who are Not Medicaid Program Providers	4-2
Sanctioned Prescribers	4-3
Accessing Prescriber Numbers	4-3

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.4 PRESCRIBERS**

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### 37.4.1 QUALIFIED PRESCRIBERS

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The Medicaid Program provides reimbursement for prescriptions provided to eligible recipients under regulations governing the Pharmacy Program. The prescriptions may be written by appropriate professionals authorized to prescribe under state law and have prescriptive authority from his/her licensing board.

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### 37.4.2 PRESCRIBER NUMBERS

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The integrity of the Louisiana Medicaid Pharmacy Benefits Management Program (LMPBM) is dependent upon utilizing accurate data.

The LMPBM System requires that each Medicaid prescriber has an individual National Provider Identifier (NPI) and a Medicaid provider/prescriber number whenever pharmacy claims for payments are submitted. The pharmacy provider should submit the prescribing provider's individual NPI in the claim. In rare cases where a prescriber does not have a NPI or the pharmacy cannot obtain the NPI, the pharmacy may substitute the prescriber's Medicaid number in the claim submission. The system will only allow claims to be submitted with a seven digit individual prescribing practitioner identification number.

Prescriber practitioners who deliver health care services in the state operated mental health clinics, developmental centers and public health clinics must also have an assigned individual prescriber identification number and a NPI as a condition for the prescription to be covered by the Medicaid program.

Louisiana Medicaid has issued individual prescriber identification numbers to all interns, residents, and fellows currently in training.

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### 37.4.3 PRESCRIBERS WHO ARE NOT MEDICAID PROGRAM PROVIDERS

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Pharmacy providers may be reimbursed for prescriptions which are issued by prescribers who do not participate in the Louisiana Medicaid program but have a valid Medicaid provider *prescriber only* number and a NPI.

**Note:** If a prescribing practitioner does not currently have an individual Medicaid provider number, he/she may contact the fiscal intermediary Provider Enrollment unit at 225-216-6370.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.4 PRESCRIBERS**

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**37.4.4 SANCTIONED PRESCRIBERS**

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Edits have been placed on the prescriber identification numbers when prescriber licenses have been restricted, suspended or revoked. Pharmacy claims will be denied when the prescribing provider does not have prescriptive authority.

Louisiana Medicaid will not reimburse pharmacy claims when the prescribing practitioner is sanctioned and/or is excluded from Medicaid program participation.

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**37.4.5 ACCESSING PRESCRIBER NUMBERS**

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Pharmacy providers must make every effort to assure that the prescribing practitioner number billed is accurate. A listing of prescribing practitioner numbers is available on the website [www.lamedicaid.com](http://www.lamedicaid.com). This listing is updated monthly.

**Note:** Refer to Section 37.22.5 Louisiana Medicaid Website; Prescriber Numbers for detailed information.

Pharmacy Providers may verify prescriber numbers by calling the POS Pharmacy Help Desk at 800-648-0790 or 225-216-6381.

In addition, pharmacy providers may contact the following institutions whenever a resident, intern or fellow in training does not include his/her prescriber number on the prescription or if the prescriber name and or number is not legible.

Academic Centers

Baton Rouge General Medical Center  
Family Medicine Residency  
Phone: 225-381-6620

LSU-New Orleans  
Graduate Medical Education  
Phone: 504-568-8632 or  
Phone: 504-568-4006

LSU-Shreveport  
Dept. of Medical Education  
Phone: 318-675-5053

Tulane University – New Orleans  
Phone: 504-988-7138

Ochsner Medical Foundation  
Phone: 800-752-6768

Earl K. Long Hospital  
Medical Director's Office  
Phone: 225-358-1065

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.4 PRESCRIBERS**

**37.4.5 ACCESSING PRESCRIBER NUMBERS, continued**

Charity Hospitals

LSU Health Science Center  
Medical Director's Office  
Phone: 318-330-7661

Walter O. Moss Hospital  
Medical Director's Office  
Phone: 337-475-8196

Huey P. Long (LSU/Tulane Residents)  
Medical Director's Office  
Phone: 318-473-1426

Washington-St. Tammany Hospital  
Medical Director's Office  
Phone: 985-732-1121

University Medical Center, Lafayette  
Medical Director's Office  
Phone: 337-261-6156

Lallie Kemp Hospital  
Medical Director's Office  
Phone: 985-878-1333

Chabert Medical Center  
Medical Director's Office  
Phone: 985-873-1265

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**Overview**

Introduction

Provided in this Section are the terms and conditions under which prescription services will be paid by Medicaid of Louisiana and a description of the authorized benefits for eligible recipients.

In This Section

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Drugs With Special Payment Criteria/Limitations	5-12
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.1 TERMS AND CONDITIONS**

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Licensed Prescribers	<p>Payment will be made for prescription services only when issued by a licensed prescribing practitioner who has an active Medicaid prescriber number.</p> <p><b>Note:</b> Refer to Section 37.4 for Prescribers for detailed information.</p>
Eligible Recipients	<p>Louisiana Medicaid will only reimburse pharmacy claims when the recipient is eligible on the date of service. Pharmacy claims submitted with a date of service after a recipient's date of death are not allowed.</p> <p><b>Note:</b> Refer to Section 37.3 Medicaid Recipient Eligibility for detailed information.</p>
Rebate Agreements	<p>In accordance with Section 4401 of the <b>Omnibus Budget Reconciliation Act of 1990 (OBRA 90)</b>, Louisiana Medicaid will pay only for those drug products for which the pharmaceutical company has entered into a rebate agreement with the U. S. Department of Health and Human Services. Provided in <b>Appendix C</b> at the end of this manual is a listing of pharmaceutical companies which have entered into an agreement with the federal government. This appendix is updated periodically and is posted at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a>. Providers should take note of the effective dates of the labeler codes.</p> <p>Louisiana Medicaid will provide coverage for only those drug products labeled by the pharmaceutical companies that are identified in <b>Appendix C</b>. The therapeutic categories, e.g., cough and cold preparations, anorexics and cosmetic drugs, will remain non-payable. The limited over-the-counter items covered by Medicaid are payable only if the manufacturer for the drug is listed in <b>Appendix C</b>.</p> <p><b>Note:</b> As new pharmaceutical companies enter into rebate agreements, labeler codes will be added, and the updated information will be mailed to providers via remittance advice messages and added to the website.</p>
Medically Accepted Indications	<p>To be reimbursed by Medicaid, a drug must be medically necessary and prescribed for medically accepted indications.</p> <p>As defined by OBRA 93, the term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: <i>American Hospital Formulary Service Drug Information</i>, <i>United States Pharmacopeia – Drug Information</i> and <i>DRUGDEX Information System</i>.</p>

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.1 TERMS AND CONDITIONS, continued**

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Drug Utilization Review	<p>OBRA 90 also requires that states have a Drug Utilization Review (DUR) program in place and that this program assures that prescriptions are appropriate, are medically necessary and are not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug review, and an educational program.</p> <p><b>Note:</b> Refer to Section 37.16 as well as this Section for detailed information regarding DUR.</p>
Patient Counseling	<p>The Louisiana Board of Pharmacy's regulations require patient counseling, patient profiles, and prospective drug review, in accordance with OBRA 90.</p> <p><b>Note:</b> Refer to Section 37.16 for detailed information.</p>
Prescription Duration	<p>Program policy requires that prescriptions shall be filled within six months of the date issued including Schedule II narcotic analgesics.</p>
Prescription Transfers	<p>Transfer of a prescription from one pharmacy to another is allowed if less than 6 months has passed since the issued date of the prescription if the transfer is done in accordance with the Louisiana Board of Pharmacy regulations.</p>
Date of Service	<p>Claims shall be submitted for the date of service the prescription was dispensed.</p>
Prescription Refills	<p>Refills can be provided if they are authorized specifically by the prescribing practitioner. However, no prescription may be refilled more than five times or more than six months after the date issued.</p>
National Drug Code	<p>The prescribed items must have an assigned National Drug Code (NDC).</p>
Prescriptions Received via Telecommunication	<p>Most prescriptions are acceptable, when received by telephone or other telecommunication device in accordance with state and federal regulations. However, providers must file and log these prescriptions as they would any other written prescriptions.</p>

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.2 TAMPER RESISTANT PRESCRIPTION POLICY**

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Written, non-electronic prescriptions for Medicaid recipients are required to be tamper-resistant.

The “TMA, Abstinence Education and QI Program Extension Act of 2007” (H.R. 3668) and the “U.S. Troop Readiness, Veterans’ Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007” (H.R. 2206) states that all handwritten prescriptions or those printed from an EMR (electronic medical record) or an ePrescribing application must contain **all three** characteristics listed below. Exceeding these guidelines is permissible.

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form,
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber and
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms

This provision applies to all written (non-electronic) prescriptions for outpatient drugs including over-the-counter drugs reimbursed by the Louisiana Medicaid Pharmacy Program, regardless of whether Medicaid is the primary or secondary payer.

It is the responsibility of the prescriber to obtain and purchase tamper-resistant prescription pads.

Note: Refer to Appendix L Table of Tamper Resistant Prescription Criteria and Examples and to [www.lamedicaid.com](http://www.lamedicaid.com) for detailed information.

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Excluded  
Prescriptions

The tamper-resistant requirement does not apply to prescriptions which are communicated by the prescriber to the pharmacy electronically, verbally or by facsimile.

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Confirming  
Non-Compliant  
Prescriptions

If a prescription does not meet the requirements for tamper-resistance, pharmacies may obtain verbal confirmation and document appropriately. The pharmacy does not need to speak with the prescriber directly. They may receive confirmation from a nurse or administrative staff person who has authority to act on behalf of the prescriber.

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Emergency  
Fills

**Emergency fills** with non-compliant written prescriptions are permissible as long as the prescriber provides a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled. If an emergency fill is confirmed with a verbal order, the pharmacist must document the call on the face of the written prescription.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.2 TAMPER RESISTANT PRESCRIPTION POLICY, continued**

Recipients with  
Retroactive  
Eligibility

When a recipient has retroactive eligibility, pharmacies are not required to obtain compliant prescriptions for the period of retroactive eligibility. However, the pharmacy must obtain a tamper-resistant prescription for any refills after the date of eligibility.

**37.5.3 AUTHORIZED BENEFITS**

Provided below are the authorized medications and/or supplies which are payable under Louisiana Medicaid.

**Note:** Refer to Section 37.5.8 Quantity Limitations and Section 37.6 Reimbursement for Services for detailed information.

Legend Drugs

The Medicaid Pharmacy program reimburses for most legend drugs that are dispensed by community pharmacies and used in outpatient settings. Legend drugs are drugs that require a prescription or that have the following statement on the label, "Caution: Federal law prohibits dispensing without a prescription."

**Note:** Refer to Section 37.5.3 Non-Covered Services for the legend drugs that Medicaid does not reimburse.

Legend Vitamin and  
Mineral Products

Only the following legend vitamin and mineral products will be reimbursed by the Medicaid Pharmacy Program:

- Legend prenatal vitamins for pregnant and lactating recipients;
- Prescription strength fluoride as a single entity;
- Vitamin A preparations;
- Vitamin B preparations;
- Vitamin C preparations;
- Vitamin D preparations;
- Vitamin E preparations;
- Geriatric Vitamin preparations;
- Pediatric Vitamin preparations;
- Vitamin K preparations;
- Vitamin B 12 preparations;
- Folic Acid preparations;
- Niacin preparations;
- Vitamin B6 preparations;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.3 AUTHORIZED BENEFITS, continued**

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	<ul style="list-style-type: none"><li>• Vitamin B1 preparations;</li><li>• Multivitamin preparations;</li><li>• Magnesium salt replacement;</li><li>• Calcium replacement; and</li><li>• Urinary pH modifiers (Phosphorus).</li></ul>
Injectable Drugs	<p>Medicaid Pharmacy Program reimburses for most injectable drugs for outpatient recipients when supplied by community pharmacies, long term care pharmacies, and home infusion pharmacies that are enrolled as Medicaid providers.</p> <p>Some injections administered in practitioners offices and clinics are reimbursed through the physicians' program.</p>
Non-Legend Drugs	<p>Only a limited number of non-legend or over-the-counter (OTC) drugs can be reimbursed by the Louisiana Medicaid program. For Medicaid reimbursement, these drugs must be prescribed by licensed practitioners. <b>Providers must bill the NDC from the actual package dispensed.</b> Also, the <b>drug manufacturer</b> must participate in the federal rebate program.</p> <p>The following non-legend drugs are covered when an authorized prescriber has written a prescription:</p> <ul style="list-style-type: none"><li>• Insulin;</li><li>• Sodium chloride solution for inhalation therapy;</li><li>• Contraceptives, topical;</li><li>• Urinary pH modifiers; and</li><li>• Other non-legend drugs that have Medicaid Pharmacy Program approval.</li></ul>
Non-Legend Items and Supplies	<p>Only a limited number of non-legend items and supplies can be reimbursed by the Louisiana Medicaid program. For reimbursement, these items and supplies must be prescribed by licensed practitioners. <b>Providers must bill the NDC from the actual package dispensed.</b></p> <ul style="list-style-type: none"><li>• OTC Vitamin D preparations;</li><li>• OTC Vitamin E preparations;</li><li>• OTC Niacin preparations;</li><li>• OTC Calcium replacement agents;</li><li>• OTC Magnesium replacement agents;</li><li>• OTC Phosphate replacement agents;</li><li>• OTC Iron replacement agents;</li><li>• Normal saline and heparin flushes;</li><li>• Disposable needles and syringes used to administer insulin;</li></ul>

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.3 AUTHORIZED BENEFITS, continued**

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Non-Legend Items  
And Supplies,  
continued

- Test strips for determining blood glucose levels;
  - Lancets;
  - Urine test strips (e.g., Clinitest® and Clinistix®);
  - Family planning items; and
  - Other non-legend items and supplies that have Medicaid Pharmacy program approval.
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Total Parenteral  
Nutrition

Total Parenteral Nutrition and associated supplies and equipment are covered services in the pharmacy program.

**Note:** Refer to Section 37.12 Total Parenteral Nutrition for detailed information.

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Medication  
Administration

Enrolled pharmacies may be reimbursed for the administration of the influenza vaccine. Pharmacists who have the Authority to Administer authorized by the Louisiana Board of Pharmacy may administer the vaccine.

**Note:** Refer to Section 37.14 Medication Administration for detailed information.

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**37.5.4 NON-COVERED SERVICES**

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Drugs Excluded  
From Coverage

The Medicaid program excludes the following drugs and/or therapeutic categories from coverage:

- Anorexics – Medicaid does not reimburse for anorexics with the exception of orlistat;  
**Note:** Refer to Section 37.5.6 for program restrictions.
- Compounded prescriptions (mixtures of two or more ingredients; the individual drugs will continue to be reimbursed);
- Cosmetic drugs;
- Cough and cold preparations;
- Drug Efficacy Study Implementation (DESI) Drugs refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness;
- Erectile dysfunction drugs
- Experimental drugs;
- Fertility drugs when used for fertility treatment;



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**37.5.4 NON-COVERED SERVICES, continued**

Drugs Excluded  
From Coverage,  
continued

- Medications which are included in the reimbursement to a facility, i.e. hospitals, skilled nursing facility for recipients receiving benefits under Part A of Title XVIII, mental hospitals, or some other nursing facilities;
- Narcotics prescribed only for narcotic addiction;
- Non-legend or OTC drugs or items with some exceptions; and  
**Note:** Refer to Section 37.5.2 Authorized Benefits for exceptions.
- Vaccines covered in other programs.

Durable Medical  
Equipment/Supplies  
Excluded

Durable medical equipment and supplies, other than those included in this Section under Authorized Benefits 37.5.2, are not covered in the pharmacy program. These items are covered in the Durable Medical Equipment Program and must be billed to that program.

**Note:** Refer to Chapter 18 Durable Medical Equipment of the Louisiana Medicaid Program Provider Manual for specific information on this program.

**37.5.5 PRIOR AUTHORIZATION AND PREFERRED DRUG LIST**

The Medicaid program administers a prior authorization process for services in its Pharmacy Benefits Management System.

This process utilizes a preferred drug list (PDL) for selected therapeutic classes. Drugs included on the PDL are automatically prior authorized. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.

PDL Provider  
Notification

Providers are notified of the drugs selected for placement on the PDL by therapeutic classes prior to implementation of the prior authorization process and as additional drugs are subsequently added to the list.

Lists of covered drug products, including those that require prior authorization, will be provided by either the Louisiana Medicaid website or provider notices.

Prior Authorization  
Process General  
Information

The Prior Authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four (24) hours of receipt of a prior authorization request. In emergency situations, providers may dispense **at least** a seventy-two (72) hour or a three (3) day supply of medication

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**37.5.5 PRIOR AUTHORIZATION AND PREFERRED DRUG LIST, continued**

Prior Authorization and  
PDL Information Site

Information is available on the Louisiana Medicaid Website at  
[www.lamedicaid.com](http://www.lamedicaid.com).

Who Can Obtain  
Prior Authorization

The prescribing practitioner is responsible for obtaining prior authorization. Pharmacist or recipient calls/requests will not be accepted. The prescribing practitioner must have and provide his/her valid individual Louisiana Medicaid prescribing provider number to obtain prior authorization. Only individual provider numbers will be accepted. The prescribing practitioner may obtain the PA by telephone, facsimile or mail.

Phone: 1-866-730-4357  
Fax: 1-866-797-2329 – Do not send a cover sheet with the facsimile  
Mail: ULM  
College of Pharmacy  
1800 Bienville Dr.  
Monroe, LA 71201-3765

The hours of operation for the ULM Prior Authorization Unit are 8am to 6pm Central Time, Monday through Saturday.

**Note:** If a prescribing practitioner does not have an individual prescriber number, refer to Section 37.4 Prescribers for detailed information.

Prior Authorization  
Request Form

A facsimile of Form RXPA is found as Appendix F. It can also be found at  
[www.lamedicaid.com](http://www.lamedicaid.com).

Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a three (3) day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.** The recipient's practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

This process may be used when the Prior Authorization Unit is closed (Sundays; Monday – Saturday before 8am and after 6 pm) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

**The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency Rx" on the hard copy prescription. When the pharmacist**

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**37.5.5 PRIOR AUTHORIZATION AND PREFERRED DRUG LIST, continued**

Emergency Procedures,  
continued

**determines the prescription is an emergency, the pharmacist must indicate “Emergency by Pharmacist” on the hard copy prescription.**

**Note:** Refer to Appendix D Point of Sale User Guide for detailed claim submission information.

Recipients are exempt from paying co-payments for emergency situations.

DHH will monitor emergency prescriptions/recipients on an ongoing basis through management reports, pharmacy provider audits, and other monitoring programs to review the number of these prescriptions and the reasons for them.

Hospital Discharge  
Prescriptions for  
Atypical Antipsychotic  
Agents

When a recipient is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if hard copy, that the prescription is a “Hospital Discharge” or if the prescription is called in to the pharmacy, the “Hospital Discharge” status of the prescription must be communicated to the pharmacist who must indicate “Hospital Discharge” on the hard copy prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a “Hospital Discharge” prescription, the pharmacist must indicate “Hospital Discharge” on the hard copy prescription.

Claims for “Hospital Discharge” prescriptions needing prior authorization (PA) will be submitted using the same process used for an emergency override.

Prescriptions for “Hospital Discharge” products shall be dispensed in a MINIMUM quantity of a 3-day supply, and **refills for the dispensing of the non-preferred products are not permitted.** The recipient’s practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the “Hospital Discharge” supply, and a new prescription must be issued.

Prescriptions Issued  
Prior to the Effective  
Dates of Prior  
Authorization

The prior authorization process does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to a drug’s effective date of prior authorization. Refills of prescriptions issued prior to an effective PA date will not be impacted as long as they are within the five refills and six-month program limits.

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**37.5.5 PRIOR AUTHORIZATION AND PREFERRED DRUG LIST, continued**

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Recipients with  
Retroactive Eligibility

Drugs that are not on the preferred drug list are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations. The Medicaid Pharmacy Program will reimburse pharmacy providers for these claims when the date of service falls within the recipients' retroactive time period. A Medicaid recipient's retroactive time period is defined as the time period between the first date of eligibility and the date that the recipient's eligibility is placed on the Medicaid recipient file. Pharmacy providers shall submit these claims electronically.

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Important Facts

Should a recipient elect to self-pay for an original prescription which requires a PA, then attempts to have Medicaid pay for a refill of this prescription, this pharmacy claim will deny.

If an approved prior authorization exists in the system, the pharmacy claim will bypass the PA edit and continue with existing POS edits. If an approved prior authorization does not exist, the pharmacy claim will be denied through the POS system.

An approved prior authorization does not guarantee payment of the claim by Medicaid. It only indicates that the drug has been approved as a course of treatment within the Medicaid Program. All existing POS claim edits will continue to be applied.

The prior authorization process does not verify recipient Medicaid eligibility. It only verifies that the recipient is "on file" (i.e., has a valid Medicaid ID number on file – not that the recipient is eligible on the date of service). Recipient eligibility will continue to be verified by the Pharmacy POS subsystem or through the MEVS or REVS automated recipient eligibility systems.

Only practitioners' individual prescriber numbers are accepted to request prior authorization of a non-preferred drug. Any provider number other than an individual prescribing provider number WILL NOT be accepted to prior authorize non-preferred drugs.

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**37.5.6 MONTHLY SERVICE LIMIT**

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Limit

Medicaid reimburses up to four (4) prescriptions per calendar month per recipient. Claims including those for emergency prescriptions and prior-authorization prescriptions that are in excess of four per calendar month per recipient will deny.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.6 MONTHLY SERVICE LIMIT, continued**

Exceptions to  
Limit

The following federally mandated recipient groups are exempt from the four prescriptions per calendar month limitations:

- Persons under twenty-one years of age;
- Persons who are residents of long-term care institutions, such as nursing homes and ICF/DD facilities; and
- Pregnant women.

Limit Override  
Procedures

The four prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates the following information to the pharmacist in his own handwriting or by telephone or other telecommunications device:

- “Medically necessary override;” and
- A valid ICD-9-CM Diagnosis Code that directly relates to each drug prescribed that is over the four prescription limit (an ICD-9-CM literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry found at [www.lamedicaid.com](http://www.lamedicaid.com) in his/her clinical assessment of the patient’s disease state or medical condition and the current drug regime before making a determination that more than four prescriptions per calendar month is required by the recipient.

Printed statements without the prescribing practitioner’s signature, check-off boxes or stamped signatures are not acceptable documentation.

An acceptable statement and ICD-9-CM are required for each prescription in excess of four for that month.

Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

**Note:** Refer to Appendix D the Point of Sale User Guide for detailed billing instructions.

**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS**

Coverage of some drugs is limited to special criteria being met. These are explained below.

**Note:** Refer to Appendix D the Point of Sale User Guide for detailed billing instructions and Section 37.9.5 for detailed override information where applicable.

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Age and Gender  
Restricted Drugs

Certain drugs have age and gender restrictions placed on them. Manufacturer guidelines are followed. (i.e. – Oral contraceptives are indicated for females aged 12 – 55.) For further assistance, providers should contact the Medicaid Pharmacy Benefits Management Section at 225-342-9768.

Amphetamines

Pharmacy claims for amphetamine drug products, when prescribed for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and narcolepsy will be reimbursed when the policy for coverage is followed.

Age limitations for most amphetamines are from three years old to twenty-one years old. When a FDA approved indication exists for an amphetamine product for ages greater than twenty-one, that product is covered when a diagnosis of ADD, ADHD or narcolepsy is submitted with the pharmacy claim. For those products which do not have a FDA approved indication for ages greater than twenty-one, only a diagnosis of narcolepsy is acceptable.

The prescription must be **hand-written** with the prescribing practitioner's written statement of the medically accepted indication for the drug. The ICD-9-CM diagnosis code is required in the claim submission.

The ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code	Description
314.00	ADD
314.01	ADHD
347	Narcolepsy

This documentation shall be retained by the pharmacy provider as evidence of compliance with program policy and readily retrievable when requested by the pharmacy audit staff.

Antihistamine/  
Decongestant Products

Prescribed single-entity antihistamines are covered for all recipients. Antihistamine-decongestant combinations are covered for all recipients when prescribed for the medically approved indication of allergic rhinitis (seasonal or perennial).

The program, in accordance with the Social Security Act Section 1927 (d) (2), excludes drugs or classes of drugs containing cough and cold agents when those products are prescribed for the treatment of cough and cold.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for policy regarding second generation antihistamines and combination agents included in the therapeutic duplication edit.

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Antipsychotic Agents  
(Typical and Atypical)

Prescriptions for typical and atypical antipsychotic agents require appropriate ICD-9-CM diagnosis codes documented on all new prescriptions.

The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9-CM code may be communicated to the pharmacist electronically or via telephone or facsimile. The ICD-9-CM diagnosis code is required for the claim submission.

Acceptable ICD-9-CM diagnosis codes are as follows:

<b>ICD-9-CM Code</b>	<b>Description</b>
290.0 – 319.9	Mental Disorders
781.0	Abnormal Involuntary Movements

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial. The pharmacist must document “Emergency” on the hard copy prescription. Additionally, the pharmacist must document the reason for the emergency.

Antipsychotic agents are also subject to Prospective Drug Utilization Reviews when a third antipsychotic agent is submitted for payment. Atypical antipsychotic agents exceeding maximum recommended doses will also deny.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication for further policy.

Buprenorphine Agents  
(Suboxone® and  
Subutex®)

Prescriptions for Buprenorphine Agents (Suboxone® and Subutex®) are reimbursed only when the following criteria are met:

- The prescriber is a physician;
- The physician has an X DEA number;
- The prescriber is licensed to prescribe Suboxone® and Subutex® and has provided a copy of his/her current Controlled Substance Registration Certificate indicating the X DEA number and a copy of a Provider Enrollment File Update Form to Provider Enrollment at 1-225-216-6370;
- Refills for Suboxone® and Subutex® are not allowed;
- Concurrent prescriptions for opioid analgesics and/or benzodiazepines are only reimbursed when written by the same physician who prescribed Suboxone® and Subutex®;
- Patients must be sixteen years of age or older;
- Prescriptions for Suboxone® are allowed a maximum daily dose of 24mg/day; and
- Prescriptions for Subutex® are allowed a maximum daily dose of 16mg/day.

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Buprenorphine Agents  
(Suboxone® and  
Subutex®),  
continued

Prescriptions for buprenorphine agents require an appropriate ICD-9-C diagnosis code documented on the hard copy prescription after written or verbal consultation with the physician. The diagnosis code is required for the claim submission.

Acceptable ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code	Description
304.0 through 304.03	Opioid Type Dependence
304.7 through 304.73	Combinations of Opioid Type Drug with Any Other

Buprenorphine Agents are also subject to Prospective Drug Utilization Reviews when concurrent opioid analgesics (including Suboxone® and Subutex®) are written by the same physician

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication for further policy as well as Appendix D Point of Sale user Guide for detailed billing information.

Buprenorphine  
Transdermal Patches  
(Butrans®)

Pharmacy claims for Buprenorphine Transdermal Patches (Butrans®) require an appropriate ICD-9-CM diagnosis code for reimbursement. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist after consultation with the prescriber. Claims submitted without a diagnosis code or with a diagnosis code related to the management of addictive disorders or substance abuse will deny.

There is no provision to override the denial when the diagnosis code is related to the management of addictive disorders or substance abuse. When the prescribing provider does not indicate a diagnosis code on the prescription and when the prescriber cannot be reached, a denial for a missing diagnosis code may be overridden if the pharmacist determines that the recipient cannot wait to receive the medication.

When the cumulative daily dosage for Buprenorphine Transdermal Patches (Butrans®) exceeds the maximum daily dosage, the claim will deny. The maximum daily dosage for this agent is 480 mcg/24hr (20mcg/hr). Do not exceed a dose of one 20mcg/hr buprenorphine patch. See prescribing information. Each patch is intended to be worn for seven days.

There is no provision for override through the Point of Sale system for Buprenorphine Transdermal Patches (Butrans®) when the maximum daily dosage is exceeded.



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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Carisoprodol

Pharmacy claims for carisoprodol will deny when the quantity exceeds ninety (90) tablets per rolling ninety (90) days. The quantity limit is cumulative and applies to all strengths and combinations of carisoprodol. The pharmacy claim will deny as exceeding the program's maximum allowed. **There are no provisions for overrides.**

Contraceptive Agents

**DROSPIRENONE/ETHINYLESTRADIOL/LEVOMEFOLATE  
CALCIUM (BEYAZ®)**

Pharmacy claims for Drospirenone/Ethinyl Estradiol/Levomefolate Calcium (Beyaz®) require an appropriate ICD-9-CM diagnosis code for reimbursement. Claims submitted with diagnosis codes for cosmetic indications will deny.

**ETONOGESTREL/ETHINYL ESTRADIOL VAGINAL RING  
(NUVARING®)**

Prescription claims for Etonogestrel/Ethinyl Estradiol vaginal ring (Nuvaring®) for quantities of four and greater will deny. There is no provision for override as these claims exceed the program maximum of a 100 days supply.

In addition, there will be a valid days supply range dependent on the quantity billed:

- If quantity = 1, then Days Supply must be 21 to 28,
- If quantity = 2, then Days Supply must be 42 to 56,
- If quantity = 3, then Days Supply must be 63 to 84.

Pharmacists are allowed to override the denial on days supply after consultation with the prescriber.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

**MEDROXYPROGESTERONE ACETATE INJECTABLE**

Prescription claims for Medroxyprogesterone Acetate injectable for a days supply less than 84 with a bill quantity of one for female recipients will deny. Quantities of two and greater will not be payable with no provision for override as they exceed the program maximum of a 100 days supply.

Claims for Medroxyprogesterone Acetate sub-q 104 injectable for a days supply less than 84 with a bill quantity of 0.65 for female recipients will also deny. Quantities of 1.3 and greater will not be payable with no provision for override as they exceed the program maximum of a 100 days supply.

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Contraceptive Agents,  
continued

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**MEDROXYPROGESTERONE ACETATE INJECTABLE, continued**

Pharmacists are allowed to override the denial on days supply after consultation with the prescriber.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

**NORELGESTROMIN/ETHINYL ESTRADIOL TRANSDERMAL  
PATCHES (ORTHO-EVRA®)**

Reimbursement of these contraceptive transdermal patches when dispensed using the package size of three (3) must be billed in multiples of three. If the quantity billed is not a multiple of three the claim will deny. There are no provisions for override.

Diabetic Testing  
Supplies

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The Medicaid Pharmacy Program reimburses claims for prescribed diabetic testing supplies.

All diabetic supply claims submitted to Medicaid will deny when recipients are Medicare Part B eligible. Medicare Part B covers diabetic supplies for all diabetic recipients regardless of insulin requirements. Pharmacy providers shall submit these claims to the Medicare DMERC. These claims will then automatically cross-over to the Medicaid fiscal intermediary for payment of the coinsurance and deductible amounts, where applicable.

Diabetic supplies and glucometers for long term care recipients are not covered in the Medicaid Pharmacy Program or through prior authorization because they are covered in the nursing home per diem rate.

It is allowable for Medicare Part B to be billed if the long term care recipient is eligible for the benefit. Medicaid is not obligated to pay the coinsurance and deductible if the items are included in the Medicaid per diem. The Medicaid fiscal intermediary will automatically deny any crossover claims for diabetic supplies for long term care recipients.

**Note:** Refer to Section 37.7 Medicare Prescription Drug Coverage for detailed information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

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Fertility Agents	<p>Fertility preparations, when they are used solely for the treatment of infertility, are not reimbursable. The drugs include Clomiphene citrate tablets 50mg, Urofollitropin ampules 75IU, and Menotropins ampules 150IU and 75IU. If prescriptions for these products are prescribed for any indications other than infertility, the physician shall certify the indication, in his own handwriting, on the prescription. In order for the pharmacist to be reimbursed for the product, a hard copy claim along with a copy of the original prescription will have to be submitted to the fiscal intermediary for processing indicating a diagnosis other than infertility.</p>
Isotretinoin	<p>Isotretinoin capsules will be covered only if a handwritten prescription signed by the prescribing practitioner, with no provisions for refills, is submitted.</p>
Ketorolac	<p>Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than twenty (20) or the days supply is greater than five (5) days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the ICD-9-CM diagnosis code and the rationale for using greater than a five days supply of ketorolac. The ICD-9-CM diagnosis code is required for the claim submission.</p> <p><b>Note:</b> Refer to Appendix D Point of Sale User Guide for detailed billing information.</p>
Nicotine Transdermal Patches, Gum and Spray	<p>Nicotine transdermal patches, nicotine polacrlix gum, and nicotine spray are covered only with a handwritten prescription signed by the prescribing practitioner. There are no provisions for refills. The physician will need to rewrite a prescription each time.</p> <p>Also, physicians must certify, in their own handwriting, either directly on the prescription or on an attachment to the prescription that the recipient is enrolled in a <b>physician-supervised</b> behavioral program in order for Medicaid to provide coverage for nicotine adhesive patches, gum and spray. Pharmacy providers should verify that the above noted documentation is written on or attached to the prescription when the prescription is dispensed.</p> <p>This information must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.</p>

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Orlistat

Medicaid will provide reimbursement to outpatient pharmacies for orlistat prescriptions based on the following criteria:

- An authorized prescriber has hand written the prescription - no facsimiles allowed;
- Patient is twelve years of age or older;
- Only original prescriptions—no refills are allowed;
- Maximums of ninety (90) capsules **and** thirty (30) days supply;
- Patient has a documented current body mass index (BMI) of twenty-seven (27) or greater and the prescriber had identified the BMI, in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription;
- Patient has other risk factors warranting the use of Orlistat and the prescriber has identified an approved **ICD-9-CM diagnosis code** in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription; and
- No provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

The following risk factors, as identified by ICD-9-CM **numeric codes only**, are acceptable:

<b>ICD-9-CM Code</b>	<b>Description</b>
250.00 through 250.93	Type II Diabetes
271.3	Impaired Glucose Tolerance
251.0 through 251.2	Hyperinsulinemia
272.0 through 272.4	Dyslipidemia
401.00 through 405.99	Hypertension
410.00 through 414.99	Ischemic Heart Disease
429.2	Cardiovascular Disease, unspecified
440.00 through 440.90	Atherosclerosis
443.00 through 443.90	Other peripheral vascular diseases
530.11 and 530.81	Gastric Reflux Disease
715.05 through 715.97	Osteoarthritis of Hips/Knees
780.51, 780.53 and 780.57	Sleep Apnea
430.00 through 438.99	Cerebrovascular Disease
348.2	Pseudotumor cerebri
454.2	Varicose Veins of the lower extremities with ulcer and inflammation
451.0	Phlebitis & Thrombophlebitis of the superficial vessels of the lower extremities
451.11	Phlebitis & Thrombophlebitis of the femoral vein

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Orlistat, continued

**ICD-9-CM Code**

**Description**

451.19	Phlebitis & Thrombophlebitis of other deep vessels
451.2	Phlebitis & Thrombophlebitis of lower extremities, unspecified
454.0	Varicose veins of lower extremities, with ulcer
454.1	Varicose veins of lower extremities, with inflammation
454.9	Varicose veins of lower extremities, without mention of ulcer & inflammation

The prescriber identified ICD-9-CM diagnosis code must be included in the claim submission. The required supporting documentation for coverage must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.

Palivizumab  
(Synagis®)

Prescriptions for Synagis® will only be reimbursed when prescriptions meet the following criteria:

- Dates of service are within the Respiratory Syncytial Virus (RSV) season;
- Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1<sup>st</sup> of the RSV season;
- Claims for Synagis® will only process for payment every twenty-eight (28) days;
- A maximum of five (5) doses of Synagis® will be reimbursed each RSV season;
- An appropriate ICD-9-CM diagnosis code must be documented on the hardcopy prescription after written, electronic or verbal consultation with the prescribing practitioner.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits, and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

**RSV Season**

Synagis® claims with dates of service outside of RSV season will deny. The RSV season in Louisiana may vary depending on the geographic location. Louisiana's RSV activity may be followed during the RSV season by frequently accessing the website <http://www.cdc.gov/surveillance/nrevss/rsv/state.html>. The RSV season begins November 1<sup>st</sup> and ends March 31<sup>st</sup>.

Claims billed for dates of service outside the RSV season will require a **hardcopy prescription with justification for Synagis® use handwritten by**

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continued

Palivizumab  
(Synagis®),  
continued

**the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

**Age Restriction**

Claims for Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1<sup>st</sup> of the RSV season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1<sup>st</sup> will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these **pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

**Early Refill**

Claims for Synagis® will only process for payment every twenty-eight (28) days. When a pharmacy submits a claim for Synagis® and there is an active paid Synagis® claim on file, the incoming claim will deny. An active prescription is a prescription in which the days supply has not expired. After consultation with and approval from the prescribing practitioner, the pharmacist may override the early refill edit.

**Maximum Number of Doses Allowed**

Claims billed for Synagis® outside the allowable number of doses will deny. Based upon the diagnosis code submitted, a maximum of five (5) doses of Synagis® will be reimbursed each RSV season. If the initial dose is given in

October, the fifth and final dose should be given in February. If initial dose is given in November, the fifth and final dose should be given in March.

If a diagnosis code of 765.27 (33-34 completed weeks of gestation) is billed, then a maximum of three (3) doses will be reimbursed each RSV season.

Claims billed for greater than the number of allowable doses of Synagis® will require **a hardcopy prescription which includes justification handwritten by the prescriber.** The prescription may be faxed to the pharmacy and must be

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Palivizumab  
(Synagis®),  
continued

retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® greater than the allowable number of maximum doses.

**ICD-9-CM Diagnosis Code Requirement**

An appropriate ICD-9-CM diagnosis code must be documented on the hardcopy prescription after written, electronic, or verbal consultation with the prescribing practitioner. Claims for Synagis® submitted without an appropriate diagnosis code or without any diagnosis code will deny. The following diagnosis codes are acceptable:

<b><u>ICD-9-CM Diagnosis Code</u></b>	<b><u>Description</u></b>
415.0	Acute cor pulmonale
416.0	Primary pulmonary hypertension
416.8	Pulmonary hypertension, secondary
745.0	Truncus arteriosus
745.10-745.11	Transposition of the great vessels
745.19	Other transposition of the great vessels
745.2	Tetralogy of Fallot
746.1	Tricuspid atresia and stenosis, congenital
746.2	Ebstein's anomaly
747.41	Total anomalous pulmonary venous return
747.83	Persistent pulmonary hypertension, primary pulmonary hypertension of the newborn (Persistent fetal circulation)
765.21	Less than 24 completed weeks of gestation
765.22	24 completed weeks of gestation
765.23	25-26 completed weeks of gestation
765.24	27-28 completed weeks of gestation
765.25	29-30 completed weeks of gestation
765.26	31-32 completed weeks of gestation
765.27	33-34 completed weeks of gestation
770.7	Chronic respiratory disease arising in perinatal period (CLD/BPD/interstitial pulmonary fibrosis of infancy/Wilson- Mikity syndrome)

Other diagnosis may be used to justify Synagis® depending on recipient-specific factors. The following diagnosis codes **could** be used to justify immunoprophylaxis with Synagis®, and are subject to prescriber assessment and judgment.

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continued

Palivizumab  
(Synagis®),  
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<b><u>ICD-9-CM Diagnosis Code</u></b>	<b><u>Description</u></b>
042	Human immunodeficiency virus (HIV) disease
045.00-045.13	Infantile paralysis
277.00-277.09	Cystic fibrosis
279.00-279.90	Disorders involving the immune system
335.0	Werdnig-Hoffman disease
335.10-335.11	Spinal muscular atrophy
335.20-335.24	Motor neuron disease
343.0-343.9	Infantile cerebral palsy
358.0-358.9	Myoneural disorders
359.0-359.9	Muscular dystrophies and other myopathies
396.0-396.9	Diseases of mitral and aortic valves
424.1	Aortic stenosis
425.00-425.90	Cardiomyopathy
428.0-428.9	Heart failure
519.1	Other diseases of the trachea and bronchus, not elsewhere classified (Must specify tracheomalacia or tracheal stenosis)
745.4	Ventricular septal defect
745.5	Atrial septal defect
745.60-745.69	Atrioventricular canal (endocardial cushion defect)
746.7	Hypoplastic left heart
746.89	Hypoplastic right heart
748.3	Other anomalies of the larynx, trachea and bronchus (Must specify congenital tracheal stenosis, atresia of trachea, absence or agenesis of bronchus, trachea)
748.4	Congenital cystic lung
748.5	Agenesis, hypoplasia, and dysplasia of the lung
748.61	Congenital bronchiectasis
750.15	Macroglossia
750.9	Uvula anomaly
759.89	Congenital malformation syndromes affecting multiple systems, not elsewhere classified (Beckwith Wiedmann syndrome)



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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

Palivizumab  
(Synagis®),  
continued

In the event, that the prescribing provider cannot be contacted, the pharmacist may override the missing or invalid diagnosis code edit. The pharmacist must document "Emergency Prescription" on the hard copy prescription and submit the appropriate override.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits, and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

Schedule II Narcotic  
Agents

All prescriptions for Schedule II narcotic agents require an ICD-9-CM diagnosis code indicating the reason for use documented on the hardcopy prescription. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist after consultation with the prescriber.

Except for methadone, when the prescribing practitioner does not indicate a diagnosis code on the prescription and when the prescriber cannot be reached, a denial for a missing diagnosis code may be overridden if the pharmacist determines that the recipient cannot wait to receive the medication.

Schedule II narcotic agents are also subject to Prospective Drug Utilization Reviews which address quantity limits.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for further policy.

**FENTANYL BUCCAL AND SUBLINGUAL AGENTS**

Claims for fentanyl buccal and sublingual agents (Abstral®, Actiq®, Fentora® and Onsolis®) **must** contain a cancer-related ICD-9-CM diagnosis code in order for the claim to process for payment through the Point of Sale System.

Acceptable ICD-9-CM diagnosis codes are as follows:

<b>ICD-9-CM Code Range</b>	<b>Description</b>
140-149.99	Malignant Neoplasm of lip, oral cavity and pharynx
150-159.99	Malignant neoplasm of digestive organs and peritoneum
160-165.99	Malignant neoplasm of respiratory and intrathoracic organs
170-176.99	Malignant neoplasm of bone, connective tissue, skin and Breast
179-189.99	Malignant neoplasm of genitourinary system
190-199.99	Malignant neoplasm of other and unspecified sites
200-208.99	Malignant neoplasm of lymphatic and hematopoietic tissue
209.0-209.39	Malignant carcinoid tumors

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continued

Schedule II Narcotic  
Agents, continued

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**FENTANYL BUCCAL AND SUBLINGUAL AGENTS, continued**

Buccal and sublingual agents are subject to Prospective Drug Utilization Reviews which address quantity limits.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for further policy.

**METHADONE**

All prescriptions for methadone must have a diagnosis code for payment. There are no provisions for an override of methadone when a diagnosis code is omitted. Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs shall only be dispensed by opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration.

**MORPHINE ER (AVINZA®)**

When the cumulative daily dosage for Morphine ER (Avinza®) exceeds the maximum daily dosage, the claim will deny. The maximum daily dosage for this agent is 1600mg per day. There is no provision for override through the Point of Sale system for Morphine ER (Avinza®) when the maximum daily dosage is exceeded.

Sildenafil (Revatio®)  
And Tadalafil  
(Adcirca®)

Prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) are payable when prescribed for primary pulmonary hypertension. An appropriate ICD-9-CM diagnosis code must be documented on all prescriptions by either the prescriber or the pharmacist. The ICD-9-CM code may be communicated to the pharmacist electronically, via telephone or facsimile. The ICD-9-CM diagnosis code is required for the claim submission.

The following ICD-9-CM diagnosis codes are acceptable:

ICD-9-CM Code	Description
416.0	Primary pulmonary hypertension
416.8	Other chronic pulmonary heart disease

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**37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS,**  
continued

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Tazarotene (Tazorac®) Pharmacy claims for Tazarotene (Tazorac®) require an appropriate ICD-9-CM diagnosis code for reimbursement. The prescribing provider must document the diagnosis code on the hard copy prescription or may communicate the diagnosis code over the phone.

The acceptable ICD-9-CM diagnosis codes are:

<b>ICD-9-CM Code</b>	<b>Description</b>
696.0	Psoriatic Arthropathy
696.1	Other Psoriasis

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS**

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Prospective drug utilization review (UniDUR) consists of criteria set forth by the state-established Drug Utilization Review (DUR) board which monitors for inappropriate use of medications and identifies potential drug conflicts. UniDUR is designed to work alongside the POS claims processing and eligibility systems. Prospective Drug Utilization Review displays alert messages, based on severity level, to alert of any possible harmful effects that a medication may have on a patient. The alerts generated are caused by various combinations of interactions between a patient's condition, patient's historical drug prescription records on file and the current medications prescribed for them.

Professional judgement regarding appropriate drug use is the responsibility of the pharmacist. Improper use of DUR override codes by pharmacy staff may result in the disallowance of these override codes and administrative sanctions by Medicaid and the Board of Pharmacy.

UniDUR has predetermined standards to monitor:

- Duration of therapy;
- Early refill;
- Duplicate drug therapy;
- Pregnancy and FDA Category X drugs;
- Therapeutic duplication;
- Drug to drug interaction;
- Unnecessary drug therapy;
- Age and gender restrictions;
- Maximum dosage;
- Quantity Limits; and
- Drugs to diagnosis.

**Note:** Refer to Section 37.16 for an overview of Patient Counseling, Drug Utilization Review (DUR) and Provider Peer Based Profiling.

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Duration of  
Therapy Limits

**Proton Pump Inhibitors, H2 Antagonists & Sucralfate**

The program utilizes a duration of therapy module for H2 antagonists, proton pump inhibitors (PPIs) and sucralfate for recipients who are 16 and older.. Acute dosage guidelines for these drugs are monitored. The chronic use of these agents at full therapeutic dosage is generally not indicated. The duration of therapy period begins every calendar year.

The acute dosage schedules of these drugs are as follows:

**Proton Pump Inhibitors**

<u>Generic Description</u>	<u>Acute mg/day dose</u>	<u>Duration of Therapy</u>
Omeprazole	20 mg	16 weeks (120 days)
Lansoprazole	30 mg	16 weeks (120 days)
Pantoprazole	40 mg	16 weeks (120 days)
Rabeprazole	20 mg	16 weeks (120 days)
Esomeprazole	40 mg	16 weeks (120 days)

**H2 Antagonists & Sucralfate**

<u>Generic Description</u>	<u>Acute mg/day dose</u>	<u>Duration of Therapy</u>
Ranitidine HCl	300 mg	12 weeks (90 days)
Cimetidine	1200 mg	12 weeks (90 days)
Nizatidine	300 mg	12 weeks (90 days)
Famotidine	40 mg	12 weeks (90 days)
Sucralfate	4000 mg	12 weeks (90 days)

Maintenance dose drug therapy will continue to be payable after the 90 days or 120 days of the appropriate drug therapy.

If, in the professional judgement of the prescriber, a determination is made to continue acute therapy beyond the appropriate duration of therapy, the prescriber must indicate in writing on the prescription or a signed and dated attachment, a diagnosis code necessitating the continuation of acute therapy. Recipient specific diagnosis information from the prescriber via facsimile is acceptable.

Only the prescriber who issues a prescription is authorized to sign off on a diagnosis override.

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continued

Duration of  
Therapy Limits,  
continued

For acute therapy to continue as a reimbursable service beyond the above listed duration of therapy, the pharmacy provider must supply the reason for service code, professional service code and result of service code.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

An acceptable ICD-9-CM diagnosis code indicating the condition identified by the prescriber which warrants continuation of the acute dosage must be written on the prescription. The pharmacy provider must supply that information accurately as provided by the prescriber. Only claims with one of the diagnoses listed below will be reimbursable for an excessive duration of therapy.

<b>ICD-9-CM Code</b>	<b>Description</b>
041.86	H. Pylori
202.60 through 202.68	Systemic Mastocytosis
237.4	Multiple Endocrine Adenomas
251.5	Zollinger-Ellison Syndrome
530.10	Esophagitis
530.11	Gastroesophageal Reflux Disease (GERD)
530.19	Esophagitis
530.81	Gastroesophageal Reflux Disease (GERD)
530.20	Barrett's Esophagitis
531.00 through 531.91	Gastric Ulcer
532.00 through 532.91	Duodenal Ulcer
533.00 through 533.91	Peptic Ulcer (H. Pylori)
535.00 through 535.51	Gastritis
535.50	Gastroduodenitis
535.51	Gastroduodenitis
535.60	Duodenitis
535.61	Duodenitis
536.80	Dyspepsia
536.80	Gastric Hypersecretion
537.90	Unspecified disorder of stomach and duodenum
555.90	Crohn's Disease
569.90	Unspecified disorder of the intestines
577.10	Chronic Pancreatitis
578.90	Gastrointestinal Bleeding

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Duration of  
Therapy Limits,  
continued

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**Palivizumab (Synagis®)**

Respiratory Syncytial Virus (RSV) Season

Synagis® claims with dates of service outside of RSV season will deny. The RSV season may begin in either October or November and ends March 31<sup>st</sup>. Claims billed for dates of service outside the RSV season will require **a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

The pharmacist may override the maximum duration of therapy edit. The pharmacy provider must document and supply the reason for service code, professional service code and result of service code.

Maximum Number of Doses Allowed

Claims billed for Synagis® outside the allowable number of doses will deny. Based upon the diagnosis code submitted, the maximum number of doses any recipient should receive is five (5). If the initial dose is given in October, the fifth and final dose should be given in February. If initial dose is given in November, the fifth and final dose should be given in March. If a diagnosis code of 765.27 (33-34 completed weeks of gestation) is billed, then a maximum of three (3) doses will be reimbursed each RSV season.

Claims billed for greater than the number of allowable doses of Synagis® will require **a hardcopy prescription which includes justification handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® greater than the allowable number of maximum doses.

The pharmacist may override the maximum duration of therapy edit. The pharmacy provider must document and supply the reason for service code, professional service code and result of service code.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Early Refill

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The Medicaid program denies pharmacy claims for early refills if the patient has requested the same medication at the same pharmacy prior to seventy-five percent of medication being utilized. This translates into a seven (7) day window based on a thirty (30) day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than eighty-five percent of the medication had been utilized. This translates into a three (3) day window based on a thirty (30) day supply.

Pharmacists must enter the actual days supply for each pharmacy claim. If the number of days is not apparent, an estimate must be given based on professional judgement.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a patient's request for medication earlier than previously reported in the estimated days supply. The pharmacist must document the circumstances on the prescription hard copy.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

Duplicate  
Drug Therapy

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A claim denial will occur if the patient attempts to obtain the same drug (form and strength) from a different pharmacy sooner than is anticipated based on the estimated days supply.

After consultation with the physician, patient and/or the POS help desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim.

The pharmacy provider shall record documentation of **circumstances and specific contacts** for the override.

For those **isolated instances** when one pharmacy has billed a claim, and special circumstances prevented the recipient from receiving the prescription from the pharmacy originally billing the claim an override is allowed. An override should only be used if the second pharmacy attempting to bill a claim for the same ingredient for the same recipient and cannot have the first claim reversed by the original billing pharmacy. A notation to that effect **must be written on the hardcopy prescription**. Please note, we will include a review of pharmacy claims billed with an override code in our pharmacy audit process.

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Duplicate  
Drug Therapy,  
continued

When **both** duplicate drug therapy and early refill clinical events occur, reimbursement will not be made. These situations indicate multiple pharmacy shopping patterns.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

Pregnancy and  
FDA Category  
X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category X drugs for pregnant women. Pharmacy claims submitted for a drug in this category for recipients with a co-payment designation of pregnancy will be denied.

The specific drugs that are currently included in FDA Pregnancy Category X are listed below. The Medicaid Program may add drugs to these lists as new drugs appear on the market or as FDA indications change.

There is no override option for these claims.

**FDA PREGNANCY CATEGORY X**

Acetohydroxamic Acid  
Acitretin  
Ambrisentan  
Anastrozole  
Androgens  
Bexarotene  
Bicalutamide  
Bosentan  
Chorionic Gonadotropin (Human)  
Clomiphene Citrate  
Danazol  
Degarelix  
Dihydroergotamine Mesylate (Inj;Nasal)  
Drospirenone  
Dutasteride  
Ergotamine Tartrate  
Estazolam  
Estradiol  
Estrogenic Agents  
Ethinyl Estradiol  
Ethinodiol Acetate  
Etonogestrel  
Finasteride  
Fluorouracil (Topical)



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Pregnancy and  
FDA Category  
X Drugs,  
continued

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Fluoxymesterone  
Flurazepam Hydrochloride  
Goserelin  
HMG COA Reductase Inhibitors  
Isotretinoin  
Leflunomide  
Leuprolide Acetate  
Levonorgestrel  
Lutropin Alpha  
Medroxyprogesterone Acetate (Intramuscular)  
Medroxyprogesterone Acetate (Non-Intramuscular)  
Megestrol Acetate  
Menotropins  
Meprobamate  
Mestranol  
Methotrexate  
Methyl Testosterone  
Miglustat  
Misoprostol  
Nafarelin Acetate  
Nandrolone (Decanoate, Phenpropionate)  
Norelgestromin  
Norethindrone (As Progestogen)  
Norgestrel (As Progestogen)  
Oral Contraceptives  
Oxandrolone  
Oxymetholone  
Quazepam  
Raloxifene  
Ribavirin  
Rosuvastatin  
Stanozolol  
Tazarotene  
Temazepam  
Testosterone  
Thalidomide  
Triazolam  
Vitamin A  
Warfarin Sodium

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Pregnancy and  
FDA Category  
D Drugs

Pharmacy claims submitted with FDA Pregnancy Category D drugs will receive an educational edit in the response from Louisiana Medicaid. These claims will not deny.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,  
continued**

**Therapeutic  
Duplication**

The Medicaid Program denies pharmacy claims for oral formulations of drugs in the following classes and specific drugs if the recipient has an **active** paid claim on file for another drug in the same therapeutic class. An active prescription is a prescription in which the days supply has not expired.

If an override is determined appropriate after contacting the prescriber, additional hard-copy documentation of the reason for service code, professional service code and result of service code is required on the new prescription for audit purposes. Additional requirements may be associated with certain drug classes or specific drugs.

**SECOND GENERATION ANTIHISTAMINES AND SECOND  
GENERATION ANTIHISTAMINE COMBINATION AGENTS**

Cetirizine	Fexofenadine/Pseudoephedrine
Cetirizine/Pseudoephedrine	Levocetirizine Dihydrochloride
Desloratadine	Loratadine
Desloratadine/Pseudoephedrine	Loratadine/Pseudoephedrine
Fexofenadine	

**ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS AND  
ACE INHIBITOR/DIURETIC COMBINATIONS**

Benazepril HCl	Lisinopril/Hydrochlorothiazide
Benazepril HCl/Hydrochlorothiazide	Moexipril HCl
Captopril	Moexipril/Hydrochlorothiazide
Captopril/Hydrochlorothiazide	Perindopril Erbumine
Enalapril Maleate	Quinapril HCl
Enalapril/Hydrochlorothiazide	Quinapril/Hydrochlorothiazide
Fosinopril Sodium	Ramipril
Fosinopril/Hydrochlorothiazide	Trandolapril
Lisinopril	

**ACE INHIBITORS/CALCIUM CHANNEL BLOCKER COMBINATIONS**

Benazepril/Amlodipine  
Trandolapril/Verapamil HCl

**ANGIOTENSIN RECEPTOR ANTAGONISTS (ARB) AND  
ARB/DIURETIC COMBINATIONS**

Candesartan Cilexetil	Losartan/Hydrochlorothiazide
Candesartan/Hydrochlorothiazide	Olmesartan Medoxomil
Eprosartan Mesylate	Olmesartan/Hydrochlorothiazide
Eprosartan/Hydrochlorothiazide	Telmisartan

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Therapeutic  
Duplication,  
continued

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**ANGIOTENSIN RECEPTOR ANTAGONISTS (ARB) AND  
ARB/DIURETIC COMBINATIONS, continued**

Irbesartan	Telmisartan/Hydrochlorothiazide
Irbesartan/Hydrochlorothiazide	Valsartan
Losartan Potassium	Valsartan/Hydrochlorothiazide

**ARB/CALCIUM CHANNEL BLOCKER COMBINATIONS**

Olmesartan Medoxomil/Amlodipine  
Valsartan/Amlodipine

**BETA-ADRENERGIC BLOCKING AGENTS AND BETA-  
ADRENERGIC BLOCKING AGENT/DIURETIC COMBINATIONS**

Acebutolol HCl	Nadolol
Atenolol	Nadolol/Bendroflumethiazide
Atenolol/Chlorthalidone	Nebivolol HCl
Betaxolol HCl	Penbutolol Sulfate
Bisoprolol Fumarate	Pindolol
Bisoprolol/Hydrochlorothiazide	Propranolol HCl
Carvedilol	Propranolol/Hydrochlorothiazide
Carvedilol CR	Sotalol AF
Labetalol HCl	Sotalol HCl
Metoprolol ER	Timolol Maleate
Metoprolol Tartrate	Timolol/Hydrochlorothiazide
Metoprolol/Hydrochlorothiazide	

**CALCIUM CHANNEL BLOCKERS**

Amlodipine	Nifedipine
Diltiazem	Nimodipine
Felodipine	Nisoldipine
Isradipine	Verapamil
Nicardipine	

**CALCIUM CHANNEL BLOCKER/ANTHYPERLIPIDEMIA AGENT  
COMBINATION**

Amlodipine/Atorvastatin Calcium

**POTASSIUM REPLACEMENT**

Potassium Acetate  
Potassium Bicarbonate / Citric Acid  
Potassium Chloride  
Potassium Citrate

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Therapeutic  
Duplication,  
Continued

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**TRICYCLIC ANTIDEPRESSANTS**

Amitriptyline HCl	Imipramine Pamoate
Amoxapine	Maprotiline HCl
Clomipramine HCl	Nortriptyline HCl
Desipramine HCl	Protriptyline HCl
Doxepin HCl	Trimipramine Maleate
Imipramine HCl	

**SELECTIVE SEROTONIN REUPTAKE INHIBITORS**

Citalopram HBr	Paroxetine HCl
Escitalopram Oxalate	Paroxetine Mesylate
Fluoxetine HCl	Sertraline HCl
Fluvoxamine Maleate	

**ANTIPSYCHOTIC AGENTS (TYPICAL AND ATYPICAL)**

Prescriptions for antipsychotic agents will deny for therapeutic duplication when the recipient has two active antipsychotic prescriptions on their file. The pharmacist must document on the hard copy prescription the reason the prescriber required the patient to receive a third antipsychotic agent.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for further policy regarding Antipsychotic Agents.

**Typical Antipsychotic Agents**

Chlorpromazine	Pimozide
Fluphenazine	Prochlorperazine
Haloperidol	Thioridazine
Loxapine	Thiothixene
Molindone	Trifluoperazine
Perphenazine	

**Atypical Antipsychotic Agents**

Aripiprazole	Paliperidone
Asenapine	Quetiapine
Clozapine	Risperidone
Iloperidone	Ziprasidone
Olanzapine	

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Therapeutic  
Duplication,  
continued

**Antipsychotic /Selective Serotonin Reuptake Inhibitor Combinations**

Pharmacy claims for olanzapine/fluoxetine will deny when there are **two** active prescriptions for antipsychotic agents on the recipient's file **or** when there is **one** active prescription for a selective serotonin reuptake inhibitor (SSRI) on the recipient's history file.

Olanzapine/Fluoxetine

**ANTI-ANXIETY AGENTS**

Alprazolam	Hydroxyzine
Buspirone	Lorazepam
Chlordiazepoxide	Meprobamate
Chlorazepate	Oxazepam
Diazepam	

The pharmacist must document on the hardcopy prescription the reason an additional anti-anxiety agent was requested by the prescriber.

An additional anti-anxiety agent may be submitted without a therapeutic duplication when the recipient has a diagnosis of **seizures**. The diagnosis code must be documented on the hardcopy prescription after written or verbal consultation with the prescriber and submitted electronically for the override.

Acceptable ICD-9-CM diagnosis codes are:

<b>ICD-9-CM Code</b>	<b>Description</b>
345.0 through 345.99	Epilepsy
780.30 through 780.39	Convulsions

**SEDATIVE HYPNOTIC AGENTS**

Estazolam	Temazepam
Eszopiclone	Triazolam
Flurazepam HCl	Zaleplon
Quazepam	Zolpidem Tartrate

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Therapeutic  
Duplication,  
continued

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**ATTENTION DEFICIT DISORDER AGENTS**

Armodafinil	Guanfacine
Atomoxetine	Lisdexamfetamine
Dexmethylphenidate	Methylphenidate
Dextroamphetamine	Modafinil
Dextroamphetamine/amphetamine	

An incoming pharmacy claim for any of the above Attention Deficit Disorder agents will deny when there is an active paid claim for any of these agents on the recipient's file written by a different prescriber.

**NON-STEROIDAL ANTI-INFLAMMATORY AGENTS**

Celecoxib	Ketorolac Tromethamine
Diclofenac Potassium	Meclofenamate Sodium
Diclofenac Sodium	Mefenamic Acid
Diclofenac Sodium / Misoprostol	Meloxicam
Diflunisal	Nabumetone
Etodolac	Naproxen
Fenoprofen Calcium	Naproxen Sodium
Flurbiprofen	Naproxen/Lansoprazole
Ibuprofen	Oxaprozin
Ibuprofen / Hydrocodone Bitartrate	Piroxicam
Ibuprofen/Oxycodone	Sulindac
Indomethacin	Tolmetin Sodium
Ketoprofen	

**SHORT ACTING OPIATE AGENTS**

Buprenorphine*	Hydrocodone/APAP
Buprenorphine/Naloxone*	Hydrocodone/Ibuprofen
Butorphanol Tartrate	Hydromorphone HCl IR
Codeine Phosphate	Levorphanol Tartrate
Codeine Phosphate/APAP	Meperidine HCl
Codeine/ASA	Methadone HCl
Codeine Sulfate	Morphine Sulfate IR
Codeine/APAP/Caffeine/Butalbital	Oxycodone HCl IR
Codeine/ASA/Caffeine/Butalbital	Oxycodone/APAP
Codeine/Carisoprodol/ASA	Oxycodone ASA
Dihydrocodeine/APAP/Caffeine	Oxycodone/Ibuprofen
Fentanyl Citrate Buccal	Oxymorphone

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Therapeutic  
Duplication,  
continued

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**SHORT ACTING OPIATE AGENTS, continued**

Pentazocine/APAP	Propoxyphene/APAP
Pentazocine/Naloxone	Tramadol HCl
Propoxyphene HCl	Tramadol HCl/APAP
Propoxyphene/Napsylate	

**\*Note:** Concurrent prescriptions for opioid analgesics with buprenorphine agents may only be overridden when issued by the same physician.

**LONG ACTING OPIATE AGENTS**

Fentanyl Transdermal	Oxycodone HCl CR
Morphine Sulfate CR	Oxymorphone ER

**PROTON PUMP INHIBITORS**

Esomeprazole	Omeprazole/Sodium Bicarbonate
Lansoprazole	Pantoprazole
Omeprazole	Rabeprazole

The Department may add drugs to these lists as new drugs appear on the market.

**Note:** Refer to Section 37.9.5 for override information as well as Appendix D Point of Sale User Guide for detailed billing information.

Drug/  
Drug Interaction

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There may be some situations where adverse interactions could potentially occur between two drugs. In these instances the UniDUR system denies one or both of these claims.

Prescriptions for nitrates will deny when there is an active prescription for Sildenafil (Revatio®) or Tadalafil (Adcirca®) on the recipient's drug history file. Conversely, prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) will deny when there is an active prescription for nitrates on the drug history file.

Upon consultation with the prescriber, the pharmacist may override this interaction. The pharmacist must document the reason the prescriber required the patient to receive a nitrate and Sildenafil (Revatio®) or Tadalafil (Adcirca®). In addition, documentation of the reason for service code, professional service code and result of service code is required on the hardcopy prescription. These DUR codes are required for the claim submission.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Unnecessary Drug  
Therapy

The FDA issued a Public Health Advisory, which stated that use of a COX-2 selective agent may be associated with an increased risk of serious cardiovascular events, especially when it is used for long periods of time or in very high-risk settings (e.g. immediately after heart surgery).

The FDA made the following interim recommendations:

- Practitioners prescribing Celecoxib (Celebrex®) should consider this emerging information when weighing the benefits against risks for individual patients. Patients who are at a high risk of gastrointestinal (GI) bleeding, have a history of intolerance to non-selective NSAIDs, or are not doing well on non-selective NSAIDs may be appropriate candidates for COX-2 selective agents.
- Individual patient risk for cardiovascular events and other risks commonly associated with NSAIDs should be taken into account for each prescribing situation.

As a result of this Public Health Advisory and to help ensure the safety and well being of Medicaid patients, the prescribing practitioner **must include**:

- **The condition being treated with the COX-2 selective agent by indicating the ICD-9-CM diagnosis code of the treated condition (e.g. Osteoarthritis – 715.0) on all new prescriptions written for a COX-2 selective agent; and**
- **The reason a COX-2 selective agent is used rather than a non-selective NSAID (e.g. treatment failure or history of a GI bleed).**

The ICD-9-CM diagnosis code and the rationale for the choice of a COX-2 selective agent must be noted in the prescriber's handwriting. A rubber stamp notation is not acceptable. The ICD-9-CM diagnosis code and the rationale may be submitted as an attachment to the original prescription via facsimile. The attachment must be dated and written in the prescriber's handwriting.

A prescription written for a COX-2 selective agent for a Medicaid patient will only process without an override when the following conditions **are met**:

- **An ICD-9-CM diagnosis code indicating the reason for treatment is documented and submitted;**
- **and when one of the following conditions exists:**
  - Patient has current prescription for H2 receptor antagonist;
  - Patient has current prescription for proton pump inhibitor;
  - Patient has current prescription for warfarin;
  - Patient has current prescriptions indicating chronic use of oral steroids; or
  - Patient is sixty years old or greater.



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Unnecessary Drug  
Therapy, continued

If, in the professional judgment of the prescriber, a determination is made which necessitates therapy with a COX-2 selective agent, the pharmacist may override this edit. The pharmacy provider must supply the reason for service code, professional service code and result of service code with the Point of Sale submission of the claim and have the information recorded on the hardcopy.

**Note:** Refer to Section 37.9.5 for override information as well as Appendix D Point of Sale User Guide for detailed billing information.

Maximum Dosage

**ATYPICAL ANTIPSYCHOTIC AGENTS**

Pharmacy claims for doses of atypical antipsychotic agents which exceed the maximum recommended doses will deny.

The maximum dosage schedules for recipients eighteen (18) years of age or older for these drugs are as follows:

<u>Generic Name</u>	<u>Brand Name</u>	<u>Maximum Dose Per Day</u>
Aripiprazole	Abilify	30mg/day
Asenapine	Saphris	20mg/day
Clozapine	Clozaril	900mg/day
Iloperidone	Fanapt	24mg/day
Olanzapine	Zyprexa	40mg/day
Olanzapine/Fluoxetine	Symbyax	18mg/day/75mg/day
Paliperidone	Invega	12mg/day
Paliperidone	Invega Sustenna	234mg/day
Quetiapine	Seroquel	1200mg/day
Risperidone	Risperdal	16mg/day
Ziprasidone	Geodon	200mg/day

Daily doses for atypical antipsychotic agents used in recipients less than eighteen (18) years of age must not exceed an established maximum daily dose. Maximum daily doses for these agents are listed below:

<u>Brand Name</u>	<u>&lt; 5 years old</u>	<u>5-12 years old</u>	<u>13-17 years old</u>
Abilify®	5 mg daily	20 mg daily	30 mg daily
Risperdal®	3 mg daily	6 mg daily	8 mg daily
Invega®	3 mg daily	6 mg daily	9 mg daily
Seroquel®	100 mg daily	600 mg daily	1000 mg daily
Geodon®	30 mg daily	60 mg daily	120 mg daily
Zyprexa®	10 mg daily	20 mg daily	30 mg daily

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Maximum Dosage,  
continued

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**ATYPICAL ANTIPSYCHOTIC AGENTS, continued**

To override a denial, the pharmacy provider must consult with the prescriber and document on the hardcopy prescription, the reason the prescriber requires a dose above the maximum recommended dose. The pharmacist must supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

**AGENTS CONTAINING ACETAMINOPHEN OR ASPIRIN**

**Due to the potential of hepatotoxicity,** claims billed with a dosage of acetaminophen that exceeds **four grams** per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds **six grams** per day. Please note that patients may also be consuming over the counter products that contain either acetaminophen or aspirin.

The maximum regimens apply to both brand name and generic products. As new products are added to the drug file, maximum daily dosages will apply.

**Overrides for the (high dose) denial are only acceptable when the prescriber is consulted and approval is given. A notation stating the reason and the codes used to override the claim should be noted on the hardcopy prescription.**

It is imperative that pharmacists use their professional judgement to determine an appropriate days supply based upon the directions noted by the prescriber.

**TAPENTADOL (NUCYNТА®)**

When the cumulative daily dosage for Tapentadol (Nucynta®) exceeds the maximum daily dosage of 700mg per day, the claim will deny.

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
continued

Maximum Dosage,  
continued

**AGENTS CONTAINING TRAMADOL**

Pharmacy claims for doses of agents containing Tramadol which exceed the maximum recommended doses will deny.

The maximum daily doses for agents containing Tramadol are as follows:

<u>Generic Name</u>	<u>Maximum Dose per Day</u>	<u>Age</u>
Tramadol Immediate Release	400mg/day	<76 years
Tramadol Immediate Release	300mg/day	>75 years
Tramadol Sustained Release	300mg/day	
Tramadol/Acetaminophen	8 tablets/day	

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.

Quantity Limits

**SCHEDULE II NARCOTIC AGENTS**

Pharmacy claims for quantities of Schedule II narcotic agents which are in excess of the quantity limit will deny. Quantity limits are cumulative and are based on a rolling thirty (30) days. Unless otherwise specified, quantity limits apply to all strengths of an agent.

Quantity limits for Schedule II narcotic agents are as follows:

<u>Generic Name</u>	<u>Dosage Form</u>	<u>Quantity Limit per 30 Rolling Days</u>
Fentanyl	Patch 12, 25, 50mcg/hr	10 units each strength
Fentanyl	Patch 75, 100mcg/hr	20 units each strength
Fentanyl Citrate	Tablet sublingual,	120 units
Immediate Release	Effervescence Lozenge HD, Film	
Hydromorphone HCl ER	Tablet ER 24hr	30 units
Morphine Sulfate SR	CPMP 24hr	30 units
Morphine Sulfate SR	Capsule SR Pellet	60 units
Morphine Sulfate SA	Tablet SA	60 units

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
Continued

Quantity Limits,  
continued

<u>Generic Name</u>	<u>Dosage Form</u>	<u>Quantity Limit per 30 Rolling Days</u>
Morphine Sulfate/ Naltrexone SR	Capsule SR Pellet	60 units
Oxycodone HCl SR	Tablet SR 12hr	60 units
Oxycodone	Tablet or Capsule	120 units
Oxycodone/ Acetaminophen	Tablet or Capsule	120 units
Oxycodone/Aspirin	Tablet or Capsule	120 units
Oxycodone/Ibuprofen	Tablet	28 units
Oxymorphone HCl SR	Tablet SR 12hr	60 units

With the exception of the fentanyl buccal and sublingual products, recipients receiving agents listed above for the management of cancer pain are not subject to quantity limits.

**Note:** Refer to 37.5.7 Drugs with Special Payment Criteria/Limitations for acceptable ICD-9-CM diagnosis codes associated with cancer.

If the prescribing practitioner chooses to exceed the quantity limit, the prescribing practitioner must provide the reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for ICD-9-CM diagnosis code policy for Schedule II narcotic agents.

**SEROTONIN AGENTS (TRIPTANS)**

Pharmacy claims for quantities of Serotonin agents (Triptans) which are in excess of the quantity limit will deny. Quantity limits are cumulative and are based on a rolling thirty (30) days. Unless otherwise specified, quantity limits apply to all strengths of an agent.

Quantity limits for Serotonin agents (Triptans) are as follows:

<u>Generic Name</u>	<u>Dosage Form</u>	<u>Quantity Limit per 30 Rolling Days</u>
Almotriptan Maleate	Tablet	12 units
Eletriptan HBr	Tablet	6 units
Frovatriptan Succinate	Tablet	9 units
Naratriptan HCl	Tablet	9 units

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**37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS,**  
Continued

Quantity Limits,  
continued

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<u>Generic Name</u>	<u>Dosage Form</u>	<u>Quantity Limit per 30 Rolling Days</u>
Rizatriptan Benzoate	Tablet, Tablet rapid dissolve	12 units
Sumatriptan Succinate/ Naproxen Na	Tablet	9 units
Sumatriptan Succinate	Tablet	9 units
Zolmitriptan	Tablet, Tablet rapid dissolve	6 units

If the prescribing practitioner chooses to exceed the quantity limit, the prescribing practitioner must provide the reason why the quantity limit needs to be exceeded. The pharmacist may override the quantity limit after consulting with the prescriber. The pharmacist must document on the hardcopy prescription the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

Age Restriction

Claims for palivizumab (Synagis®) therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1<sup>st</sup> of the Respiratory Syncytial Virus (RSV) season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1<sup>st</sup> will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber. This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacist may override the age restriction edit. The pharmacist must document and supply the reason for service code, professional service code and result of service code.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.9 QUANTITY LIMITATIONS**

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Prescriptions payable under Louisiana Medicaid are limited as follows:

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Maximum  
Allowable Quantities

The maximum quantity payable is either a one month's supply or 100 unit doses, whichever is greater.

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Maintenance  
Medication Quantities

Prescribed maintenance drugs for chronic illnesses should be prescribed and dispensed in economic quantities sufficient to meet the medical needs of the recipient. Listed below are drugs to be considered as maintenance drugs; these drugs should be dispensed in a one month's supply:

- Anti-coagulants;
  - Anti-convulsants;
  - Oral anti-diabetics;
  - Calcium gluconate and calcium lactate;
  - Cardiovascular drugs, including diuretics, anti-hypertensives, and anti-hyperlipidemics;
  - Estrogens;
  - Iron supplements;
  - Potassium supplements;
  - Thyroids and anti-thyroid drugs; and
  - Vitamins – D, K, B12 injections, folic acid, and nicotinic acid.
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**37.5.10 COVERAGE AND LIMITATIONS FOR LONG TERM CARE  
RECIPIENTS**

Quantities  
for Long Term Care  
Recipients

Providers shall dispense a one month's supply, unless the prescribing provider specifies a smaller quantity for medical reasons, to recipients in long term care facilities. Dispensing a smaller quantity should only be done in exceptional cases.

Specific quantity limitations for maintenance medications and prn prescriptions are as follows:

“Maintenance” medications are those used to treat chronic conditions or illnesses. Initial therapy of a “maintenance” medication may be dispensed in a small quantity (e.g. a ten-day supply) to ensure patient tolerance before dispensing a one month's supply of medication. The prospective DUR compliance module will only allow a refill on the eighth day of a ten-day therapy period. If on the eighth day of therapy the patient has progressed with no adverse effects, a one-month's supply shall be dispensed unless otherwise specified by the prescriber.

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**37.5.10 COVERAGE AND LIMITATIONS FOR LONG TERM CARE  
RECIPIENTS**

Quantities  
for Long Term Care  
Recipients, continued

“PRN” prescriptions are those prescriptions that patients utilize on an “as needed” basis. For “prn” prescriptions, thirty units or a ten-day supply shall be supplied, unless otherwise specified by the prescriber.

The nursing home pharmacy consultant should periodically review if the “prn” order has become a “maintenance” one. In that event, refer to the “maintenance” drug policy. Otherwise, if every six months, a quantity of the “prn” medication remains unused by the resident, the health care team (nursing home administration, medical, nursing or pharmacy consultant) should reevaluate the necessity of the order as well as the quantity of the prescribed medication. Should the prescriber authorize an additional “prn” medication, then the subsequent dispensed quantity shall be reduced to an amount equal to the utilization of the prior six-month period.

Pharmacies are providing twenty-four hours coverage to the long term care facilities. Prescription reorders should not be made until a three-day supply remains.

Co-Payment  
Exemption

Long Term Care (LTC) recipients are exempt from co-payments and monthly prescriptions limits.

**Note:** Refer to Chapters 26 & 34 of the Louisiana Medicaid Program Provider Manual for detailed information regarding recipients in LTC facilities (ICF/MR and Nursing Homes).

Over the Counter  
(OTC) Drugs

LTC facilities are responsible for providing all OTC drugs to Medicaid recipients.

Diabetic  
Supplies

Medicaid will not reimburse pharmacies for claims for diabetic supplies when an individual resides in a long term care facility.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations; Diabetic Testing Supplies for detailed information.

Nebulizer  
Medications

Medicaid will reimburse pharmacies for the nebulizer medications for those individuals who reside in a long term care facility who do not have Medicare.

Medicare Skilled  
Nursing Facilities

When a resident of a skilled nursing facility is in Medicare payment status, payment for prescription medications is the responsibility of the facility, as prescription services are included in the per diem paid by Medicare.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**37.5.10 COVERAGE AND LIMITATIONS FOR LONG TERM CARE  
RECIPIENTS, continued**

Emergency  
Kits

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All drugs dispensed from an emergency kit shall be billed to Louisiana Medicaid indicating the date of service that coincides with the date of administration.

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**37.5.11 OUTPATIENT DRUGS COVERED BY MEDICARE PART B**

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Medicare Part B covers oral anticancer drugs, antiemetics, diabetic supplies, glucometers, antihemophilia factor products, oral immunosuppressive drugs, nebulizer medication and some other medications. Providers must be enrolled as Medicare suppliers and must bill Medicare first if the recipient receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances.

**Note:** Refer to Section 37.7 Medicare Prescription Drug Coverage for detailed information on drugs covered by Medicare Part B.

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**37.5.12 DRUG SERVICES FOR HOSPICE RECIPIENTS**

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“Hospice” is a concept that extends a process of care to terminally ill patients.

Hospice is a program of palliative (control of pain and symptoms) and supportive services that provides physical, psychological, social, and spiritual care for dying persons and their families. Hospice care concentrates on assuring the quality of the terminal patient’s remaining life rather than on trying to prolong the length of that life.

For Medicare/Medicaid patients who have elected Hospice, services covered in the patient’s plan of care should not be billed to Medicaid. These services are covered in the hospice reimbursement.

To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid). The hospice shall assume that the distinction in billing drugs is understood by enrolled pharmacists who render services to the Medicaid recipients who have elected hospice.



**37.5.12 DRUG SERVICES FOR HOSPICE RECIPIENTS, continued**

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The pharmacy provider shall bill Louisiana Medicaid for out-patient pharmacy claims only for those drugs unrelated to the terminal illness.

Recoupment of drug claims erroneously paid to a pharmacy provider through Medicaid for those Medicaid recipients who have elected hospice will be performed as they are identified. Any provider of services to a hospice recipient

needs to clear with the hospice that the billed service is not included in the recipient's plan of care. Erroneous payment will be recouped as identified.

**Note:** Refer to Chapter 24 Hospice of the Louisiana Medicaid Program Provider Manual for detailed information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

## **37.6 REIMBURSEMENT FOR SERVICES**

### **Overview**

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Introduction                      This Section describes the methodologies that Medicaid uses to reimburse for prescribed drug services.

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In This Section                      This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Usual and Customary Charges	6-3
Drug Estimated Acquisition Cost (EAC)	6-4
Multiple Source Drugs	6-4
Co-payments for Prescription Services	6-6
Medicare Crossover Claims	6-8
Third Party Liability Claims	6-8

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

**37.6.1 REIMBURSEMENT METHODOLOGY**

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The amount of reimbursement to pharmacies is determined by federal regulations and state policy. The fiscal intermediary has weekly checkwrites to reimburse the provider for those valid claims which are processed.

Medicaid reimburses the lowest of the:

- Estimated Acquisition Cost (EAC) of the drug, plus the maximum allowable overhead cost (commonly known as the dispensing fee);
- Federal Upper Limit (FUL), plus the maximum allowable overhead cost (commonly known as the dispensing fee);
- Louisiana Maximum Allowable Cost (LMAC), plus the maximum allowable overhead cost (commonly known as the dispensing fee);
- Amount billed by the pharmacy, which cannot exceed the pharmacy's usual and customary charge to the general public; and
- The maximum payment for insulin and diabetic supplies will be the prevailing wholesale cost plus an overhead cost (dispensing fee) which may not exceed 50% of the wholesaler price shown in the pharmacy's purchasing records.

**Note:** For those pharmacy providers enrolled in Medicaid as a 340B provider, refer to Section 37.11 Public Health Services 340B Drug Pricing Program for detailed reimbursement policy.

**National Drug  
Code (NDC)**

---

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an eleven-digit number. The first five digits identify the manufacturer or supplier, the next four digits identify the product, and the last two digits identify the package size.

The provider must enter the entire eleven-digit NDC for the actual product and package size dispensed on the claim as the NDC is critical for accurate reimbursement. Billing an NDC number other than the one for the product dispensed is a false claim and a violation of Medicaid policy.

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid computer system drug file.

Medicaid uses ingredient costs that are supplied and updated each week by First Data Bank's National Drug Data File electronic service.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

**37.6.1 REIMBURSEMENT METHODOLOGY, continued**

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Maximum Allowable  
Overhead Cost  
(Dispensing Fee)

Maximum allowable overhead cost means the expense incurred by pharmacy providers in dispensing covered drugs as determined by Medicaid. Each pharmacy's records shall establish that the overhead cost paid by the Louisiana Medicaid Program does not exceed reimbursement overhead costs paid by others.

Medicaid reimburses the pharmacy a maximum dispensing fee of \$5.77 per prescription.

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Provider Fee

Pharmacy providers and dispensing physicians are responsible for a ten cent (10¢) provider fee on **all** prescriptions they fill. The Medicaid maximum allowable overhead cost (dispensing fee) includes the provider fee mandated under state law.

**Note:** Refer to Section 37.2.2 Provider Rights and Responsibilities regarding the provider fee policy.

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**37.6.2 USUAL AND CUSTOMARY CHARGES**

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Federal regulations governing the Medicaid Program require that participating providers agree to charge no more for services to eligible recipients than they charge for similar services to the general public. General public is defined as all other non-Medicaid prescriptions including third-party insurance, pharmacy benefit management plans and cash.

In implementing this regulation, the Medicaid Program states that providers in the Pharmacy Program may not charge a higher maximum allowable overhead cost (dispensing fee), on the average, for recipients' prescriptions than is charged for non-recipients' prescriptions (Third party and insurance prescriptions are components of the non-recipient group). Consequently, pharmacists are required to indicate their usual and customary charge on their claims for prescription services even if this charge exceeds the Medicaid maximum payment.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

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**37.6.3 DRUG ESTIMATED ACQUISITION COST**

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“Estimated Acquisition Cost” (EAC) means the **modified** Average Wholesale Price of the drug dispensed and identified by the manufacturer number, product number, and package number usually purchased by a provider from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. EAC for drug products supplied through repackaging into smaller quantities by chain drugstore central purchasing shall be based on the package size purchased by the central purchasing unit. Supporting documentation (invoices) shall be made available to the agency or its designee upon request. This limitation includes drug products which are repackaged or relabeled by the manufacturer or third party under any type of purchase contract or agreement. Bulk purchase practices which result in price reductions not generally available to all pharmacies shall also be subject to this limitation. If the package size is larger than the largest size listed by Medicaid of Louisiana, then EAC will be based on the largest size listed in the American Druggist Blue Book or other national compendia utilized by the State to update the Medicaid Management Information System (MMIS).

“**Modified**” means the lower of the following applicable limits:

- AWP minus either 13.5% for independent pharmacies (all pharmacies not included in the chain pharmacy designation) or 15% for chain pharmacies (more than fifteen Medicaid enrolled pharmacies under common ownership) for:
    - Other drugs not subject to LMAC limits; and
    - Drugs exempt from LMAC or Federal Upper Limits by physician override;
  - LMAC limits on multiple source drugs established by Medicaid of Louisiana; and
  - Federal Upper Limits on multiple source drugs established by CMS.
- 

**37.6.4 MULTIPLE SOURCE DRUGS**

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The federal government and the Louisiana Medicaid Program have established Federal Upper Limits (FUL) and Maximum Allowable Costs (MAC) for certain multiple source drugs. These maximums must be used as the costs for these drugs in determining reimbursement unless a specific brand is medically necessary.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

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**37.6.4 MULTIPLE SOURCE DRUGS, continued**

Federal Upper  
Limits (FUL)  
Regulations

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Federal Upper Limit (FUL) prices are established by the Centers for Medicare and Medicaid Services (CMS). Federal regulations prohibit Medicaid from reimbursing providers more than the FUL except as instructed.

**Note:** Refer to Appendix A-1 or [www.lamedicaid.com](http://www.lamedicaid.com) for the current listing.

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Louisiana Maximum  
Allowable Cost  
(LMAC) Regulations

The state Medicaid Program also establishes upper limit prices on certain categories of multiple source drugs not reviewed by CMS. This pricing is known as the Louisiana Maximum Allowable Cost (LMAC).

**Note:** Refer to Appendix A-1 or [www.lamedicaid.com](http://www.lamedicaid.com) for the current listing.

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Override of  
FUL or LMAC

The FUL and LMAC regulations neither supersede nor contravene state anti-substitution laws. They do not authorize or require pharmacists to dispense drugs in violation of state law.

Any drug with EACs exceeding the FUL or LMAC costs will be reduced to the lower of the FUL or LMAC.

When a prescriber indicates the brand name product is medically necessary for a particular recipient, certifying that in his professional judgement the generic equivalent is not indicated, therefore the FUL or LMAC limitations will not apply. The following procedure will apply in these cases:

- The certification must be in the prescriber's handwriting and signed;
- The certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription;
- The standard phrases written by the prescriber on the prescription should testify to the medical necessity of the brand name drug. The only acceptable phrases are **brand necessary** or **brand medically necessary**;
- **If multiple prescriptions are written on the same prescription blank, the prescriber must certify which drugs require the brand name product, indicating Brand Medically Necessary for each prescription which requires the branded product;**

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

**37.6.4 MULTIPLE SOURCE DRUGS, continued**

- 
- Phrases such as *do not substitute*, *no generics*, or *dispense as written* are not acceptable for overriding MAC limitations;
  - **Providers should verify that the appropriate wording is properly documented at the time of dispensing;**
  - Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable; and
  - A handwritten statement transferred to a rubber stamp and then stamped on the prescription blank is unacceptable.
- 

**37.6.5 CO-PAYMENTS FOR PRESCRIPTION SERVICES**

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The co-payment will be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the co-payment amount for which the recipient is liable. Providers shall continue billing their usual and customary charges for prescription services. The fiscal intermediary will calculate and deduct the co-payment amount from the amount allowed.

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Co-payment  
Schedule

The following is the prescription co-payment schedule:

Calculated State Payment	Co-Payment
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

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**37.6.5 CO-PAYMENTS FOR PRESCRIPTION SERVICES, continued**

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Co-payment  
Exemptions

The following pharmacy services are exempt from the co-payment requirement:

- Services furnished to individuals under twenty-one years of age;
- Services furnished to pregnant women if such services are related to the pregnancy, or any other medical conditions that complicate the pregnancy;
- Services furnished to any individual who is an inpatient in a hospital, long term care facility, or other medical institution. Individuals in group homes are classified in this category;
- Emergency services provided in a hospital, clinic, physician's office, or other facility equipped to furnish emergency care; or
- Family planning services and supplies. (Prescriptions for family planning services may be prescribed by any prescribing practitioner). These drugs and supplies include contraceptives, spermicides, and condoms, and require a prescription;
- Services furnished to individuals determined to be American Indians.

**Note:** Refer to Appendix D, POS User Guide for billing instructions.

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Other Co-payment  
Policies

In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the co-payment amount. The recipient's assertion of his/her inability to pay the co-payment establishes the inability. Under 42 CFR 447.15, this service statement does not apply to any individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the co-payment.

Providers shall not waive the recipient's co-payment liability.

The pharmacy provider shall collect a co-payment for each drug dispensed by the provider and covered by Medicaid. This co-payment is NOT taxable. Providers should not collect tax on the co-payment.

Quantities dispensed by pharmacists **shall not** be adjusted to reflect the co-payment amounts paid by the recipient. By participation in the pharmacy program, providers have agreed to accept, as payment in full, the amounts paid by the agency plus any deductible, co-insurance or co-payment.



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.6 REIMBURSEMENT FOR SERVICES**

**37.6.5 CO-PAYMENTS FOR PRESCRIPTION SERVICES, continued**

Other Co-Payment  
Policies, continued

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Department monitoring and auditing will be conducted to determine provider compliance. Violators of this policy will be subject to penalty such as suspension from the program for one year.

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**37.6.6 MEDICARE CROSSOVER CLAIMS**

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Refer to Section 37.7 Medicare Prescription Drug Coverage regarding payment of services for which Medicaid reimburses providers for participants' responsibilities of coinsurance and deductible payments.

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**37.6.7 THIRD PARTY LIABILITY CLAIMS**

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Refer to Section 37.8 Third Party Liability/Coordination of Benefits, regarding services which must be billed to Medicaid as the payor of last resort.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**Overview**

Introduction

---

This Section describes the coordination of benefits between the Medicare program and Louisiana Medicaid for dual eligibles.

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In This Section

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Medicare Part B Crossover Claims	7-3
General Medicare Part B Crossover Reimbursement Policies	7-4
Medicare Part B Outpatient Drug Coverage	7-6
Medicare Part D Outpatient Drug Coverage	7-7

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.1 MEDICARE**

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Medicare was enacted by Congress as part of the Social Security Amendments of 1965. It is a federal program managed by the Centers for Medicare and Medicaid Services (CMS). The State of Louisiana has no authority over the rules and laws that govern the Medicare program.

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Medicare Part A Medicare Hospital Insurance, referred to as Part A, provides coverage for medically-necessary inpatient hospital care, specified skilled nursing care, specified services of a home health agency, and other services.

Medicare imposes cost sharing expenses by requiring deductible and coinsurance amounts that are paid by the Medicare beneficiary, a supplemental insurance policy, or Medicaid.

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Medicare Part B Medicare Supplemental Medical Insurance, referred to as Part B, provides basic health care coverage for the services provided by doctors, suppliers, therapists, and other health care providers.

Medicare imposes cost sharing expenses by requiring deductible and coinsurance amounts that are paid by the Medicare beneficiary, a supplemental insurance policy, or Medicaid.

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Medicare Part C A Medicare Advantage Plan (formerly Medicare + Choice) allows beneficiaries to enroll in private health plans. These health plans administer the Medicare benefits. Beneficiaries must be enrolled in Part A and Part B to be eligible.

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Medicare Part D The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made prescription drug coverage, also known as Medicare Part D, available to all Medicare beneficiaries. Prescription drug coverage will be available through private prescription drug plans (PDPs), which offer only prescription drug coverage, and Medicare Advantage Plans (MA PDs), which offer drug coverage integrated with the health coverage provided by the managed care plan.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.2 MEDICARE PART B CROSSOVER CLAIMS**

---

Medicare Part B covers a limited number of outpatient prescription drugs.

Medicare crossover claims are claims that have been approved for payment by Medicare and sent to Medicaid for payment towards the Medicare deductible and coinsurance.

For those individuals who are QMB only, Medicaid will pay a crossover claim only if the service is covered by Medicaid, otherwise the claim will deny as non-covered.

Coinsurance and deductibles are reimbursed through the POS system for covered Medicare Part B drugs and supplies when a dual eligible is enrolled in Medicare Advantage (Part C) Plan. The claims must be submitted to the Medicare Advantage Plan for payment prior to submitting to Medicaid as a coordinated claim.

**Note:** Refer to Section 37.3.3 Eligibility Groups for detailed information.

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Medicare Crossover  
Claims Submission

After providing a service to a dual-eligible recipient, the provider sends a claim to its Medicare carrier or intermediary. After Medicare processes the claim, it sends the provider an explanation of Medicare benefits. If Medicare has approved the claim, Medicaid will pay the deductible and/or coinsurance.

Medicare crossover claims are submitted to the Medicaid fiscal agent by one of the following methods:

- An electronic submission generated automatically by the Medicare intermediary or carrier; or
  - A paper submission by the provider that includes the claim and Explanation of Medicare Benefits (EOMB).
- 

Automated Crossover  
Carrier/ Intermediary

The automated Medicare intermediary/carrier for Part B prescription drugs is Cigna (also known as DMERC).

The provider may contact the National Supplier Clearinghouse at 866-238-9652.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.3 GENERAL MEDICARE PART B CROSSOVER REIMBURSEMENT  
POLICIES**

Provider Participation	<p>A provider must be enrolled as a Medicaid provider in order to submit Medicare crossover claims.</p>
Time Limits	<p>The time limit for filing crossover claims to Louisiana Medicaid is six months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (twelve months from the date of service).</p>
Reimbursement	<p>Effective January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are one hundred and six (106) percent of the Average Sales Price (ASP).</p>
Mandatory Assignment on all Drugs	<p>Under Section 114 of the Federal Benefits Improvement and Protection Act of 2000, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.</p> <p>Assignment is an agreement between the provider and the beneficiary. The provider agrees to accept the Medicare-approved amount as full payment for covered items or services.</p> <p>If the provider accepts assignment, the beneficiary pays only twenty (20) percent of the Medicare-approved charge, plus any portion of the unmet deductible. The beneficiary is not responsible for charges over the Medicare-approved amount.</p> <p>Pharmacy providers who have agreed to accept assignment on all of their services are called “participating” providers. These providers always accept the Medicare-approved amount as payment in full for covered services.</p> <p>Providers who choose to participate must do so for the calendar year. Providers who do not participate may still accept assignment on a claim-by-claim basis.</p>
Coordination of Benefits with Medicare Part B	<p>Pharmacy claim reimbursement must be coordinated with Medicare Part B and any private insurance plan in which a recipient is enrolled. Medicare Part B may be primary or secondary to a private insurance plan. To determine whether Medicare is primary or not, contact Medicare at 1-800-999-1118.</p>

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.3 GENERAL MEDICARE PART B CROSSOVER REIMBURSEMENT  
POLICIES**

Answers to  
Questions

If providers have questions or concerns about Medicare claim processing or Medicare policy, they must follow Medicare's procedures for resolving those issues.

If there are problems or concerns regarding Medicaid's payment of crossover claims, the provider should contact the fiscal intermediary.

**37.7.4 MEDICARE PART B OUTPATIENT DRUG COVERAGE**

Medicare Part B covers a limited number of outpatient prescription drugs. Medicare Part B covers oral anticancer drugs, antiemetics, diabetic supplies, glucometers, antihemophilia factor products, oral immunosuppressive drugs, nebulizer medication and some other medications. Providers must be enrolled as Medicare suppliers and must bill Medicare first if the recipient receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances. Pharmacy providers must accept assignment on Medicare-covered prescription drugs.

Listed below are some of the outpatient drugs covered by Medicare and their payment criteria if applicable.

**Note:** Refer to DMERC and the local Part B carrier for complete coverage information and updated HCPCS codes utilized in claim submissions.

Immunosuppressive  
Drugs

Immunosuppressive drugs are covered only for Medicare covered transplants.

When a prescription is filled for these drugs and the individual is not an organ transplant patient or Medicare Part B did not cover the transplant, refer to the Medicare Part D prescription drug plan.

Oral Cancer  
Chemotherapy Drugs

Medicare Part B provides coverage of oral, self-administered, anticancer chemotherapeutic agents.

These drugs must be billed with NDC numbers.

Antiemetic  
Drugs

When oral antiemetic drugs are used in conjunction with intravenous cancer chemotherapeutic regimens, pharmacies shall bill Medicare first. The oral medication must be used as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment and must not exceed a forty-eight hour dosage regimen.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.4 MEDICARE PART B OUTPATIENT DRUG COVERAGE, continued**

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Nebulizer Drugs	Medicare will pay for medications used in a nebulizer for those recipients eligible for Medicare Part B. Refer to the Medicare Part D prescription drug plan when the recipient is in a long term care facility.
Diabetic Supplies	<p>Medicare Part B covers diabetic supplies (lancets, lancet devices, glucose control solutions and blood glucose strips). Glucometers are covered in some instances.</p> <p>Diabetic supplies and glucometers for long term care recipients are covered in the nursing home per diem rate. It is allowable for Medicare Part B to be billed if the long term care recipient is eligible for the benefit. Medicaid is not obligated to pay the coinsurance and deductible if the items are included in the Medicaid per diem. The Medicaid fiscal intermediary will automatically deny any crossover claims for diabetic supplies for long term care recipients.</p>
Dispensing/Supply Fees	Medicare reimburses for dispensing/supply fees when submitted with certain Part B payable drug claims. Dispensing fees are associated with nebulizer drugs. Supply fees are associated with oral anticancer drugs, oral antiemetic drugs or immunosuppressive drugs.
Antihemophilia Drugs	Claims submitted by pharmacy providers for blood clotting factors shall be processed by the local Part B carrier. The local Medicare Part B carrier for Louisiana is Blue Cross/Blue Shield of Arkansas (1-800-462-9666).

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**37.7.5 MEDICARE PART D OUTPATIENT DRUG COVERAGE**

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Medicare Part D covered drugs include most prescription drugs, biological products, certain vaccines, insulin, and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). Some drugs will be excluded from Medicare Part D coverage as they are part of the Medicaid non-mandatory coverage provisions under sections 1927 (d)(2) and (d)(3) of the Social Security Act or they are covered by Medicare Part A or B. The one exception is smoking cessation products, such as nicotine patches and gum, which will be covered by Medicare Part D. Reimbursement of prescription claims are determined by each individual prescription drug plan.

Medicare Part D will not cover those medications reimbursed by Medicare Part B. However, should Medicare Part B deny coverage because the drug does not meet the criteria for a Part B covered indication, the pharmacy provider should contact the Part D prescription plan.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.5 MEDICARE PART D OUTPATIENT DRUG COVERAGE, continued**

Medicaid Coverage  
for Excluded  
Part D Drugs

To the extent that the Louisiana Medicaid Program covers the following Medicare excluded drugs for Medicaid recipients who are not full benefit dual eligibles, Medicaid will be required to cover the excluded drugs for full benefit dual eligibles.

All existing Louisiana Medicaid Pharmacy Program limits, co-payments and reimbursement policies apply to the Part D excluded prescriptions paid by Louisiana Medicaid.

Louisiana Medicaid will not cover PDP or MA PD non-preferred drugs, as there is a Medicare appeal process to obtain these medications.

The following excluded drugs are covered by Louisiana Medicaid unless they are covered by Medicare Part B or Part D.

- Benzodiazepines
- Barbiturates
- Agents when used for anorexia, weight loss or weight gain (Orlistat only);
- Agents when used to promote fertility when used for non-fertility treatment as described under specific state criteria;
- Agents when used for cosmetic purposes or hair growth (Isotretinoin only);
- Agents when used to promote smoking cessation as described under specific state criteria;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride:
  - Vitamin A preparations;
  - Vitamin B preparations;
  - Vitamin C preparations;
  - Vitamin D preparations;
  - Vitamin E preparations;
  - Geriatric Vitamin preparations;
  - Pediatric Vitamin preparations;
  - Vitamin K preparations;
  - Vitamin B 12 preparations;
  - Folic Acid preparations;
  - Niacin preparations;
  - Vitamin B6 preparations;
  - Vitamin B1 preparations;
  - Multivitamin preparations;
  - Magnesium salt replacement;
  - Calcium replacement; and
  - Urinary pH modifiers (Phosphorus).
- Non prescription drugs:
  - Sodium Chloride inhalation agents;
  - Contraceptives, topical;
  - Urinary pH modifiers;



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.7 MEDICARE PRESCRIPTION DRUG COVERAGE**

**37.7.5 MEDICARE PART D OUTPATIENT DRUG COVERAGE, continued**

Medicaid Coverage  
for Other Excluded  
Part D Items

- Antihistamines (Diphenhydramine only);
- 2<sup>nd</sup> Generation Antihistamines; and
- 2<sup>nd</sup> Generation Antihistamine – Decongestant Combinations

The Louisiana Medicaid agency provides coverage for the following items which are not covered under 1927(d)(2) of the Social Security Act to all Medicaid recipients, including full benefit dual eligibles.

The following excluded items are covered by Louisiana Medicaid unless Medicare Part B or Part D plans reimburse for these items.

- OTC Vitamin D preparations;
- OTC Vitamin E preparations;
- OTC Niacin preparations;
- OTC Calcium replacement agents;
- OTC Magnesium replacement agents;
- OTC Phosphate replacement agents;
- OTC Iron replacement agents;
- Normal Saline and Heparin flushes;
- Diabetic Supplies; and
- Family Planning items.

Co-payments

The Medicaid co-payment schedule will apply for prescriptions for those Part D excluded drugs that are covered by Medicaid.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

**37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

**Overview**

Introduction

This Section describes the Medicaid Pharmacy Program's policy regarding recipients who have other third party resources that can be applied to their pharmacy expenses.

In This Section

This Section contains:

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

### 37.8.1 THIRD PARTY LIABILITY (TPL)

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Federal regulations and applicable state laws require that third party resources be used before Medicaid is billed. *Third party* refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid recipient's medical and health expenses.

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### 37.8.2 COORDINATION OF BENEFITS (COB)

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Federal law mandates that Medicaid is the payor of last resort. Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale system. Providers must bill recipients' primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the recipient's responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount. This will be accomplished by Medicaid payment of the outstanding balance remaining after the payment by the primary payor has been deducted from the usual and customary charge. Again the payment will be up to the maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

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### 37.8.3 PHARMACY PROVIDERS' ROLES

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The provider should inquire of the recipient, if that recipient has private insurance coverage with prescription benefits. This information is entered in the patient's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company/companies. The other payor's paid amount should be submitted on the pharmacy claim to Medicaid.

Pharmacy claims billed to Medicaid first when drug coverage with another insurance company is noted on the recipient's resource file and with no indication that the applicable private insurance has been previously billed will deny.

Providers may log in [www.lamedicaid.com](http://www.lamedicaid.com) to view the Medicaid Eligibility Verification System (MEVS). Providers may view the recipient's other insurance company and Medicaid carrier code number.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

**37.8.3 PHARMACY PROVIDERS' ROLES, continued**

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Valid insurance coverage may differ from what is on the recipient's resource file. Pharmacy providers may enter the correct coverage and coordinate benefits. Providers may contact the DHH TPL Unit at 225-342-8662 with updated **traditional Medicare** insurance coverage. Providers may contact Health Management Systems (HMS), the DHH TPL collections contractor, at 1-877-204-1324 with updated **private insurance or Medicare Advantage Plan** coverage. Also, providers may instruct recipients to contact their local Medicaid offices to update their insurance coverage.

**Note:** Refer to Appendix D POS User Guide for claim submission details.

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**37.8.4 COORDINATION OF BENEFITS EXEMPTIONS**

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Certain conditions exist that are exempt from coordination of benefits and Medicaid is mandated to pay and chase claims. A pharmacy provider may override the coordination of benefits edit when:

- A Medicaid recipient has court ordered medical child support;
- Pharmacy claims are deemed preventative care for ages under twenty-one; and
- Pharmacy claims are deemed preventive care for pregnant women.

**Documentation of court ordered medical child support or preventative care on the hard copy prescription by the pharmacist is required for the above circumstances.**

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**37.8.5 EXEMPTIONS TO MEDICAID PROGRAM RESTRICTIONS**

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Certain restrictions will be by-passed. Claims that are coordinated with primary insurance companies will process without edits for:

- Prior Authorization for non-preferred drugs;
  - Four prescription monthly limit; and
  - Orlistat excluding the age edit.
-

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

**37.8.6 CLAIMS FOR RECIPIENTS WITH MULTIPLE INSURANCE  
COVERAGE**

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Some recipients have one or more insurance companies for prescription coverage. The pharmacy should coordinate payment with other insurance companies prior to billing Medicaid, as Medicaid is the payor of last resort.

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**37.8.7 OVERRIDE CAPABILITIES AND CODES**

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Override capabilities exist to allow providers to process claims and receive payment when a recipient would be delayed in receiving their prescriptions.

**Note:** Refer to Appendix D, POS User Guide for detailed billing information.

The Pharmacy Unit monitors pharmacy providers' usage of override codes. Corrective actions will be offered to better utilize the coordination of benefits process.

The following are scenarios for usage of override codes:

- No other coverage
  - Pharmacy submits claim to other insurance company. Claim denies due to coverage expired. Pharmacist inquires of recipient regarding other insurance coverage. Recipient does not have or cannot supply pharmacy with other insurance information.
  - Pharmacy submits claim to other insurance company. The other insurance company does not include a pharmacy benefit. Pharmacist asks recipient for other insurance coverage, but recipient has none.
- Other coverage billed - Claim not covered
  - Pharmacy submits claim to other payor. The other payor denies due to non-coverage of drug.
- Other coverage exists - Payment not collected
  - Recipient has insurance coverage (ex. 80-20 insurance) which requires the recipient to pay for the prescriptions then the insurance company would reimburse the recipient a certain percentage of the claim.
  - Pharmacy submits claim to other payor. The recipient must meet a deductible before benefits pay for pharmacy claims. The other payor applies the claim to the recipient's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS**

**37.8.7 OVERRIDE CAPABILITIES AND CODES, continued**

- 
- Recipient has court ordered medical child support.
  - Preventative care for a recipient under the age of twenty-one or a woman who is pregnant.
  - Pharmacy submits claim to other insurance company. The other insurance company is a mail-order only company.
  - Recipient has other insurance coverage. The pharmacy claim requires prior authorization from the other insurance. The prior authorization process shall be commenced by the provider. Should the access of the recipient's prescription be delayed due to the prior authorization process, the pharmacy may submit the claim to Medicaid with the above other coverage code. However, once the prior authorization is acquired, **the claim must be reversed** and coordinated with all insurance carriers with Medicaid as last payor.
  - Recipient has insurance coverage but the pharmacy and/or physician is out of the insurance company's network.
-

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

**37.9 CLAIM SUBMISSION**

**Overview**

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Introduction This Section describes claim submission requirements, including expression of drug quantities, overrides and time limits for claim submission. This Section also describes methods of claim submission.

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In This Section This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
National Drug Code (NDC)	9-2
Drug Quantities and Units of Measurement	9-2
Prescriber Numbers	9-4
Diagnosis Codes	9-4
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.1 NATIONAL DRUG CODE (NDC)**

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Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an eleven-digit number. The first five digits identify the manufacturer or supplier, the next four digits identify the product, and the last two digits identify the package size.

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Use of NDCs

The provider must enter the entire eleven-digit NDC for the **actual product dispensed** on the claim. Billing an NDC number other than the one for the product dispensed is a false claim and a violation of Medicaid policy.

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NDC Code Not  
on the Drug File

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid computer system drug file. If the NDC code is not on the Medicaid drug file, the provider can call the Medicaid Pharmacy Benefits Management Section at 225-342-9768 and request that the drug be added.

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**37.9.2 DRUG QUANTITIES AND UNITS OF MEASUREMENT**

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Billing Unit Standard

Medicaid has adopted the National Council for Prescription Drug Programs (NCPDP) unit of measurement for the billing unit standard.

The NCPDP standard uses only three billing units to describe all drug products: “each,” “ml,” and “gm.”

The use of “tablet,” “patch,” “kit,” etc. is not appropriate, since these are dosage forms or package descriptions.

---

Dosage Forms  
Expressed as “Each”

The dosage forms that are expressed as “each” are:

- Solid oral medications such as tablets, capsules, etc., even when presented in dose packs or cycles;
  - Suppositories;
  - Transdermal patches;
  - Powder packets;
  - Disposable syringes; and
  - Powder-filled vials, ampules and syringes for injection; irrigation; or inhalation (the quantity is the total number of vials dispensed, not the mls or gms of the final product).
-



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

**37.9.2 DRUG QUANTITIES AND UNITS OF MEASUREMENT, continued**

Dosage Forms  
Expressed as “ml”

Dosage Forms that are expressed as “ml” are:

- Liquid oral medications;
- Ophthalmic and otic drops and suspensions;
- Reconstitutable oral products (the quantity is the number of milliliters in the bottle after reconstitution);
- Topical lotions or solutions;
- Liquid-filled vials, ampules, or syringes for injection, irrigation or inhalation (the quantity is the total number of milliliters dispensed); and
- Inhalers and aerosols that are specified in milliliters by the manufacturer on the labeling.

Dosage Forms  
Expressed as “gm”

Dosage forms that are expressed as “gm” are:

- Topical or ophthalmic ointments and creams;
- Inhalers and aerosols that are specified in grams by the manufacturer on the labeling.

Exceptions to the  
NCPDP Standard

The following are examples of exceptions to the NCPDP billing unit standard:

- Antihemophilic products must be expressed as the number of antihemophilic units dispensed, which will vary from vial to vial;
- Cordran® Tape and EpiPen® must be expressed as “each”;
- One Imitrex® or Diastat® kit with two syringes must be expressed as one “each”;
- One tube of Emla® cream with Tegaderm® patches must be expressed as one “each”;
- One heparin flush kit containing one syringe of heparin and two syringes of saline packaged in the same bag must be expressed as one “each”; and
- Helidac® combination therapy must be expressed as 56 dosing units.

Metric Decimal  
Quantities

Metric decimal quantity is used to express quantity dispensed. Providers must bill for drug quantities using decimal numbers—whole drug numbers are no longer required. The provider must ensure that his software enters the correct quantity in the metric decimal field (i.e., 0.030 does not equal 30.000). Rounding is not allowed (i.e., 3.500 cannot be billed as 4.000).

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.2 DRUG QUANTITIES AND UNITS OF MEASUREMENT, continued**

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Billing Questions

Billing questions regarding the correct unit type should be directed to the Molina Point of Sale Help Desk at 800-648-0790 or 225-216-6381 from 8am to 5pm, Monday through Friday.

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**37.9.3 PRESCRIBER NUMBERS**

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All prescription claims must indicate a valid **individual** Louisiana Medicaid prescriber number or NPI until only the NPI is required. Group practice numbers, hospital numbers and clinic numbers are not acceptable.

**Note:** Refer to Section 37.4 Prescribers for detailed prescriber policy.

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**37.9.4 DIAGNOSIS CODES**

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Some pharmacy claims require ICD-9 CM diagnosis codes as a condition for program coverage and override of monthly prescription limits.

**Note:** Refer to Section 37.5 Covered Services, Limitations and Exclusions for specific program policy involving ICD-9 CM diagnosis codes.

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**37.9.5 OVERRIDES**

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Listed below are the detailed policies regarding overrides of the Louisiana Medicaid Pharmacy Benefits Management Section. Refer to Appendix D Point of Sale User Guide for details regarding claims submission requiring overrides.

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FUL/LMAC  
Limitations

A prescriber may certify that a specified brand is medically necessary for a particular recipient. The FUL or LMAC limitations for that medication will not apply.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES**, continued

FUL/LMAC  
Limitations,  
continued

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The certification must be written either directly on or must be a signed attachment (which may be faxed) to the prescription. The certification must be in the prescriber's handwriting. The only acceptable phrases are "brand necessary" or "brand medically necessary."

**Note:** Also refer to Section 37.6.4 Multiple Source Drugs for detailed information.

---

Four Prescriptions  
Monthly Limit

The four prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device noted on or attached to the hard copy prescription:

- "Medically Necessary Override"
  - A valid numeric ICD-9-CM diagnosis code that directly relates to each drug prescribed that is over the four prescription limit. (An ICD-9-CM literal description is not acceptable.)
- 

Early Refills

If the patient has requested the same medication at the **same pharmacy** seven or more days early for a thirty day supply or prior to seventy-five percent of medication being utilized, a claim is denied for early refill. Narcotic analgesics will deny for an early refill edit when less than eighty-five percent of the medication has been utilized. This translates into a three (3) day window based on a thirty (30) day supply.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a patient's request for medication earlier than previously reported in the estimated days supply. With those requests, pharmacists may override this edit by documenting the circumstances on the prescription hard copy and reference the Point of Sale User Guide for detailed claims filing instructions.

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Ingredient  
Duplication

A claim denial will occur as the patient attempts to obtain the same drug from a **different pharmacy** sooner than is anticipated based on the estimated days supply.

After consultation with a physician, patient and/or the POS help desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim. If extenuating circumstances exist, the provider must use procedures to initiate an override of the denial for the duplicate ingredient.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

**37.9.5 OVERRIDES, continued**

Ingredient  
Duplication,  
continued

The provider must document on the prescription hard copy the circumstances for the override and reference the Point of Sale User Guide for detailed filing instructions.

Duration  
of Therapy

The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program has duration of therapy modules for the H2 antagonists, proton pump inhibitors (PPIs), sucralfate and palivizumab (Synagis®).

Acute dosage guidelines for these H2 antagonists, PPIs and sucralfate are being monitored. The chronic use of these agents at full therapeutic dosages is generally not indicated. The duration of therapy period begins every calendar year. An acceptable ICD-9-CM diagnosis code which indicates the condition identified by the prescriber warranting the continuation of the acute dosage is required.

Synagis® claims with dates of service outside of Respiratory Syncytial Virus (RSV) season will deny. Additionally, claims billed for Synagis® outside the allowable number of doses will also deny. Based upon the diagnosis code submitted, the maximum number of doses any recipient should receive is five (5).

Claims billed for dates of service outside the RSV season and/or in excess of the allowable number of doses will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber. This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacy provider must supply that information accurately as provided by the prescriber and reference the Point of Sale User Guide for detailed claims filing instructions.

**Note:** Refer to Section 37.5 Covered Services, Limitations and Exclusions and Appendix D Point of Sale User Guide for detailed information.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES, continued**

Therapeutic  
Duplication

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The Medicaid Program denies pharmacy claims for drugs in the following classes if the recipient has an **ACTIVE** paid claim on file for another drug in the same therapeutic class. Antipsychotic agents require two (2) active prescriptions on file to deny for therapeutic duplication.

- Second generation antihistamines and second generation antihistamine combination agents;
- Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations;
- ACE Inhibitors/Calcium Channel Blocker Combinations;
- Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations;
- ARB/Calcium Channel Blocker Combinations;
- Beta Adrenergic Blocking Agents and Beta-adrenergic Blocking Agent/Diuretic Combinations;
- Calcium Channel Blockers;
- Calcium Channel Blocker/Antihyperlipidemia Agent Combination;
- Potassium Replacement Agents;
- Tricyclic Antidepressants;
- Selective Serotonin Reuptake Inhibitors;
- Antipsychotic Agents (typical and atypical);
- Antipsychotic/Selective Serotonin Reuptake Inhibitor Combinations;
- Anti-anxiety Agents;
- Sedative Hypnotic Agents;
- Attention Deficit Disorder Agents
- Non-steroidal Anti-inflammatory Agents (inclusive of COX-2 selective agent);
- Short Acting Opiate Agents;
- Long Acting Opiate Agents; and
- Proton Pump Inhibitors.

Override provisions will be allowed after contacting the prescriber. If an override is determined appropriate, additional hard-copy documentation on the new prescription is necessary. The reason for service code, professional service code and result of service code are required for audit purposes. Diagnosis codes may be required in some instances.

**Note:** Refer to Section 37.5 Covered Services, Limitations and Exclusions and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES**, continued

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Unnecessary  
Drug Therapy

The LMPBM has an unnecessary drug therapy module for the COX-2 selective agent. A valid ICD-9-CM code is required as well as a valid condition warranting the COX-2 selective agent.

Should the recipient not have a valid condition, and the prescriber determines that the drug therapy is necessary, the pharmacy provider must supply the reason for service code, professional service code and result of service code with the POS submission. This information must be documented on the hard copy prescription.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for detailed information.

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Drug/Drug  
Interaction

A valid ICD-9-CM diagnosis code is required for all Sildenafil (Revatio®) and Tadalafil (Adcirca®) prescriptions.

Override provisions for the drug to drug interaction between Sildenafil or Tadalafil and nitrates will be allowed after contacting the prescriber. The pharmacist must document the reason the prescriber required both drugs. Additionally, documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription and for submission of the Point of Sale claim.

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Coordination  
of Benefits

Certain circumstances allow for the override of edits which allows Medicaid to be the primary payor.

**Note:** Refer to Section 37.8.7 Override Capabilities and Codes for detailed information on these overrides.

---

Pregnancy  
Co-Payment

Services furnished to pregnant women if such services are related to the pregnancy, or any other medical conditions that complicate the pregnancy are exempt from co-payments.

When a prescribing provider issues a prescription to a pregnant woman, he or she shall indicate on the prescription that the recipient is pregnant. In the case of a telephoned prescription, the information that the recipient is pregnant shall be communicated to the pharmacist and the pharmacist must document on the prescription that the recipient is pregnant.

When the prescribing provider authorizes a prescription for a pregnant recipient, the pharmacist shall maintain the proper documentation on the prescription for audit purposes indicating that the individual is pregnant.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed claims filing instructions.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES**, continued

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Age and Gender  
Overrides

Some drugs have age and/or sex restrictions (Examples: Oral Contraceptives for females under 12 and over 55 and Depo-Provera® for men).

Overrides of these restrictions are permitted when medically necessary and documentation is provided by the prescriber.

In these cases it is necessary to contact the Medicaid Pharmacy Benefits Management Section at 225-342-9768 for assistance in processing the claim.

Claims for palivizumab (Synagis®) therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1<sup>st</sup> of the Respiratory Syncytial Virus (RSV) season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1<sup>st</sup> will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber. This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacist may override the age restriction edit. The pharmacist must document and supply the reason for service code, professional service code and result of service code.

**Note:** Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

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Maximum Dosage

Prescriptions for atypical antipsychotic agents, agents containing tramadol and tapentadol (Nucynta®) will deny when the maximum recommended doses are exceeded.

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds six grams a day.

The prescriber must be consulted and the reason and override codes must be documented on the hard copy prescription. The pharmacy must supply the reason for service code, professional service code and result of service code with the POS submission.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES, continued**

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Quantity Exceeds  
Program Maximum

Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than twenty (20) or the days supply is greater than five (5) days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the ICD-9-CM diagnosis code and the rationale for using greater than a five day supply of ketorolac. The ICD-9-CM diagnosis code is required for the claim submission.

Pharmacy claims for selected medications used in the management of pain are subject to maximum quantities. Quantity limits are cumulative, are based on a rolling thirty (30) days and apply to all strengths of an agent. If the prescriber chooses to exceed the limit, he/she must provide the reason why the quantity limit needs to be exceeded. After consulting with the prescriber, the pharmacist must document the prescriber's reason and DUR override codes on the hardcopy prescription. The pharmacist should reference the Point of Sale User Guide for detailed claims filing instructions.

Most prescriptions for recipients who have confirmed diagnosis of cancer are exempt from quantity limits. In order to determine which prescriptions should be exempt, all prescriptions for Schedule II narcotic agents require an ICD-9-CM diagnosis code documented on the hardcopy prescription. When a diagnosis code is not on the prescription and the prescriber cannot be reached, the pharmacist can then determine if the recipient cannot wait to receive the medication and override the edit.

---

Prior Authorization  
Emergency

This emergency procedure may be used when the Prior Authorization Unit is closed (Sundays; Monday-Saturday before 8am and after 6pm) or when the PA system is unavailable. The pharmacist should also use professional judgement in situations that would necessitate an emergency supply.

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a seventy-two (72) hour or a three-day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.**

**The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency by Pharmacist" on the hard copy prescription.**

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Hospital Discharge  
Prescriptions for  
Atypical Antipsychotic  
Agents

When a recipient is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if hard copy, that the prescription is a "Hospital Discharge" or if the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy of the prescription.



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.5 OVERRIDES, continued**

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents, continued	<p>In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is “Hospital Discharge” prescription, the pharmacist must indicate “Hospital Discharge” on the hard copy prescription.</p> <p>Claims for “Hospital Discharge” prescriptions needing prior authorization (PA) will be submitted using the same process used for an emergency override.</p> <p>Prescriptions for “Hospital Discharge” products shall be dispensed in a MINIMUM quantity of a 3-day supply and refills for the dispensing of the non-preferred products are not permitted. The recipient’s practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the “Hospital Discharge” supply, and a new prescription must be issued.</p>
Lock-In Emergency	<p>This override is provided because DHH recognizes that there maybe unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not the Lock-In provider. Payment will be made to any pharmacist enrolled in Medicaid of Louisiana who grants services to a Lock-In recipient in emergency situations or when life sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed.</p> <p><b>The notation “Emergency Prescription” or “Discharge Prescription” should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist.</b> Please ensure that the notation is included on the hard copy claim for audit purposes.</p>

**37.9.6 TYPES OF PHARMACY CLAIMS**

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Types of Claim Submissions	<p>Providers can submit prescribed drug claims through the Point of Sale system, an electronic batch system upon testing and approval, or on paper claim forms. The paper claim form for Medicaid prescribed drug services is the NCPDP Universal Claim Form.</p>
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**37.9.7 POINT OF SALE (POS) CLAIM SUBMISSION**

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Medicaid pharmacy providers can submit Medicaid claims through a DHH authorized electronic switch vendor using on-line, real time, Point of Sale (POS) processing. The transaction is processed through the claims processing cycle, and the disposition of the claim is returned to the pharmacy within seconds of submission.

POS processing is available through authorized telecommunication vendors that are connected to virtually every pharmacy in the United States.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.7 POINT OF SALE (POS) CLAIM SUBMISSION, continued**

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Features of Point  
of Sale

The POS system is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication that are in place for other pharmacy POS processing. POS uses the HIPAA approved telecommunication standard, NCPDP D.0.

The POS system is available twenty-four hours per day, seven days per week, except for scheduled downtime for system maintenance.

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Authorization to Use  
Point of Sale

To obtain authorization to submit Medicaid claims through POS, the provider must submit the POS authorization agreements to the Medicaid fiscal agent.

**Note:** Refer to Section 37.2.8 Point of Sale Enrollment for information on provider enrollment.

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**37.9.8 ELECTRONIC CLAIM SUBMISSION (BATCH)**

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Providers interested in using the NCPDP 1.2 Batch version must contact the Point of Sale Help Desk at 800-648-0790. Testing and approval are required.

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**37.9.9 HARD COPY CLAIM SUBMISSION**

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When it is necessary to paper bill Louisiana Medicaid for services, pharmacy providers must use the NCPDP Universal Claim Form (UCF) regardless of date of service. No photocopied versions are acceptable.

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Ordering the Claim  
Forms

NCPDP Universal Claim Forms may be purchased from:

**Communi Form, LLC**  
**Phone: 1-800-869-6508**  
**[www.communiform.com/ncdpd](http://www.communiform.com/ncdpd)**

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.9 CLAIM SUBMISSION**

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**37.9.9 HARD COPY CLAIM SUBMISSION, continued**

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Claim Submission	All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. Claims submitted on the UCF claim form should be submitted to the following address for processing:
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**Molina/LA Medicaid  
P. O. Box 91019  
Baton Rouge, LA 70821**

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Retroactive Eligibility Claim Submission	When filing prescription claims for recipients with retroactive Medicaid, with a date of service greater than one year, providers must file these claims hard copy for special handling.
---------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Claims less than one year may be submitted on-line, with some exceptions. Claims over one year for recipients with retroactive coverage, e.g., spend-down medically needy recipients, should be sent to the Bureau with a note of explanation or a copy of the recipient's Medicaid identification card as soon as possible. These claims must be sent to the Bureau of Health Services Financing for review and authorization at the following address:

**Bureau of Health Services Financing  
MMIS Unit  
P. O. Box 91030  
Baton Rouge, LA 70821**

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Billing Instructions	All fields of the Universal Claim Form are not numbered; however, all fields are denoted as "Required", "Not Required", or "Leave Blank" as appropriate.
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"Required" information must be entered to ensure processing of the claim. "Not required" information is optional, based on entry of a previous field. "Leave Blank" is a field unrelated to pharmacy claims.

**Note:** Refer to Appendix G for an example of the Universal Claim Form and billing instructions.

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**37.9.10 CLAIM ADJUSTMENTS**

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From time to time some claims submitted and paid require adjustments. This can be done through the Point of Sale claim reversal process, which involves reversing the incorrect claim and resubmitting a new, corrected claim via Point of Sale. Claims requiring adjustments may be reversed within the timely filing period by using the pharmacy provider NPI, date of service and prescription number. Upon reversal, the claim may be resubmitted with the corrected information.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

**37.9.10 CLAIM ADJUSTMENTS, continued**

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In some instances, it is necessary to submit a hard copy adjustment claim form.

**Note:** Refer to Appendix D Point of Sale User Guide for instructions for both types of claim adjustments.

**Note:** Refer to Appendix H for Form 211 Drug Adjustment Form and instructions for completion.

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**37.9.11 TIME LIMIT FOR SUBMISSION OF MEDICAID CLAIMS**

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Timely Claim  
Submission

Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline.

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Twelve Month Filing  
Limit

A claim for services rendered must be received by the department or its fiscal intermediary no later than twelve months from the date of service.

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Dates of Service  
Greater Than  
Two Years Old

Claims with dates of service over two years old are not to be submitted to the fiscal intermediary or to Medicaid for overriding of the timely filing edit unless one or more of the guidelines listed below is met:

- The recipient was certified for retroactive Medicaid benefits;
  - The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; and/or
  - The failure of the claim to pay was the state's, rather than the provider's, fault each time the claim was adjudicated.
- 

Medicare/Third Party  
Payor Insurance  
Claims

Claims for recipients who have Medicare or other insurance must be submitted to a third party payor prior to sending the claim to Medicaid.

A claim coordinated with a third party payor shall be submitted to the fiscal intermediary within twelve months of the date of service.

The time limit for filing Medicare crossover claims to Louisiana Medicaid is six months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (twelve months from the date of service).

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.9 CLAIM SUBMISSION**

---

**37.9.11 TIME LIMIT FOR SUBMISSION OF MEDICAID CLAIMS, continued**

---

Proof of  
Timely Filing

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

- A Remittance Advice indicating that the claim was processed earlier (within the specified timeframe)

**OR**

- Correspondence from either the state or local Medicaid office of Family Support concerning the claim and/or the eligibility of the recipient.

When resubmitting the claim and documentation, providers must be certain that the claim is legible to ensure accurate processing. Documentation must reference the individual recipient and date of service.

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**37.9.12 BILLING FOR SPEND-DOWN MEDICALLY NEEDY RECIPIENTS**

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Any provider who has medical bills from the exact date of the recipient's spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from the local Medicaid office. This form will notify the provider of the co-payment amount due by the recipient and the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under recipient liability. If service(s) were provided on the date of spend-down but does not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

**Note:** Refer to Section 37.3 Medicaid Recipient Eligibility for detailed information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

**37.10 CLAIMS PROCESSING/PAYMENTS**

**Overview**

Introduction

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Claims for Medicaid reimbursement are processed by the Medicaid fiscal intermediary. This Section describes claims processing and gives the provider information about the remittance advice as well as how to obtain help with claims processing problems.

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In This Section

This Section Contains:

<b>TOPIC</b>	<b>PAGE</b>
Claim Processing	10-2
Point of Sale Claims	10-2
Paper Claims	10-3
Denied Claim Facsimiles	10-3
Remittance Advice	10-3
Help Desk	10-7

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

**37.10.1 CLAIMS PROCESSING**

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Claim Entry	Point of Sale (POS) claims enter the claims processing system directly through a telecommunications network and adjudicate in real time. Paper claims are keyed directly into the system for adjudication. Paper claims should be submitted to:
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**Molina  
P. O. Box 91020  
Baton Rouge, LA 70821**

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Claim Adjudication	The system edits the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.
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Disposition of Claim	<p>A claim disposition can be:</p> <ul style="list-style-type: none"><li>• Paid: payment is approved in accordance with program criteria; or</li><li>• Denied: payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.</li></ul>
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Processing Time Frames	<p>Payments are made on a weekly basis.</p> <p>POS claims submitted by end of day Thursday are typically paid the following Tuesday. Paper claims are processed for adjudication within ten to thirty days.</p>
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**37.10.2 POINT OF SALE CLAIMS**

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Pharmacy claims are processed through a DHH approved switch vendor through the Point of Sale System. The POS System is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication which are in place for other pharmacy Point of Sale processing.

**Note:** Refer to Appendix D of the Point of Sale User Guide for comprehensive information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

**37.10.3 PAPER CLAIMS**

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A received paper claim is screened for missing information. If information is missing, the claim will not be entered into the system. It will be returned to the provider. The provider needs to correct the error, attach any missing documentation, and return the claim for processing.

Pharmacy providers should verify payment or denial of paper claims on their weekly remittance advice. Pharmacy providers should resubmit these paper claims if the services meet the criteria for payment.

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**37.10.4 DENIED CLAIM FACSIMILES**

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In some instances, denied claim facsimiles are generated for both Point of Sale and paper claims. Pharmacy providers should correct and submit these claim facsimiles to the fiscal intermediary for processing if necessary. Some corrected claims may be submitted Point of Sale if applicable.

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**37.10.5 REMITTANCE ADVICE**

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The Remittance Advice (RA) plays an important communication role between the provider, the Medicaid Program, and Molina. Aside from providing a record of transactions, the Remittance Advice assists providers in resolving and correcting possible errors and reconciling paid claims. The RA also serves as a bulletin board for messages from the Medicaid Program.

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

On the line immediately below each claim, a code will be printed representing denial reasons and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to sixteen alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

**37.10.5 REMITTANCE ADVICE, continued**

**Internal Control  
Number (ICN)**

At the end of each claim line is the thirteen-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the thirteen digits of the ICN and what they represent:

Position 1	Last Digit of Current Year
Positions 2-4	Julian Date - ordinal day of 365-day year
Position 5	Media Code - 0 = paper claim with no attachments 1 = electronic batched claim 3 = system adjustment 4 = system void 5 = paper claim with attachments 6 = resubmission 7 = pharmacy POS electronic claim
Positions 6-8	Batch Number - for Molina internal purposes
Positions 9-11	Sequence Number - for Molina internal purposes
Positions 12-13	Number of Lines within Claim - 00 = first line 01 = second line 02 = third line, etc.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider's responsibility to provide the contracted agency with copies of the RA's or other billing related information in order to bill the claims and reconcile the accounts.

When providers or contractors are attempting to reconcile old accounts, if RA's are not available through the provider, it is necessary for the provider to order a claims history, which is available through Molina Provider Relations.

**Electronic  
Remittance Advice  
(ERA)**

The EMC Department now offers Electronic Remittance Advices (ERA) in the ANSI X12 835 format. The 835 would be in addition to the NCPDP response. This allows providers to have their Remittance Advices transmitted from the fiscal intermediary and posted to accounts electronically. There is a minimal fee for this service. Further information may be obtained by calling the Molina EMC Coordinator at 225-216-6335.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

**37.10.5 REMITTANCE ADVICE, continued**

Remittance Advice  
Breakdown

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Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the fiscal intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims."

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Remittance  
Summary

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

**It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.**

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

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**37.10.5 REMITTANCE ADVICE, continued**

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When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to the provider's check and the payment should be posted to the appropriate recipient's account. If money is being recouped, it will be deducted from the provider's check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each.

- **Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;
- **Approved Original Claim** - Total of all approved (paid) claims appearing on this RA;
- **Adjustment Claims** - Total of all claims being adjusted on this RA;
- **Previously Paid Claim** - Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;
- **Void Claims** - Total of all claims being voided on this RA;
- **Net Current Claims Transactions** - Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process);
- **Net Current Financial Transactions** - Total number of all financial transactions appearing on the RA;
- **Prior Negative Balance** - If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.);

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.10 CLAIMS PROCESSING/PAYMENTS**

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**37.10.5 REMITTANCE ADVICE, continued**

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- **Recoupment Bypassed by DHH;**
  - **Withheld for Future Recoveries** - Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.);
  - **Total Payments This RA** - Total of current check;
  - **Total Copayment Deducted This RA** - Total pharmacy co-payments deducted for this RA;
  - **Suspense Balance Carried Forward** - Total of Suspense Balance Brought Forward and withheld for future recoveries;
  - **Y-T-D Amount Paid** - Total amount paid for the calendar year;
  - **Denied Claims** - Total of all denied claims appearing on this RA; and
  - **Claims in Process** - Total of all pending claims appearing on this RA.
- 

Messages

Important messages appear on the RA pertinent to the pharmacy program. Updates to program policy as well as changes in participating manufacturers in the federal rebate program are included. Changes in the Federal Upper Limits (FULs) and Louisiana Maximum Allowable Costs (LMACs) are also listed.

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**37.10.6 HELP DESK**

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Point of Sale information is available to Pharmacy providers between 8am and 5pm Monday through Friday by contacting the Molina POS Helpdesk at 800-648-0790 or 225-216-6381.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.11 PUBLIC HEALTH SERVICES 340B DRUG PRICING**  
**PROGRAM**

**37.11 PUBLIC HEALTH SERVICES 340B DRUG PRICING PROGRAM**

**Overview**

Introduction

This Section explains the reimbursement methodology for the Public Health services (PHS) 340B Drug Pricing Program that ensures all State Medicaid agencies obtain the full pricing advantages available.

In This Section

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Reimbursement Methodology	11-4
Contacts	11-4

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.11 PUBLIC HEALTH SERVICES 340B DRUG PRICING**  
**PROGRAM**

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**37.11.1 PUBLIC HEALTH SERVICES 340B PROGRAM**

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The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service (PHS) Act.

In 1990, Congress created the Medicaid Rebate Program to lower the cost of pharmaceuticals reimbursed by state Medicaid programs. The program required drug companies to pay rebates as a precondition to having their drugs covered by Medicaid. As a result of the Medicaid rebate law, many drug companies increased the prices of their products to offset the Medicaid discounts. Other federally and state-supported providers' drug expenses increased significantly because of the companies' changes in pricing strategies and eventually offset any savings realized as part of the Medicaid rebate law.

In order to remedy this situation, Congress enacted the Veterans Health Care Act of 1992. Section 602 of that Act added section 340B to the PHS Act requiring drug companies whose drugs are covered by the Medicaid Program to provide discounts on covered drugs purchased by certain government-supported facilities and/or entities. Significant savings on pharmaceuticals may be seen by those entities that participate in this program

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**37.11.2 DEFINITIONS**

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Actual Acquisition Cost	The covered entity's net payment made to purchase a drug product, after taking into account such items as purchasing allowances, discounts, wholesaler fees and rebates.
Contract Pharmacy	A pharmacy under contract with a covered entity that lacks its own pharmacy whereby the contract pharmacy is authorized to dispense 340B-discounted drugs on behalf of the covered entity in accordance with 1996 Health Resources and Services Administration (HRSA) guidelines ( <i>61 FR 43549, August 23, 1996</i> ). Contract pharmacies may also serve as billing agents for covered entities.
Covered Entity	A provider or program that meets the eligibility criteria for participating in the 340B Program as set forth in Section 340B(a)(4) of the PHS Act. Covered entities include eligible disproportionate share hospitals that are owned by or under contract with state or local government, community health centers, migrant health centers, health centers for public housing, health centers for the

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**PROGRAM**

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**37.11.2 DEFINITIONS, continued**

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Covered Entity, continued	homeless, AIDS drug assistance programs and other AIDS clinics and programs, black lung clinics, hemophilia treatment centers, native Hawaiian health centers, urban Indian clinics/638 tribal centers, school-based programs, Title X family planning clinics, sexually-transmitted disease clinics, and tuberculosis clinics.
Dispensing Fee	The fee paid by Medicaid for the professional services provided by a pharmacist when dispensing a prescription, including the \$.10 provider fee assessed for each prescription filled in the State of Louisiana per legislative mandate.
Medicaid Carve-Out	A billing mechanism is available to covered entities that implements the 340B requirement protecting manufacturers from giving a 340B discount and paying a Medicaid rebate on the same drug. If a covered entity elects to implement the Medicaid carve-out option, the covered entity only purchases through the 340B Program covered drugs dispensed to non-Medicaid patients; drugs dispensed to Medicaid patients are purchased outside the 340B Program.
Patient	An individual eligible to receive 340B discounted drugs from a covered entity by virtue of being the covered entity's patient as defined in HRSA's 1996 patient definition guideline (61 FR 55156, October 24, 1996).
340B Program	The federal drug discount program established under Section 340B of the PHS Act and administered by the Office of Pharmacy Affairs within HRSA.

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**37.11.3 PHARMACY ELIGIBILITY AND ENROLLMENT**

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In order to become eligible to participate in the 340B Program, a facility must submit a request to the Office of Pharmacy Affairs within the Health Resources and Services Administration (HRSA), Department of Health and Human Services.

Entities must enroll in Louisiana Medicaid in order to bill and receive reimbursement for self-administered drugs purchased through the 340B Program and dispensed to eligible 340B patients.

**Note:** Refer to Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines for additional enrollment and participation information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.11 PUBLIC HEALTH SERVICES 340B DRUG PRICING  
PROGRAM**

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**37.11.4 REIMBURSEMENT METHODOLOGY**

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Covered Entity	Self-administered drugs that are purchased by a covered entity through the 340B program and dispensed to patients who are covered by Medicaid shall be billed to Medicaid at actual acquisition cost unless the covered entity has implemented the Medicaid carve-out option, in which case such drugs shall be billed in accordance with existing state Medicaid reimbursement methodologies.
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Contract Pharmacies	In that the covered entity has entered into a contract pharmacy arrangement and the contract pharmacy serves as the covered entity's billing agent, the contract pharmacy shall bill Medicaid at actual acquisition cost under the covered entity's Medicaid pharmacy billing number, unless the covered entity has implemented the Medicaid carve-out option, in which case such drugs shall be billed in accordance with existing state Medicaid reimbursement methodologies under the contract pharmacy's Medicaid pharmacy billing number.
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Dispensing Fee	The covered entity shall be paid a dispensing fee of \$8.10 for each prescription dispensed to a Medicaid patient, unless the covered entity has implemented the carve-out option, in which case the covered entity shall be paid the state's existing non-340B dispensing fee. With respect to contract pharmacy arrangements in which the contract pharmacy also serves as the covered entity's billing agent, the contract pharmacy shall be paid the \$8.10 dispensing fee on behalf of the covered entity, unless the covered entity elects the Medicaid carve-out, in which case the contract pharmacy shall be paid the state's existing non-340B dispensing fee.
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**37.11.5 CONTACTS**

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Any questions regarding the 340B program should be directed to HRSA, Office of Pharmacy Affairs at:

Office of Pharmacy Affairs  
HSB/HRSA  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-4353  
800-628-6297  
[OpaStaff@hrsa.hhs.gov](mailto:OpaStaff@hrsa.hhs.gov)  
<http://www.hrsa.gov/opa>

Providers may also contact the LMPBM Section at 225-342-9768.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

## **37.12 TOTAL PARENTERAL NUTRITION**

### **Overview**

#### **Introduction**

This Section explains the LMPBM program's Total Parenteral Nutrition (TPN) therapy coverage, limitations, prior authorization, reimbursement methodology and claim submission.

#### **In This Section**

This Section contains:

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.1 DEFINITIONS**

**Parenteral Nutrition  
Therapy**

Parenteral Nutrition Therapy is the introduction of nutrients by some means other than through the gastrointestinal tract, in particular intravenous, subcutaneous, intramuscular, or intramedullary injection. Intravenous nutrition is also referred to as TPN (Total Parenteral Nutrition) or Hyperalimentation Therapy.

**Intradialytic Parenteral  
Nutrition Therapy**

Intradialytic Parenteral Nutrition Therapy is a parenteral nutrition therapy provided to an end stage renal disease (ESRD) patient while the patient is being dialyzed.

**37.12.2 PROVIDER ENROLLMENT**

Refer to Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines for enrollment instructions.

**37.12.3 PROGRAM COVERAGE**

The program covers the following services, equipment and supplies when medical necessity and other program criteria are met:

- Parenteral Nutrition Therapy/Total Parenteral Nutrition Therapy (TPN) is covered for a patient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition;
- Intradialytic Parenteral Nutrition Therapy (IDPN) provided to an end stage renal disease (ESRD) patient while the patient is being dialyzed; and/or
- Equipment and Supplies-Infusion pumps and accessories.

**TPN Medical  
Necessity Criteria**

- A. Parenteral nutrition is covered for a recipient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition.

**37.12.3 PROGRAM COVERAGE, continued**

TPN Medical  
Necessity Criteria,  
continued

- B. Parenteral nutrition is considered to be medically necessary when any of the following conditions exists. The conditions must be deemed to be severe enough that the recipient would not be able to maintain his/her weight and strength on only oral intake or tube enteral nutrition. The recipient:
1. Has undergone recent (within the past three months) massive small bowel resection leaving less than or equal to 5 feet of small bowel beyond the ligament of Treitz; or
  2. Has a short bowel syndrome that is severe enough that the recipient has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50 percent of the oral/enteral intake and the urine output is less than 1 liter/day; or
  3. Requires bowel rest for at least three months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula is not possible; or
  4. Has complete mechanical small bowel obstruction where surgery is not an option; or
  5. Is significantly malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl) and has very severe fat malabsorption (fecal fat exceeds 50 percent of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72 hour fecal fat test); or
  6. Is significantly malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication. Prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses and is demonstrated either:
    - a. Scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by six hours following ingestion); or
    - b. Radiographically (barium or radiopaque pellets fail to reach the right colon by six hours following administration).
- Note:** These studies must be performed when the recipient is not acutely ill and is not on any medication which would decrease bowel motility.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.3 PROGRAM COVERAGE, continued**

TPN Medical  
Necessity Criteria,  
continued

- 
- C. Maintenance of weight and strength commensurate with the recipient's overall health status must require intravenous nutrition and must not be possible utilizing all of the following approaches:
    - 1. Modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.); and
    - 2. Utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.).
  - D. Recipients who do not meet the criteria in B.1-6 must meet criteria in C.1-2 (modification of diet and pharmacologic intervention) in addition to the following criteria:
    - 1. The recipient is malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl); and
    - 2. A disease and clinical condition has been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).
  - E. The following are some examples of moderate abnormalities which would require a failed trial of tube enteral nutrition before PN would be covered:
    - 1. Moderate fat malabsorption - fecal fat exceeds 25 percent of oral/enteral intake on a diet of at least 50 gm fat/day as measured by a standard 72 hour fecal fat test;
    - 2. Diagnosis of malabsorption with objective confirmation by methods other than 72 hour fecal fat test (e.g., Sudan stain of stool, dxylose test, etc.);
    - 3. Gastroparesis which has been demonstrated:
      - a. Radiographically or scintigraphically as described in Subsection B above with the isotope or pellets failing to reach the jejunum in three to six hours; or
      - b. By manometric motility studies with results consistent with an abnormal gastric emptying, and which is unresponsive to prokinetic medication;
    - 4. A small bowel motility disturbance which is unresponsive to prokinetic medication, demonstrated with a gastric to right colon transit time between three to six hours.
    - 5. Small bowel resection leaving greater than 5 feet of small bowel beyond the ligament of Treitz.
    - 6. Short bowel syndrome which is not severe (as defined in B.2);

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.3 PROGRAM COVERAGE, continued**

TPN Medical  
Necessity Criteria,  
continued

- 
7. Mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula;
  8. Partial mechanical small bowel obstruction where surgery is not an option.
- F. Documentation must support that a concerted effort has been made to place a tube. For gastroparesis, tube placement must be post-pylorus, preferably in the jejunum. Use of a double lumen tube should be considered. Placement of the tube in the jejunum must be objectively verified by radiographic studies or fluoroscopy. Placement via endoscopy or open surgical procedure would also verify location of the tube.
- G. A trial with enteral nutrition must be documented, with appropriate attention to dilution, rate, and alternative formulas to address side effects of diarrhea.
- H. PN can be covered in a recipient with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral or oral/enteral/parenteral intake as long as the following criteria are met:
1. A permanent condition of the alimentary tract is present which has been deemed to require parenteral therapy because of its severity;
  2. A permanent condition of the alimentary tract is present which is unresponsive to standard medical management; and
  3. The person is unable to maintain weight and strength.
- I. If the medical necessity criteria for parenteral nutrition are met, medically necessary nutrients, administration supplies and equipment are covered. PN solutions containing little or no amino acids and/or carbohydrates would be covered only in situations stated in B.1, 2, or 4 above.
- 

Documentation  
Requirements

Recipients covered under Paragraph B.4 must have documentation of the persistence of their condition. Recipients covered under B.5–D.2 must have documentation that sufficient improvement of their underlying condition has not occurred which would permit discontinuation of parenteral nutrition. Coverage for these recipients would be continued if the treatment has been effective as evidenced by an improvement of weight and/or serum albumin. If there has been no improvement, subsequent claims will be denied unless the physician clearly documents the medical necessity for continued parenteral nutrition and any changes to the therapeutic regimen that are planned, e.g., an increase in the quantity of parenteral nutrients provided.

A total caloric daily intake (parenteral, enteral and oral) of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual recipient.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.3 PROGRAM COVERAGE, continued**

Documentation  
Requirements,  
continued

Parenteral nutrition would usually be noncovered for recipients who do not meet criteria in H.1-3, but will be considered on an individual case basis if detailed documentation is submitted.

Recipients covered under criteria in B.1 or 2 must have documentation that adequate small bowel adaptation had not occurred which would permit tube enteral or oral feedings.

Recipients covered under B.3 must have documentation of worsening of their underlying condition during attempts to resume oral feedings.

The ordering physician must document the medical necessity for protein orders outside of the range of 0.8-1.5 gm/kg/day, dextrose concentration less than 10 percent, or lipid use greater than 15 units of a 20 percent solution or 30 units of a 10 percent solution per month.

If the medical necessity for special parenteral formulas is not substantiated, authorization of payment will be denied.

For the initial request and for revised requests or reconsiderations involving a change in the order, there must be additional documentation to support the medical necessity of the following orders, if applicable.

- The need for special nutrients;
- The need for dextrose concentration less than 10 percent;
- The need for lipids more than 15 units of a 20 percent solution or 30 units of a 10 percent solution per month.

After the first six months, the PA request must include a physician's statement describing the continued need for parenteral nutrition. For situations described in B.5-D.2 under Medical Necessity Criteria, the PA request must include the results of the most recent serum albumin (within two weeks of the request date) and the recipient's most recent weight with the date of each. If the results indicate malnutrition, there should be a physician's statement describing the continued need for parenteral nutrition and any changes to the therapeutic regimen that are planned.

Exclusionary Criteria

Parenteral nutrition will be denied as non-covered in situations involving temporary impairments. The recipient must have:

- A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or
- A disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the GI system. There must be objective evidence supporting the clinical diagnosis.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.3 PROGRAM COVERAGE, continued**

Exclusionary Criteria,  
continued

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Parenteral nutrition is non-covered for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:

- A swallowing disorder;
  - A temporary defect in gastric emptying such as a metabolic or electrolyte disorder;
  - A psychological disorder impairing food intake such as depression;
  - A metabolic disorder inducing anorexia such as cancer;
  - A physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease;
  - A side effect of a medication; or
  - Renal failure and/or dialysis.
- 

IDPN Criteria

Intradialytic Parenteral Nutrition Therapy (IDPN) is parenteral nutrition therapy provided to a recipient with end stage renal disease (ESRD) while the recipient is being dialyzed.

In order to cover IDPN, documentation must be clear and precise to verify that the recipient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The supporting documentation must substantiate that the recipient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the recipient must be intravenously infused with nutrients.

Infusions must be vital to the nutritional stability of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis. Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted. Recipients receiving IDPN must also meet the criteria for parenteral nutrition.

If the medical necessity criteria for parenteral nutrition are met, one supply kit and one administration kit will be covered for each day that parenteral nutrition is necessary and used.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

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**37.12.3 PROGRAM COVERAGE, continued**

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Equipment and  
Supplies Criteria

An infusion pump is used to deliver nutritional requirements intravenously. Infusion pumps are covered for the delivery of parenteral nutrition for those recipients who cannot absorb nutrients by the gastrointestinal tract. Only one pump (ambulatory or stationary) will be covered at any one time. Additional pumps will be denied as not medically necessary.

- An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral nutrition. It is designed to be carried or worn by the recipient.
- A stationary infusion pump is an electrical device, which serves the same purpose as an ambulatory pump, but is larger and typically mounted on a pole.

An IV pole is a device to suspend fluid to be administered by gravity or pump. An IV pole will be covered when a recipient is receiving parenteral fluids and the recipient is not using an ambulatory infusion pump.

Infusion pumps, ambulatory and stationary, are indicated for the administration of parenteral medication in the home when parenteral administration of the medication in the home is reasonable and medically necessary, and an infusion pump is necessary to safely administer the medication.

An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried or worn by the recipient.

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**37.12.4 PRIOR AUTHORIZATION**

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Prior Authorization  
Requirements

Parenteral nutrition therapy may be approved by the Prior Authorization Unit (PAU) at periodic intervals not to exceed six months. However, Medicaid will pay for no more than one month's supply of nutrients at any one time. All requests to the PAU shall include:

- The prognosis as well as the diagnosis;
- The date the recipient was first infused;
- Whether the recipient has been trained to use parenteral equipment;
- A statement that the recipient is capable of operating the parenteral equipment;
- Either the Medicaid certificate of medical necessity form for TPN, or the Medicare certificate of medical necessity form, Form DMERC 10.02A, completed and signed by the treating physician;
- Documentation showing that the recipient has a permanent impairment. Permanence does not require a determination that there is no possibility that the recipient's condition may improve sometime in the future. Medical documentation must substantiate that the condition is expected to last a long and indefinite duration (at least three months).



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.4 PRIOR AUTHORIZATION, continued**

Prior Authorization  
Requirements,  
continued

Additional documentation must be included with the initial request for parenteral nutrition.

In the situations addressed in B.1-4 under Medical Necessity Criteria, the documentation must include copies of the operative report and/or hospital discharge summary and/or x-ray reports and/or a physician letter which document the condition and the necessity for PN therapy.

For the situations addressed in B.5 and D.2 under Medical Necessity Criteria (when appropriate), include the results of the fecal fat test and dates of the test.

For the situations addressed in B.6 and D.2 under Medical Necessity Criteria, include a copy of the report of the small bowel motility study and a list of medications that the recipient was on at the time of the test.

For the situations addressed in B.5 – D.2 under Medical Necessity Criteria, include the results of serum albumin and the date of the test (within one week prior to initiation of PN) and a copy of a nutritional assessment by a physician, dietitian or other qualified professional within one week prior to initiation of PN, to include the following information:

- Current weight with date and weight one – three months prior to initiation of PN;
- Estimated daily calorie intake during the prior month and by what route (e.g., oral, tube);
- Statement of whether there were caloric losses from vomiting or diarrhea and whether these estimated losses are reflected in the calorie count;
- Description of any dietary modifications made or supplements tried during the prior month (e.g., low fat, extra medium chain triglycerides, etc.).

For situations described in D.2 under Medical Necessity Criteria, include:

- A statement from the physician;
- Copies of objective studies; and
- Excerpts of the medical record giving the following information:
  - Specific etiology for the gastroparesis, small bowel dysmotility, malabsorption;
  - A detailed description of the trial of tube enteral nutrition including the beginning and ending dates of the trial, duration of time that the tube was in place, the type and size of tube, the location of tip of the tube, the name of the enteral nutrient, the quantity, concentration, and rate of administration, and the results;
  - A copy of the x-ray report or procedure report documenting placement of the tube in the jejunum;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

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**37.12.4 PRIOR AUTHORIZATION, continued**

- 
- Prokinetic medications used, dosage, and dates of use;
  - Nondietary treatment given during prior month directed at etiology of malabsorption (e.g., antibiotic for bacterial overgrowth); and
  - Any medications used that might impair GI tolerance to enteral feedings (e.g., anticholinergics, opiates, tricyclics, phenothiazines, etc.) or that might interfere with test results (e.g., mineral oil, etc.) and a statement explaining the need for these medications.

Any other information which supports the medical necessity for parenteral nutrition may also be included.

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**Prior Authorization  
Requests**

The Prior Authorization request shall be submitted to the fiscal intermediary prior authorization unit where it will be considered for payment. Provider may contact the PAU at 800-488-6334.

Request may be mailed to:

Molina/LA Medicaid  
P. O. Box 14919  
Baton Rouge, LA 70898-4919

OR

Fax To: 225-929-6803

Providers may complete and submit electronic PA forms. These forms may be accessed at [www.lamedicaid.com](http://www.lamedicaid.com). For more information contact the Prior Authorization Unit at 800-488-6334.

**Note:** Refer to Appendix I for Form PA01 and instructions or providers may access this form at [www.lamedicaid.com](http://www.lamedicaid.com).

Once a prior authorization request is approved, the provider and recipient are notified of the approval, as well as, what services have been approved. A prior authorization number is attached to the approved request. This number is to be used in the billing process.

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**Emergency Requests**

A request is considered an emergency if a delay in obtaining the parenteral nutrition therapy would be life-threatening to the recipient. Providers should call the Prior Authorization (PA) Unit toll-free number. Providers should then fax a completed PA 01 form, documentation of the parenteral therapy and life-threatening situation (i.e. pending discharge). Once an approval or denial is determined within 48 hours, the procedure codes, authorized reimbursement rate and prior authorization number is phoned to the provider. A determination letter is later mailed to the provider and recipient.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.4 PRIOR AUTHORIZATION, continued**

Medicare Crossover  
Claims

Claims for Total Parenteral Nutrition and equipment reimbursed by Medicare do not require prior authorization from Medicaid when these claims crossover from Medicare to Medicaid for payment.

Claims denied by Medicare due to lack of medical necessity will not be considered for coverage by Medicaid.

Medicare non-covered services may be considered for coverage by Medicaid Claims, when that service is a Medicaid covered service, however prior authorization is necessary.

Third Party  
Liability

When a Medicaid recipient has private insurance and Medicaid, prior authorization is required from all payors including Medicaid.

**37.12.5 REIMBURSEMENT METHODOLOGY**

The following is the Medicaid reimbursement schedule:

- Reimbursement for Parenteral Nutrition Therapy (TPN) formula is 80 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount;
- Reimbursement for TPN supplies is 70 percent of the Medicare Fee Schedule or billed charges, whichever is the lesser amount; and
- Reimbursement for TPN infusion pumps is 70 percent of the Medicare Fee Schedule or billed charges, whichever is the lesser amount.

**37.12.6 CLAIM SUBMISSION**

Medicaid  
Claims

Claims for TPN should be submitted on the CMS-1500. The form may be accessed at [www.lamedicaid.com](http://www.lamedicaid.com).

Medicare  
Crossover  
Claims

Medicare claims will automatically crossover to Medicaid when the provider is enrolled as a Medicare provider.

**Note:** Refer to 37.7.2 Medicare Part B Crossover Claims for detailed information.

Third Party  
Liability

When a recipient has both Medicaid and private insurance, the provider is required to submit the claim to the private insurance first. The provider's

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.12 TOTAL PARENTERAL NUTRITION**

**37.12.6 CLAIM SUBMISSION, continued**

Third Party  
Liability Claims,  
continued

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remittance advice from the private insurance company should be submitted with the claim to Medicaid.

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Adjustments/Voids

Providers should complete Form 213 Adjustment/Void form for TPN Services submitted which require adjustments or voids.

**Note:** Refer to Appendix K for a copy of this form.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.14 MEDICATION ADMINISTRATION**

**37.14.1 MEDICATION ADMINISTRATION**

**Overview**

Introduction

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The Louisiana Board of Pharmacy has set minimum requirements regarding the administration of medications to patients by licensed Louisiana pharmacists. Currently Louisiana Medicaid will reimburse enrolled pharmacies when these credentialed pharmacists administer the influenza vaccine.

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In This Section

This Section Contains:

TOPIC	PAGE
Medication Administration by Pharmacists	14-2
Pharmacist Provider Number	14-2
Influenza Vaccine Administration by Pharmacist	14-3

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.14 MEDICATION ADMINISTRATION**

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**37.14.1 MEDICATION ADMINISTRATION BY PHARMACISTS**

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Louisiana Board of Pharmacy	Pharmacists in Louisiana who wish to administer medications must be registered by the Louisiana Board of Pharmacy. Louisiana Board of Pharmacy Regulations regarding Prescription Orders to Administer Medications may be found at LAC, 46:LIII, §521.
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**37.14.2 PHARMACIST PROVIDER NUMBER**

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Authorized Pharmacists	Pharmacists who are registered with the Louisiana Board of Pharmacy and have the Authority to Administer are required to obtain a Medicaid pharmacist provider number in order to bill Louisiana Medicaid. To confirm or request enrollment, authorized pharmacists should contact:
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Molina Provider Enrollment  
225-216-6370

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National Provider Identifier (NPI)	Pharmacists who have an NPI should report it to Molina and may include their NPI in the claim submission.
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**37.14.3 INFLUENZA VACCINE ADMINISTRATION BY PHARMACIST**

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Claim Requirements	Louisiana Medicaid will reimburse enrolled pharmacies when this immunization is given by a pharmacist who has the Authority to Administer authorized by the Louisiana Board of Pharmacy. The administering pharmacist's Louisiana Medicaid provider number or his/her NPI must be submitted in the claim.
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When a prescription for the influenza vaccine is written by a prescribing practitioner, that practitioner's NPI or Louisiana Medicaid number should be sent in the claim. When a prescription order does not exist, the vaccinating pharmacist shall enter his/her Louisiana Medicaid provider number or NPI as the prescriber and submit the claim.

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Vaccination Reimbursement	Louisiana Medicaid reimburses enrolled pharmacies for the cost of the influenza vaccine as well as the administration of the vaccine for Medicaid recipients who are nineteen years of age and older when the administering pharmacist is an enrolled Medicaid provider. No reimbursement of the vaccine or supplies will be made for children under the age of nineteen years of age. Only the administration fee will be reimbursed for these recipients.
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.14 MEDICATION ADMINISTRATION**

**37.14.3 INFLUENZA VACCINE ADMINISTRATION BY PHARMACIST**

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Bypassed Editing	Claims for influenza vaccines will process without edits for the four prescription limit, requirements to bill other insurance and Lock-In.
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Copayments	Recipients may not be charged co-payments for the influenza vaccines.  <b>Note:</b> Refer to Appendix D Point of Sale User Guide for detailed information regarding the submission of these claims.
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Electronic Drug Inquiry (e-CDI)	Paid claims for administration fees will be posted on the Electronic Clinical Drug Inquiry (e-CDI). When Medicaid reimburses a pharmacy for an administration fee claim, the name of the influenza vaccine and date of payment will be listed. This application is available in the secured provider site of <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> .
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Vaccination Documentation	Once administered, pharmacists shall document these immunizations in the Louisiana Immunization Network for Kids Statewide (LINKS) registry.
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**Note:** This document and LINKS may be found at [www.dhh.la.gov](http://www.dhh.la.gov).

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.16 PATIENT COUNSELING, DRUG UTILIZATION REVIEW**  
**(DUR) AND PROVIDER PEER BASED PROFILING**

**37.16 PATIENT COUNSELING, DRUG UTILIZATION REVIEW (DUR) AND  
PROVIDER PEER BASED PROFILING**

**Overview**

Introduction

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Federal and state laws and regulations require that pharmacists provide the pharmaceutical care services described below. The intent of the laws and regulations is to improve the quality of pharmaceutical care by ensuring that medications are appropriate, medically necessary, and not likely to have adverse medical results.

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In This Section

This Section contains:

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Prospective Drug Utilization Review (UniDUR)	16-3
Retrospective Drug Utilization Review	16-6
Provider Peer Based Profiling	16-7
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### **37.16.1 INTRODUCTION**

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The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) System utilizes several different drug utilization review (DUR) applications in its program that are either federally and/or state mandated.

In 1990 the federal Omnibus Budget Reconciliation Act (OBRA) amended the Social Security Act to include the specific requirement that states must administer a Drug Utilization Review (DUR) Program with a DUR Board. OBRA 90 states that a drug use review program assures that prescriptions are appropriate, are medically necessary, and are not likely to result in adverse medical results. In accordance with the Act and federal regulations, states are mandated to have a Medicaid DUR program with the goal, "...to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individual drug therapy." The federal DUR program's required components are:

- Patient counseling;
- Prospective drug review;
- Retrospective drug use review;
- An educational program; and
- A state Drug Utilization Review Board.

In 2001 the Louisiana Legislature amended La. R.S. 46:153.3 by Act 395 to mandate the Department of Health and Hospitals (DHH) develop peer-based prescribing and dispensing practice patterns for health care providers participating in Medicaid and to promote these practice patterns. This program is called the **Provider Peer Based Profiling Program**.

### **37.16.2 PATIENT COUNSELING**

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Patient counseling must be offered and provided in accordance with the Louisiana Board of Pharmacy Regulations at LAC, 46:LIII, §517.

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#### **Components of Patient Counseling**

In accordance with those regulations, the pharmacist, at a minimum, should be convinced that the patient or caregiver is informed of the following:

- Name and description of the medications;
- Dosage form, dosage, route of administration, and duration of therapy;
- Special directions and precautions for preparation, administration, and use by the patient;

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**37.16.2 PATIENT COUNSELING, counseling**

- 
- Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required in the event of their occurrence;
  - Techniques for self-monitoring drug therapy;
  - Proper storage of the medication;
  - Prescription refill information, if any; and
  - The action to be taken in the event of a missed dose.
- 

Communication  
to the Patient

Counseling to the patient or caregiver should be in person if possible. If that is not possible or appropriate, then a pharmacist should counsel using alternative methods including, but not limited to, telephonic or electronic communication with the patient or caregiver.

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Exceptions to  
Counseling  
Requirement

Counseling is not required for inpatients of a hospital or institution where a nurse or other licensed health care professional is authorized to administer medications.

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Waiver

According to the regulations, no pharmacist or pharmacy may solicit or encourage blanket waivers for patient counseling. However, the regulations do not prohibit the patient or caregiver from declining patient counseling.

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**37.16.3 PROSPECTIVE DRUG UTILIZATION REVIEW (UNI-DUR)**

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Prior to filling or refilling a prescription, the pharmacist must review the prescription and the patient record for therapeutic appropriateness.

If there is an indication of possible drug contraindications or abuse, the pharmacist must take appropriate action to resolve the issue(s).

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**37.16.3 PROSPECTIVE DRUG UTILIZATION REVIEW (UNI-DUR), continued**

UniDUR  
Features

UniDUR has the following features.

- UniDUR provides real-time screening of all Point of Sale (POS) prescription drug claims against the Louisiana Medicaid clinical database.
- UniDUR reports “clinical events” as defined by the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) Section. The events are based on extensive development research done by the LMPBM System staff, contractors, Molina and University of Louisiana at Monroe (ULM) School of Pharmacy; and the Drug Utilization Review (DUR) Board.
- UniDUR provides an on-line response to a pharmacy within seconds of significant UniDUR events with the disposition of the claim.

How UniDUR  
Works

The UniDUR system accepts POS transactions from the Medicaid claims adjudication system, and screens each prescription against a patient’s prescription profile. The profile includes the patient’s active drug products, medical diagnosis profile, gender and age.

Screening occurs using one or more of the clinical screening modules that are based upon the clinical criteria defined by the LMPBM System staff. The results of the screening are returned to the claims adjudication system in the form of clinical events. The system then completes the adjudication of the claim according to the program’s established parameters and sends a response to the pharmacy.

Clinical Events

If a potential drug issue is identified, a clinical event is triggered, and the pharmacy will receive a UniDUR message. The LMPBM screens prescriptions for the following potential drug issues:

- Compliance Monitoring – refills too early or too late;
- Prescribing Limits – excessive or inadequate dosages, or duration of therapy;
- Therapeutic Duplication – two or more prescriptions with duplicative actions, whether prescribed by the same or different prescribers;
- Drug-Drug Interaction – drugs that should not be taken concurrently;
- Drug-Disease Precaution – specific drugs that may cause harm in patients with certain known medical conditions;
- Disease-Drug Precaution – diseases where specified drugs are suggested for use to deter disease progression or complications;

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**37.16.3 PROSPECTIVE DRUG UTILIZATION REVIEW (UNI-DUR), continued**

- 
- Pregnancy Precaution – drugs with high risk of fetal harm dispensed to childbearing women.

**Note:** Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for detailed policy information.

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Medicaid Responses  
to a Clinical Event

Depending on the severity of the clinical event, Medicaid may:

- Suppress the response to the pharmacy, but report it in aggregate to Medicaid staff;
  - Return the response to the pharmacy for informational purposes, not require any action, and pay the claim as submitted; or
  - Return the response to the pharmacy and require the pharmacist to take appropriate action and report that action in the form of a claim override. Medicaid will deny payment if the pharmacist does not correctly override the claim.
- 

Required Action

When a UniDUR response is received, the pharmacist must verify the information against the patient's drug profile and current prescription, evaluate the conflict, and decide whether or not to dispense the drug. Actions can range from conferring with the patient and checking the patient's profile to consulting with the prescriber.

If the message is "early refill" or "therapeutic duplication" the pharmacist must determine whether the prescription should be filled, refused, or changed.

If the pharmacist or recipient is unaware of any conflicting prescriptions, the pharmacist may call the Molina Point of Sale Help Desk at 1-800-648-0790 for additional information on the UniDUR message.

**Note:** Refer to Appendix D Point of Sale User Guide and Section 37.5.8 for detailed information and instructions on the Prospective Drug Utilization Review (UniDUR) feature of the LMPBM System.

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**37.16.4 RETROSPECTIVE DRUG UTILIZATION REVIEW**

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The federal retrospective DUR requirements recognize the functions of Medicaid Management Information Systems (MMIS) and Surveillance and Utilization Review (SUR) subsystems which were in effect prior to OBRA 1990. The regulations, therefore, permit states to *limit retrospective DUR review activities to those that focus on appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program.*

---

LaDUR

The retrospective drug utilization review program in Louisiana is called LaDUR. The LMPBM System, through a contract with the fiscal intermediary, Molina, administers LaDUR as a component of its Drug Utilization Review (DUR) system.

The LaDUR program includes four regional committees, each comprised of three pharmacist providers and one physician provider located throughout the state, who conduct monthly reviews of Medicaid patients' prescription profiles. (These reviews assess the possibility of underutilization, over-utilization, or contra-indications of prescription therapy by querying a recipient's disease history and drug utilization.) The committees correspond with patients' prescribers and pharmacists regarding their observations in an effort to identify prescription therapies and utilization patterns that correspond to specified therapeutic criteria.

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LaDUR's  
Enhanced Focus

LaDUR has been enhanced in recent years by shifting its focus from a fundamental review of therapeutic drug criteria based on a patient's prescription utilization to the examination of a patient's disease states.

Extensive technical programming enhancements have allowed identification of prescription use or absence within a disease state. This shifts the program's focus from issues of over-utilization and drug duplication to a disease management focus. For example, clinical practice guidelines from the American Diabetes Association were reviewed by the DUR Board to develop standards for LaDUR. Standards developed include reviewing the drug regimens of patients with diabetes and concurrent hypertension for angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) utilization.

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### **37.16.5 PROVIDER PEER BASED PROFILING**

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Provider Peer Based Profiling (PPBP) is one of the newest components of the LMPBM System's Drug Utilization Review System. In accordance with the Louisiana Legislature's mandate, the LMPBM System is required to develop peer-based prescribing and dispensing practice patterns for health care providers who participate in the Louisiana Medicaid Program and to develop and maintain a process to promote such practice patterns through the Drug Utilization Review Board.

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**PPBP  
Objectives**

The objectives of this program are to:

- Identify, evaluate, and monitor existing levels of delivery of pharmaceutical care by prescribing providers;
  - Improve the quality of recipients' pharmaceutical care; and
  - Identify and help correct aberrant prescribing and dispensing patterns of pharmaceutical care services delivery patterns.
- 

**PPBP  
Functions**

The program focuses on educational outreaches to the providers whose prescribing and/or dispensing practices are aberrant to his/her peers. By intervening with prescribers and pharmacists having questionable practices, the LMPBM System's educational components will motivate change.

The program provides database extract programs to:

- Identify peer-based appropriate/acceptable standards of prescribing and dispensing patterns by parish or region;
  - Rank providers within these patterns;
  - Develop provider specific educational interventions to address aberrant practicing patterns; and
  - Develop reporting system for:
    - Audit trails
    - Intervention Tracking Reports
    - Special Projects Reports
- 

### **37.16.6 DRUG UTILIZATION REVIEW BOARD**

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The federal OBRA '90 statute requires each state to establish a Drug Utilization Review (DUR) Board. The Louisiana Department of Health and Hospitals' Bureau of Health Services Financing has established a Drug Utilization Review Board to assist the agency in assessing its Drug Utilization Review Program.



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**37.16.6 DRUG UTILIZATION REVIEW BOARD, continued**

**DUR Board  
Functions**

The Board should:

- Make recommendations and approve predetermined criteria established in retrospective DUR and prospective DUR;
- Evaluate the use of predetermined criteria and standards in use, and make recommendations to the Bureau concerning modification or elimination of existing predetermined criteria and standards or the adoption of new ones;
- Recommend guidelines governing written predetermined criteria and standards that pharmacies not using approved software must use in performing prospective DUR;
- Identify educational topics to improve prescribing and dispensing practices;
- Make recommendations regarding interventions to improve quality of drug therapy;
- Periodically re-evaluate educational interventions;
- Be a knowledgeable group, dedicated to assisting the agency in the administration of its Drug Utilization Review Program in an advisory capacity; and
- Prepare annual report.

**Membership**

Federal statute specifies the general board membership.

The membership of the DUR Board shall consist of at least one-third but not more than 51% licensed and actively practicing physicians and at least one third licensed and actively practicing pharmacists. Whenever possible, the Board will include representation of the Louisiana Schools of Pharmacy and the pharmaceutical manufacturers.

The committee shall be composed of at least eight members (or approved designees) appointed by the secretary of the Department of Health and Hospitals.

The committee shall consist of healthcare professionals who have recognized knowledge in:

- Clinically appropriate prescribing of covered outpatient drugs;
- Clinically appropriate dispensing and monitoring of covered outpatient drugs;
- Drug use review, evaluation and intervention; and
- Medical quality assurance.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.17 LOCK-IN PROGRAM**

**37.17 LOCK-IN PROGRAM**

**Overview**

Introduction

The Bureau of Health Services Financing (BHSF) has developed a program to educate recipients who may be misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse or over-utilize pharmacy and/or physician benefits may be restricted to the use of one pharmacy and one physician, or one pharmacy provider (for pharmacy only Lock-In).

In This Section

This Section contains:

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Lock-In Emergencies	17-2
Referrals	17-3

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.17 LOCK-IN PROGRAM**

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### 37.17.1 CHOOSING A LOCK-IN PROVIDER

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A Medicaid recipient loses his/her freedom of choice of providers when selected for enrollment in the Lock-In program. A Lock-In recipient is asked to choose one primary care physician provider, specialist when warranted, and one pharmacy provider to be the Lock-In providers. Only physicians can prescribe medications for Lock-In recipients. Approval of selections is required from the Louisiana Medicaid Pharmacy Program.

Under most circumstances, recipients with providers listed under the Lock-In segment of REVS or MEVS are restricted to receiving physician and pharmacy services from these providers.

The Lock-In system affects the recipients **only in the areas of physician and pharmacy services**. Services other than physician or prescription drug services may be rendered to eligible recipients without Lock-In restrictions.

If a recipient chooses to change Lock-In provider(s) or add a specialist, the recipient must contact their local Medicaid office. If a provider chooses to no longer be a recipient's Lock-In provider, the provider should contact the Lock-In Unit at 225-216-6245 or Fax 225-216-6334.

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Specialist

The recipient may add up to three specialist providers when his/her medical condition warrants treatment by a specialist.

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Infusion Pharmacy

In special circumstances, a recipient may need the services of an infusion pharmacy and is allowed to add a second pharmacy to bill intravenous medication only.

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### 37.17.2 LOCK-IN EMERGENCIES

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Providers not named on the Lock-In segment accessed through MEVS or REVS can provide services; however, no payment will be made to these providers. The Bureau of Health Services Financing (BHSF) recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not named on the eligibility file on REVS or MEVS. Payment will be made to any physician or pharmacist **enrolled** in Louisiana Medicaid who grants services to a Lock-In recipient in emergency situations, or when life-sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed. These claims should be submitted electronically with an emergency override. The notation "Emergency

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.17 LOCK-IN PROGRAM**

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**37.17.2 LOCK-IN EMERGENCIES, continued**

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Prescription” or “Discharge Prescription” should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

**Note:** Refer to Appendix D Point of Sale User Guide for detailed information regarding submission of these claims.

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**37.17.3 REFERRALS**

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There may be circumstances under which it is necessary for a Lock-In physician to refer the Lock-In recipient for consultation with another physician on a short term basis. (The consulting physician may be reimbursed for the consultation if that consulting physician enters the name and provider number of the referring Lock-In physician in the **Referring Physician** block on the claim).

Prescriptions written by the consulting physician will deny when submitted by the Lock-In pharmacy. These prescriptions may be rewritten by one of the recipient’s Lock-In physicians or may be authorized by one of the Lock-In physicians. The pharmacist should submit these prescription claims with the authorizing Lock-In physician’s Medicaid provider number.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.18 DISEASE MANAGEMENT PROGRAM**

**37.18 DISEASE MANAGEMENT PROGRAM**

**Overview**

Introduction

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This Section describes the pharmacy disease management program, features and initiatives.

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In This Section

This Section contains:

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Program Initiatives	18-3

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.18 DISEASE MANAGEMENT PROGRAM**

### **37.18.1 INTRODUCTION**

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The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) System utilizes state-of-the-art features to operate an outstanding disease state management program for its entire Medicaid population. These features include:

- Federally approved Medicaid Management Information (MMIS) system;
- Web-based Clinical Drug Inquiry Support Application and Clinical Data Inquiry (e-CDI);
- Prospective and Retrospective Drug Utilization Review Programs;
- Prescribing Practitioner and Pharmacy Peer-Based Profiling Program; and
- Recipient Prescription Lock-In Program.

The LMPBM Section contracts with its fiscal intermediary, Molina, and the University of Louisiana at Monroe (ULM) School of Pharmacy to provide the administrative and technical support functions for the Disease State Management Program. In addition, it utilizes the expertise of the state Drug Utilization Review Board, the Interdisciplinary Medicine and Pharmacy Council, and the Pharmacy Advisory Committee for consultation relative to the Disease State Management Program.

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### **37.18.2 EDUCATIONAL TOOLS**

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Educational Brochures	The fiscal intermediary in conjunction with the ULM School of Pharmacy, produces and mails several educational brochures throughout the year. The brochures are disease-state specific brochures for prescribers and pharmacists in addition to brochures for recipients. These brochures are available on the web at <a href="http://rxweb.ulm.edu/pharmacy/oore/disease_management.html">http://rxweb.ulm.edu/pharmacy/oore/disease_management.html</a> .
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Educational Articles	The State's Medicaid provider newsletter, The Provider Update, published by the fiscal intermediary several times a year includes educational articles for prescribers and pharmacists on various disease states and treatment modalities.
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Recipient Prescription Lock-In Program	Recipients placed in Lock-In have been identified as using medications inappropriately and in many cases using multiple prescribers and pharmacies. Restricting them to a prescriber and a pharmacy enables the practitioners to better manage their care.
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**Note:** Refer to Section 37.17 Lock-In for detailed information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.18 DISEASE MANAGEMENT PROGRAM**

**37.18.3 PROGRAM INITIATIVES**

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The Disease State Management initiatives focus on diseases such as asthma, diabetes, arthritis, hyperlipidemia and heart failure. Outcomes studies on these initiatives are conducted by ULM staff. A report issued on a study of the Asthma Disease State Management Program disclosed that as a result of the disease management program, asthma-related physician office visits declined in all areas of the state; there was a decline in asthma-related inpatient utilization in all areas of the state; emergency room visits declined in three of the four regions of the state; there was an increase in the use of long-term control medications rather than quick-relief medications; and while pharmacy expenditures increased, the increases were accompanied by decreases in spending on other health services resulting in a decline in total asthma-related expenditures.

The Louisiana Medicaid Pharmacy Benefits Management Program currently supports two pharmaceutical care programs, Asthma HELP (Health Education by Louisiana Pharmacists) and Diabetes HELP, for Louisiana Medicaid recipients. The ULM College of Pharmacy, Office of Outcomes Research and Evaluation (OORE), a team consisting of pharmacists, health data analysts, and administrative personnel, developed, implemented, and currently operate both of these programs.

For more information or for patient referral, call 1-866-762-2404

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**Asthma HELP**

Asthma HELP is a telephone-based disease management program designed to promote positive health outcomes for Louisiana Medicaid recipients diagnosed with asthma. It was implemented in April 2005. Recipients who have had 2 or more asthma-related emergency department visits within a 6 month period are targeted for enrollment. However, any Louisiana Medicaid recipient diagnosed with asthma is eligible for participation. Recipients may also be referred by their physicians. Each recipient who chooses to enroll is assigned to a specific pharmacist certified in asthma education by the National Asthma Educator Certification Board (NAECB). One pharmacist is assigned to the recipient throughout enrollment. Enrollees are offered the following products and services:

- Telephone counseling sessions monthly, or more frequently if needed, on various asthma-related topics, such as triggers, types of asthma medications, management of asthma exacerbations, and action plans;
- Educational materials, such as brochures, games, puzzles, and children's books;
- Instructions for use of various asthma-related devices, such as nebulizers, peak flow meters, and metered-dose inhalers;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.18.3 PROGRAM INITIATIVES, continued**

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Asthma HELP,  
continued

- Communication with the physician on behalf of the patient, on matters such as refill requests for controller medications and requests for development of action plans; and
- Toll-free help line where asthma educators are available 6 days a week, 10 hours per day.

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Diabetic HELP

Diabetes HELP, a group-based diabetes educational program with an emphasis on self-management, was developed to improve the health and quality of life of Louisiana Medicaid recipients diagnosed with diabetes through education and support. The 8-week program consists of weekly two hour group sessions. The first of which is primarily diabetes education with a hands-on approach, followed by another hour of group discussion. Licensed pharmacists deliver diabetes education and facilitate the group discussions. Some of the educational topics covered include nutrition, exercise, medication, long term complications, and additional training on stress management and coping skills which are needed for those with a chronic condition such as diabetes. Recipients who complete the 8-week program are provided with monthly telephone support, educational mailings, and continued participation in weekly support group sessions. The goal of the program is to equip the participants with the necessary knowledge and support which will enable them to manage their diabetes.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

## **37.19 MEDICAID FRAUD AND ABUSE**

### **Overview**

#### **Introduction**

This section describes Medicaid provider and recipient fraud and abuse, its detection and penalties or correction, and the rights of the provider and recipient relative to abuse and fraud investigation.

**Note:** Providers should refer to Chapter 6 of the Medicaid Program Provider Manual for additional information on Program Integrity and Fraud and Abuse.

#### **In This Section**

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Civil Causes of Action	19-5
Fraud and Abuse Detection	19-5
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

### **37.19.1 GENERAL**

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To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, and the federal and state agencies have promulgated regulations and policies concerning fraud and abuse. It is the provider's responsibility to become familiar with these laws and regulations. This section will assist the provider in becoming familiar with the laws and regulations concerning fraud, abuse, and other incorrect practices. This section is not all-inclusive nor does it constitute legal authority.

Providers, recipients, and others may be subject to criminal prosecution, civil action, and/or administrative action if they violate laws, rules, regulations, or policies applicable to the Medicaid Program. Federal and state laws and regulations require that the Medicaid Program establish criteria that are consistent with recognized principles that afford due process of law where there may be fraud, abuse or other incorrect practices. They also stipulate as well as arranging for the prompt referral to the proper authorities for investigation or review to ascertain the facts without infringing on the legal rights of the individuals involved. These laws and regulations authorize the Department to conduct reviews of claims before and after they are paid in order to maintain the programmatic and fiscal integrity of the Medicaid Program.

In general, suspected criminal activities are investigated and prosecuted by the Medicaid Fraud Control Unit of the Attorney General's Office; civil actions are investigated and brought by the Department and/or the Attorney General's Office. Administrative actions are investigated and brought by the Department. Depending on whether the action is criminal, civil, or administrative, different standards of proof and levels of due process apply.

To report Medicaid fraud and/or abuse, contact Medicaid Program Integrity's hotline at 800-488-2917.

### **37.19.2 FRAUD**

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Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. In criminal proceedings, the definition of fraud that governs between citizens and state government agencies is found in La. R.S. 14:67 and La. R.S. 14:70.01.

- Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

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**37.19.2 FRAUD, continued**

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- Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts; and
  - All legal action is subject to due process of law and to the protection of the rights of the individual under the law.

Federal law also defines what is criminal conduct within federally funded programs. Refer to the applicable federal laws and regulations.

The lists below are not all inclusive but rather illustrative of practices which may be considered fraudulent activities and subject to criminal prosecution.

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**Provider Fraud**

Examples of situations in which providers should be referred to the proper authorities for investigation include but are not limited to:

- Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid recipients;
  - Billing for supplies or equipment that are unsuitable for the recipient needs or are so lacking in quality or sufficiency as to be virtually worthless;
  - Claiming costs for non-allowable supplies or equipment disguised as covered items;
  - Materially misrepresenting dates and descriptions of services rendered, the identity of the provider or of the recipient;
  - Duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
  - Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.
- 

**Recipient Fraud**

Cases involving one or more of the following situations constitute sufficient grounds for a recipient fraud referral:

- The misrepresentation of facts in order to become or to remain eligible to receive Medicaid benefits or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;
  - A recipient transferring a Medicaid Eligibility Card to a person not eligible to receive services or to a person whose benefits have been restricted or exhausted, thus enabling the person to receive unauthorized medical benefits; and
  - The unauthorized use of a Medicaid Eligibility Card by persons not eligible to receive medical benefits under Medicaid.
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
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**37.19.3 ABUSE**

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Abuse and other incorrect practices by providers, recipients, and others include practices that are not criminal acts and may even be technically legal but still represent the inappropriate use of public funds. These acts are subject to sanctions.

Federal law also provides for civil remedies for abusive and incorrect practices. Refer to the applicable federal laws and regulations.

The lists below are not all-inclusive but rather illustrative of practices that are abusive or improper.

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**Provider Abuse**

Cases involving one or more of the situations listed below may constitute sufficient grounds for investigation of a provider for incorrect practices or abuse.

- The provision of services that are not medically necessary;
  - Flagrant and persistent overuse of medical or paramedical services with little or no regard for the patient's medical condition or needs, or for the doctor's orders;
  - The intentional misrepresentation of dates and descriptions of services rendered, of the identity of the recipient of the services, or of the individual who rendered the services in order to gain a larger reimbursement than is entitled; and
  - The solicitation or subsidization of anyone by paying or presenting any person money or anything of value for the purpose of securing patients. Providers, however, may use lawful advertising that abides by the Bureau's rules and regulations.
- 

**Recipient Abuse**

Cases involving one or more of the following situations may constitute sufficient grounds for a recipient abuse referral:

- Unnecessary or excessive use of the prescription medication benefits of the Medicaid Program;
  - Unnecessary or excessive use of the physician benefits of the program; and
  - Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.
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**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

**37.19.4 CIVIL CAUSES OF ACTION**

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The Louisiana Medical Assistance Program Integrity Law (MAPIL) which is contained in La. R.S. 46:437.1-46:440.3 provides for civil causes of action that can be taken against providers and others who violate the provisions of MAPIL. MAPIL prohibits illegal remuneration, false claims, illegal acts regarding eligibility, and recipient lists among other things. These civil causes of action are set out in La. R.S. 46:438.1-46:438.5. Individuals, who are found by a court of law to have violated the provisions of MAPIL, are subject to triple damages, fines, cost, and fees.

**Note:** Refer to Section 37.2.2 Provider Rights and Responsibilities for detailed information.

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**37.19.5 FRAUD AND ABUSE DETECTION**

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Fraud and abuse are detected by several methodologies.

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**Referrals**

Situations involving potential fraud and/or abuse which are to be followed up for review by Medicaid of Louisiana may include any or all of the following:

- Cases referred by the U.S. Department of Health and Human Services. Medicaid of Louisiana in turn refers suspected cases of fraud in the Medicare Program to the Centers for Medicare and Medicaid Services (CMS) and works closely with that agency in such matters;
  - Situations brought to light by special review, internal controls, or provider audits or inspections; and/or
  - Referrals from other agencies or sources of information.
- 

**Recipient Verification  
Notices (REOMBs)**

The federal regulations (42 CFR 433.116(e) and (f)) for MMIS require that Medicaid of Louisiana provides prompt written notice of medical services which are covered to the recipients of these services. The information contained in the notice includes the name of the person(s) furnishing medical services, the date on which the services were furnished, and the amount of payment required for the services. A predetermined percentage of the recipients who have had medical services paid on their behalf during the previous month will receive the required notice, that is, the Recipient's Explanation of Medical Benefits (REOMB).

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**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

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**37.19.5 FRAUD AND ABUSE DETECTION, continued**

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The REOMB contains the following information:

- The recipient's Medicaid identification number;
- The recipient's name;
- The date of the REOMB (monthly, on the 15<sup>th</sup>);
- The date of service for the services provided;
- A narrative description of the services provided;
- The place of service for the services provided;
- The provider of the services; and
- The amount paid for the services by Medicaid of Louisiana

On the reverse side of the REOMB, preprinted instructions request the recipients to use the space provided to call attention to any mistakes they feel were made on their bill. For example, if a service is listed on the REOMB that was not received by a recipient, or if the recipient was made to pay for a service that is covered by Medicaid of Louisiana, that recipient is expected to write a brief explanation of the error. The recipient should include his/her phone number and return the REOMB, postage paid, to the fiscal intermediary. The fiscal intermediary will then research the claim copy and provider remittance documents to make sure the recipient, provider, and services on the returned REOMB are accurately presented. If the information on the returned REOMB is not accurate, the REOMB and all documentation will be reviewed by the Surveillance Utilization Review Subsystem (SURS) Unit.

All situations that require inquiry are reviewed by SURS. Situations that require criminal investigation are referred to the State Attorney General's Medicaid Fraud Control Unit.

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**Recipient Prescription  
Verification Letters**

Prescription verification letters are sent to recipients in an effort to ensure that pharmacy services billed to Medicaid were received by the correct recipient and correctly billed. Each dispense date includes a picture of the actual drug(s) billed to Medicaid on the patient's behalf. The recipient is asked to make sure they received a drug on that date of service, that the drug they received looks like the drug in the picture, as well as confirm the amount of co-payment that they were asked to pay, if any. All exceptions are investigated.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

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**37.19.5 FRAUD AND ABUSE DETECTION, continued**

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Surveillance Utilization  
Review Subsystem  
(SURS)

The fiscal intermediary through its Surveillance Utilization Review Subsystem (SURS) can identify potential fraud and abuse situations by means of profile reports. A profile report is produced by a computer from information gathered in the state's claims payment operation. Providers are classified into peer groups according to geographic location, medical specialties and other categories.

Profile reports include the following information:

- A statistical profile of each peer group classification to be used as a base line for evaluation;
- A statistical profile of each individual provider compatible with the peer group profile;
- An evaluation of each individual provider profile against its appropriate group profile; and
- A listing of individual providers who deviate significantly from their group norm. (The individuals are reported as exceptional and are flagged for analysis.)

Each profile reported as exceptional is reviewed and analyzed by SURS staff and medical consultants. The analysis can include a review of the provider's paid claims, a review of the provider's reply to Medicaid of Louisiana's written request for information, a review of hospital charges and patient records, and a review of other relevant documents. The overall review is not necessarily limited to areas identified as exceptional on the profile report.

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**37.19.6 ADMINISTRATIVE ACTIONS/SANCTIONS**

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Federal laws and regulations and state laws provide the Department with the responsibility and authority to bring administrative actions against providers, recipients and others who engage in fraudulent, abusive and/or other incorrect practices. Sanctions which may be imposed through the administrative process include, but are not limited, to denial or revocation of enrollment, recommendation of revocation of licenses and/or certificates, withholding of payments, exclusion from the program, recovery of overpayments, and imposition of administrative fines.

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed either prior to or after payment is made by the Bureau. Administrative sanctions may be imposed against any Medicaid provider who does not comply with laws, rules, regulations, or policies.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

**37.19.6 ADMINISTRATIVE ACTIONS/SANCTIONS, continued**

Definition

Administrative sanctions refer to any administrative actions taken by the Department against a medical service provider. Sanctions are designed to remedy inefficient and/or illegal practices that do not comply with the Bureau's policies and procedures, statutes, and regulations.

Grounds for  
Sanctioning Providers

Medicaid of Louisiana may impose sanctions against any provider of medical goods or services if it discovers that any of the following conditions occur:

- A provider is not complying with the Bureau's policies, rules, and regulations, or the provider agreement that establishes the terms and conditions applicable to each provider's participation in the program;
- A provider has submitted a false or fraudulent application for provider status;
- A provider is not properly licensed or qualified, or a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated;
- A provider has engaged in a course of conduct or has performed an act for which official sanction has been applied by the licensing authority, professional peer population, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing authority indicating that the conduct should cease;
- A provider has failed to correct deficiencies in the delivery of services or billing practices after having received written notice of these deficiencies from the Bureau;
- A provider has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142, or has been convicted of Medicaid fraud (La. R.S. 14:70.1);
- A provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to negligent practice resulting in death or injury to the provider's patient;
- A provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
- A provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which Medicaid has already made a payment;
- A provider has rebated or accepted a fee or a portion of a fee for a patient referral;
- A provider has failed to repay or arrange to repay an identified overpayment or otherwise erroneous payment;
- A provider has failed, after having received a written request from the Bureau, to keep or to make available for inspection or audit, copies of records regarding payments claimed for providing services;



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

**37.19.6 ADMINISTRATIVE ACTIONS/SANCTIONS, continued**

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- A provider has failed to furnish any information requested by the Bureau or the fiscal intermediary regarding payments for providing goods and services;
  - A provider has made, or caused to be made, a false statement or a misrepresentation of a material fact concerning the administration of the Medicaid Program;
  - A provider has furnished goods or services to recipients that are in excess of the recipient's needs, not medically necessary, harmful to the recipient, or of grossly inadequate or inferior quality. (This determination would be based upon competent medical judgment and evaluation.);
  - The provider, or a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) five percent or more of the shares of stock or other evidences of ownership in a corporation, an owner of a sole proprietorship, or a partner in a partnership that is found to fall into one or more of the following categories:
    - Was previously barred from participation in the Medicaid Program;
    - Was a person with management responsibility for a previously terminated provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid Program;
    - Was an officer, owner or person owning (directly or indirectly) five percent or more of the shares of stock or other evidences of ownership or owner of a sole proprietorship or a partner of a partnership that was provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid Program;
    - Was engaged in practices prohibited by federal or state law or regulation;
    - Was a person with management responsibility for a provider at the time that the provider engaged in practices prohibited by state or federal law or regulation;
    - Was convicted of Medicaid fraud under federal or state law or regulation;
    - Was a person with management responsibility for a provider at the time that the provider was convicted of Medicaid fraud under federal or state law or regulation;
    - Was an officer or owner or person owning (directly or indirectly) five percent or more of the shares of stock or other evidences of ownership; or sole proprietorship or a partnership that was a provider at the time the provider was convicted of Medicaid fraud under federal or state law or regulation; or

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

**37.19.6 ADMINISTRATIVE ACTIONS/SANCTIONS, continued**

- 
- Was an owner or a sole proprietorship or partner in a partnership that was a provider at the time such a provider was convicted of Medicaid fraud under federal or state laws and regulations.

Federal laws and regulations also provide for administrative actions. Providers should refer to the applicable federal laws, regulations, and applicable sanctions.

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**Levels of Sanctions**

Examples of the different levels of administrative sanctions that Medicaid may impose against a Medicaid provider:

- Issue a warning to a provider through written notice or consultation;
- Require that the provider receive education in policies and billing procedures;
- Refer the provider to professional or quasi-professional boards or peer review organizations;
- Refer the provider to outside law enforcement agencies;
- Suspend the provider or withhold payments from the provider;
- Require that the provider terminate business association with an individual or entity;
- Limit the services that may be provided or the individuals to whom the services are provided;
- Recoupment;
- Recovery;
- Impose judicial interest on outstanding recoveries or recoupments;
- Exclude an individual or entity from participation;
- Require forfeiture of a posted bond;
- Impose an arrangement to repay;
- Impose withholding of payments;
- Withhold payments and recover money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
- Refer a provider to the appropriate state licensing authority for investigation;
- Impose fines and costs;
- Impose bonds or other forms of security; and
- Payment may be suspended to any provider who fails to meet the requirements for participation in the Medicaid Program for any other authorized reason.

**Note:** This list is not all-inclusive. The provider should refer to the laws and regulations related to Medicaid participation.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.19 MEDICAID FRAUD AND ABUSE**

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**37.19.7 APPEALS**

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The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Department's Bureau of Appeals is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained from the Bureau of Appeals at the following address:

**DHH Bureau of Appeals  
Post Office Box 4183  
Baton Rouge, LA. 70821-41822  
Phone 225-342-0263 or Fax 225-342-0443**

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.20 PROVIDER AUDITS**

**37.20 PROVIDER AUDITS**

**Overview**

Introduction

Federal and State laws and regulations require the State Medicaid Agency to ensure the integrity of the program through various monitoring, review and audit mechanisms. The Louisiana Pharmacy Benefits Management Program Section is responsible for auditing Medicaid pharmacy providers. This section explains the audit program and provider responsibilities relative to audits.

In This Section

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
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Audit Authority	20-2
Audit Overview and Process	20-2
Provider Responsibilities	20-3

**37.20.1 AUDIT PURPOSE**

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The purpose of the pharmacy review/audit function is to assure that Medicaid pharmacy providers are billing and being reimbursed in compliance with federal and state laws and regulations and Louisiana Medicaid Pharmacy Program policy.

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**37.20.2 AUDIT AUTHORITY**

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State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations **42 CFR 447.202**.

The Louisiana Department of Health and Hospitals (DHH) is a covered entity under HIPAA. Therefore, DHH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to DHH contractors when acting on behalf of DHH. The federal HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose Protected Health Information (PHI) for treatment, payment, or health care operations. In addition, a “HIPAA Authorization” or “Opportunity to Agree or Object” by the individual is not required for uses and disclosures required by law.

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**37.20.3 AUDIT OVERVIEW AND PROCESS**

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Since the inception of Medicaid, the Louisiana Medicaid Pharmacy Program has complied with the federal audit mandate. This was done primarily by conducting annual field audits of providers and auditing each pharmacy for multiple types of discrepancies.

Louisiana has revised and enhanced its pharmacy compliance review/audit process through new technology to make audits more efficient and cost effective.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.20 PROVIDER AUDITS**

**37.20.3 AUDIT OVERVIEW AND PROCESS, continued**

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The LMPBM Section uses a technology based risk assessment methodology to identify paid pharmacy claims that may be out of compliance with Medicaid rules and policies. This review ensures the review of paid claims on a timely basis, resulting in quicker corrective action by the provider.

Medicaid monitors the use of overrides for bypassing denial edits. Improper use of overrides and codes associated with these overrides by pharmacy providers may result in the disallowance of these overrides and administrative sanctions by Medicaid and the Board of Pharmacy.

Program reviews are also conducted of billings to assure required documentation is noted on hardcopy prescriptions for all pharmacy claims when an override indicator was used.

Therefore, pharmacists may receive written or telephonic requests from the auditors requesting additional information or copies of the hardcopy prescriptions or invoices in an effort to complete audit functions. When applicable, they may only ask for affirmation of correct billing.

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**37.20.4 PROVIDER RESPONSIBILITIES**

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Each provider upon enrolling in the Title XIX Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the Louisiana Medicaid Program Provider Manual and other directives.

In an effort to facilitate the pharmacy audit process, information must be available upon request. This information is necessary in order to comply with the requirements for a pharmacy services provider enrolled in Louisiana's Medicaid Program as stated in the PE-50 (Provider Enrollment Form) and to meet the requirements of the Louisiana State Board of Pharmacy.

At the time of audit, all Medicaid pharmacy providers must be able to produce a daily log, or prescription register. This daily log whether routinely produced in hard copy or producible in hard copy at the time of audit, must contain at a minimum, for audit purposes, the following prescription data:

- Prescription number;
- Indicator as to new or refill prescription (0-5);
- Date of dispensing;
- Patient's name;
- Prescriber's name;

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.20 PROVIDER AUDITS**

**37.20.4 PROVIDER RESPONSIBILITIES, continued**

- 
- Drug name;
  - NDC number;
  - Quantity dispensed;
  - Plan identifier indicating case or plan making payment; and
  - Amount paid (including both copayment and plan payment, which may or may not be separated, i.e., *AMOUNT PAID = AMOUNT PLAN PAID + AMOUNT PATIENT PAID*).

Providers are required to refund overpayments identified by the audits and take appropriate corrective action.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.21 MEDICAID DRUG REBATE PROGRAM**

**37.21 MEDICAID DRUG REBATE PROGRAM**

**Overview**

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Introduction      This Section presents an overview of the federally mandated and state supplemental drug rebate programs administered by the Medicaid Pharmacy Benefits Management Section.

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In This Section      This Section contains:

TOPIC	PAGE
Rebate Programs	21-2
Federally Mandated Drug Rebate Program	21-2
State Supplemental Drug Rebate Program	21-3



**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.21 MEDICAID DRUG REBATE PROGRAM**

**37.21.1 REBATE PROGRAMS**

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The Pharmacy Benefits Management Section administers the federally mandated drug rebate program and the State Supplemental Drug Rebate Program for Louisiana's Medicaid Program. The Pharmacy Benefits Management Section contracts with the University of New Orleans to operate both drug rebate programs.

Pharmacists must bill the actual NDC of the drug dispensed to ensure that the rebate paid by the drug manufacturer is correct.

Manufacturers are allowed to audit utilization data of both rebate programs. The Medicaid Pharmacy Benefits Management Section also audits this data to ensure accurate provider billing as this data is used to calculate the rebate amounts. Providers may be contacted by rebate staff in an effort to resolve rebate disputes with the manufacturers. Providers must respond to the auditor's request for information.

The state supplemental and federal unit rebate amounts are confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

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**37.21.2 FEDERALLY MANDATED DRUG REBATE PROGRAM**

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The federally mandated drug rebate program is one of the provisions included by Congress in its budget bill, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). It is the result of Congress' attempt to reduce and control Federal and State expenditures for prescription drug products provided to Medicaid patients and to eliminate discriminatory pricing.

The law requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients.

The drug rebate program is administered at the national level by CMS' Center for Medicaid and State Operations (CMSO).

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**37.21.3 STATE SUPPLEMENTAL DRUG REBATE PROGRAM**

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Louisiana Medicaid's State Supplemental drug rebate program provides state and manufacturer contracted rebates in addition to those received through the federally mandated rebate program.

CMS authorized Louisiana, effective October 1, 2004, to expand its supplemental rebate program and enter into a Multi-State Pooling Supplemental Rebate Agreement (SRA) with the intent of increasing efficiency and economy in the Medicaid program.

The state separately reports the supplemental rebate agreements to the Secretary of Health and Human Services and remits the federal portion of any state supplemental rebates collected as it does with the federally mandated rebates.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

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## **37.22 LOUISIANA MEDICAID WEBSITE**

### **Overview**

#### **Introduction**

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This Section explains the Louisiana Medicaid Website that is available to Medicaid providers. This website assists providers with information necessary to provide services to Medicaid recipients. The website is accessible at [www.lamedicaid.com](http://www.lamedicaid.com).

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#### **In This Section**

This Section contains:

<b>TOPIC</b>	<b>PAGE</b>
www.lamedicaid.com	22-2
Provider Access	22-2
Clinical Drug Inquiry	22-2
Preferred Drug List	22-3
Prescriber Numbers	22-3
MEVS	22-4
TPL Carrier Code List	22-4
Manuals and Appendices	22-4
Provider Education and Communication	22-5
Forms	22-5
Links	22-6

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

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**37.22.1 [WWW.LAMEDICAID.COM](http://WWW.LAMEDICAID.COM)**

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Louisiana Medicaid's provider website, [www.lamedicaid.com](http://www.lamedicaid.com) has several applications that can be used by pharmacy providers. Many of the most commonly requested items from providers include, but are not limited to, preferred drug listings, clinical drug inquiries, eligibility and prescriber numbers are available online. These applications require that providers establish an online account.

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**37.22.2 PROVIDER ACCESS**

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To establish an online account with LAMEDICAID.COM providers must have the following:

- A valid seven-digit provider identification number assigned by Louisiana Medicaid;
- An Internet account with an Internet Service Provider (not provided by DHH or Molina);
- A valid e-mail address (not provided by DHH or Molina); and
- A web browser that supports SSL with 128-bit encryption, for example, Microsoft Internet Explorer v5 or v6 or Netscape Navigator v6 or v7.

For technical support, call the webmaster at 877-598-8753.

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**37.22.3 CLINICAL DRUG INQUIRY**

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The Clinical Drug Inquiry is a component of the Clinical Data Inquiry (e-CDI) that is available to pharmacists. It promotes the deliberate evaluation by providers to help prevent duplicate or inappropriate drug therapy. The Clinical Drug Inquiry is available twenty-four hours a day and is updated on a daily basis. The Clinical Drug Inquiry will provide clinical historical data on each Medicaid recipient for the current month, prior month and prior four months. A print friendly version of the displayed information will be accessible and suitable for the recipient's clinical chart.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

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### **37.22.4 PREFERRED DRUG LIST**

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The website is a reference for the most current listing of the LMPBM preferred drugs as well as those drugs requiring prior authorization. In addition, this area of the website gives details about the prior authorization program and process.

**Note:** Refer to Section 37.5.5 Prior Authorization and Preferred Drug List for detailed policy information.

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### **37.22.5 PRESCRIBER NUMBERS**

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A listing of prescribing practitioner numbers and NPIs is available on the website. This listing is updated on a daily basis.

Listed below are the instructions for obtaining this information via the web.

- On the computer connected to the Web, launch the internet browser (Internet Explorer or Netscape Navigator).
- Type [www.LAMEDICAID.com](http://www.LAMEDICAID.com) in the address bar or the browser.
- Once the web site has been loaded, look on the left side of the screen at the list of available links.
- Go to the link labeled Forms/Files/User Guides.
- Under Forms/Files/User Guides, select the RXPA Files, then RXPA PPN Link.
- This will start a download of the prescriber zip file (called PPN.zip) to the PC. Download this file to the PC.
- Open the file PPN.zip using WINZIP. (Free WINZIP, downloads are available on the internet at [www.winzip.com](http://www.winzip.com).)
- Once opened, double click the PPN.PDF file.
- A prompt will appear on the screen requiring a password in order to un-zip the file. The password is KARNARDO2002. (Password is case sensitive).
- The PPN.pdf file can be viewed with Adobe Acrobat. (A free download of Adobe Acrobat is available at [www.adobe.com](http://www.adobe.com).)

**Note:** Refer to Section 37.4.5 Accessing Prescriber Numbers for more detailed information.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

**37.22.6 MEDICAID ELIGIBILITY VERIFICATION SYSTEM (MEVS)**

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MEVS	MEVS is an electronic system used to verify Medicaid recipient eligibility information. This electronic verification process expedites reimbursement, reduces claim denials, and helps to eliminate fraud. Eligibility information for a recipient, including third party liability, primary care providers and any restrictions, including lock-in, may be obtained by accessing information through MEVS. Only one eligibility inquiry at a time may be made when using the web application. This system is available seven days a week, twenty-four hours per day except for occasional short maintenance periods.
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REVS	A telephonic system is also available to providers to verify eligibility information. REVS may be accessed through touch-tone telephone equipment using Molina toll-free telephone number 800-776-6323 or 225-216-7387
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**37.22.7 TPL CARRIER CODE LIST**

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Private insurance companies are assigned a unique Louisiana carrier code. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payor.

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**37.22.8 MANUALS AND APPENDICES**

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POS User Guide	The Point of Sale User Guide details the required information for claim submittal. This helpful manual lists NCPDP fields and instructions for proper usage.
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SwitchVendor Specifications	Pharmacy providers using the Medicaid POS system are required to transmit their POS claims through an authorized telecommunications switch vendor. This document outlines the requirements necessary for switch vendors to transmit pharmacy claims.
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Appendix A	Appendix A is a list of drugs payable on the drug file.
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Appendix A-1	Appendix A-1 is a list of drugs with applicable Louisiana Maximum Allowable Costs (LMAC) and Federal Upper Limits (FUL).
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

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**37.22.8 MANUALS AND APPENDICES, continued**

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Appendix B	Appendix B is a list of the Drug Efficacy Study Implementation (DESI) drugs by national drug code. These drugs are non-payable.
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Appendix C	Appendix C is a list of pharmaceutical companies participating in the Federal Medicaid Drug Rebate Program.
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**37.22.9 PROVIDER EDUCATION AND COMMUNICATION**

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Provider Update	Provider Updates are sent to providers to inform them of the latest Medicaid policy. These updates may be accessed by month and year of publishing.
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Remittance Advice (RA) Messages	The RA is the control document which informs the provider of the current status of submitted claims. It is sent out weekly when the provider's claims have been adjudicated. The RA also includes messages to providers of any changes in policy. These messages may be accessed on the website by the date of the RA message.
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Provider Training Packet	The provider training packet presents the latest policy changes that affect providers.
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DHH Letters	Selected provider correspondences are posted on this website.
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Provider Relations	Provider relations may be contacted at 800-473-2783 or 225-924-5040. Field analysts are available to train new providers on site and to assist with complex billing problems. A list of analysts and parishes that they serve is available.
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**37.22.10 FORMS**

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RXPA Form	The Prior Authorization Form used to submit a prior authorization drug request may be downloaded. This form must be submitted by the prescriber.
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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37.22 LOUISIANA MEDICAID WEBSITE**

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**37.22.10 FORMS, continued**

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Form 211, Drug  
Adjustment/Void  
Form

This form is used to submit pharmacy claim adjustments, voids, and DUR overrides.

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PA01

Total Parenteral Nutrition providers are required to utilize this form to request prior authorization for TPN services.

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CMS-1500

This form is submitted to receive reimbursement for Total Parenteral Nutrition services.

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**37.22.11 LINKS**

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Board of Pharmacy

[www.labp.com](http://www.labp.com)

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Board of Medical  
Examiners

[www.lsbme.org](http://www.lsbme.org)

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Centers for Medicare  
and Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: GLOSSARY**

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<b>TERM</b>	<b>DEFINITION</b>
<b>Average Wholesale Price (AWP)</b>	The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions.
<b>Bureau of Health Services Financing (BHSF)</b>	The Bureau within the Department of Health and Hospitals which administers the Medicaid Program.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	The government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. Formerly known as the Health Care Financing Administration (HCFA).
<b>Department of Health and Hospitals (DHH)</b>	The Louisiana Department of Health and Hospitals is the single state agency designated to administer the Louisiana Medicaid Program.
<b>Drug Efficacy Study Implementation (DESI) Drugs</b>	DESI drugs refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness
<b>Dispense As Written (DAW)</b>	A prescribing directive issued by physicians to indicate that the pharmacy should not in any way alter a prescription. Such alterations are usually done in order to substitute a generic drug for the brand-name drug ordered.
<b>Drug Utilization Review (DUR)</b>	The quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.
<b>Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)</b>	The EPSDT program covers screening and diagnostic services to determine physical or mental deficiencies in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.
<b>Eligible</b>	An eligible is an individual who has been determined to meet the Medicaid program's eligibility criteria and is enrolled in the program.
<b>Estimated Acquisition Cost (EAC)</b>	An estimate of the price generally, and currently, paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.
<b>Federal Upper Limits (FUL)</b>	The upper limit amount that Medicaid can reimburse for a drug product if there are three or more generic versions of the product rated therapeutically equivalent and at least three suppliers listed in the current editions of published national compendia. These limits are intended to assure that the federal government acts as a prudent buyer of drugs. The upper limits program seeks to achieve savings by taking advantage of current market prices.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: GLOSSARY**

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<b>TERM</b>	<b>DEFINITION</b>
<b>Fiscal Intermediary</b>	A contractor that processes or pays vendor claims on behalf of a Medicaid agency. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and the Medicaid agency.
<b>Full Benefit Dual Eligibles</b>	The term describes a population of low-income elderly and individuals with disabilities who qualify for both Medicare and Medicaid coverage. While Medicare covers basic health services, including physician and hospital care, full benefit dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care and prescription drugs. However starting in 2006, Medicare will pay for most of the full benefit dual eligibles prescription drugs.
<b>Intermediate Care Facility for The Mentally Retarded (ICF/MR)</b>	The ICF/MR benefit is an optional Medicaid Benefit for States. Section 1905(d) of the Social Security Act created this benefit to fund “institutions” (4 or more beds) for people with mental retardation, and specifies that these institutions must provide health and/or rehabilitative services.
<b>Intermediate Classification of Diseases, 9<sup>th</sup> Edition (Clinical Modification) (ICD-9-CM)</b>	A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communications on claim forms.
<b>Long Term Care</b>	A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.
<b>Medicaid</b>	A federally aided state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program. Also referred to as State Medical Assistance Programs.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: GLOSSARY**

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<b>TERM</b>	<b>DEFINITION</b>
<b>Medicaid Management Information System (MMIS)</b>	Federally developed guidelines for a computer system designed to achieve national standardization of Medicaid claims processing, payment, review and reporting for all health care claims.
<b>Medicare (Part A/Part B)</b>	A U. S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).
<b>Medicare Part D</b>	<p>The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made prescription drug coverage, also known as Medicare Part D, available to all Medicare beneficiaries. Prescription drug coverage is available through private prescription drug plans (PDPs), which offer only prescription drug coverage, and Medicare Advantage Plans (MA PDs), which offer drug coverage integrated with the health coverage provided by the managed care plan.</p> <p>Full benefit dual eligible Medicaid recipients <b>no longer receive</b> their pharmacy benefits through the Louisiana Medicaid Pharmacy Program with the exception of some drugs excluded from the Part D benefit.</p>
<b>National Drug Code (NDC)</b>	A national classification system for identification of drugs. Similar to the Universal Product Code (UPC).
<b>National Provider Identifier (NPI)</b>	<p>The National Provider Identifier (NPI) is a ten digit number mandated by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers.</p> <p>The NPI is a single provider identifier that replaces the multiple provider identifiers currently used to bill health plans.</p>
<b>Over-the-Counter (OTC)</b>	A drug product that does not require a prescription under Federal or State law.
<b>Point of Sale System (POS)</b>	POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed entirely through the claims processing cycle in real-time, and within seconds of submission, a response is returned to the pharmacy that the recipient is eligible or ineligible and the claim is either payable, duplicated or rejected.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: GLOSSARY**

---

<b>TERM</b>	<b>DEFINITION</b>
<b>Preferred Drug List (PDL)</b>	Drugs that do NOT require further Prior Authorization.
<b>Prior Authorization</b>	The process of obtaining prior approval for a service or medication before payment can be made by the program. Prior authorization does not guarantee coverage as all program criteria must be met such as recipient eligibility.
<b>Providers</b>	Pharmacies or physicians, which are enrolled with the state to prescribe/dispense prescriptions to Medicaid recipients.
<b>Rebate</b>	A monetary amount that is returned to a payor from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.
<b>Recipient</b>	A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.
<b>Retrospective Review</b>	Determination of medical necessity and/or appropriate billing practice for services already rendered.
<b>Telecommunication Switch Vendor</b>	A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.
<b>Third Party Liability</b>	Under Medicaid, third-party liability exists if there is any entity (i.e., other government programs or insurance) which is or may be liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or recipient of Medicaid.
<b>UniDUR</b>	As part of the Point of Sale system, claims are subjected to editing for prospective drug utilization review. Molina and First Data Bank developed the software used to edit pharmacy claims. The UniDUR software is updated twice a month to reflect the most current UniDUR information available to the industry.

**ACRONYMS**

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<b>AFDC</b>	Aid to Families with Dependent Children
<b>AMP</b>	Average Manufacturer's Price
<b>APRN</b>	Advanced Practice Registered Nurse
<b>ASP</b>	Average Sales Price
<b>AWP</b>	Any Willing Provider OR Average Wholesale Price
<b>B/CC</b>	Breast and Cervical Cancer
<b>BHSF</b>	Bureau of Health Services Financing
<b>BMI</b>	Body Mass Index
<b>CCN</b>	Card Control Number
<b>CDI</b>	Clinical Drug Inquiry
<b>CFR</b>	Code of Federal Regulations
<b>CHAMP</b>	Child Health and Maternity Program
<b>CMS</b>	Centers for Medicare and Medicaid Services (formerly HCFA)
<b>CMSO</b>	Center for Medicaid and State Operations
<b>COB</b>	Coordination of Benefits
<b>CRNA</b>	Certified Registered Nurse Anesthetist
<b>DAC</b>	Disabled Adult Children
<b>DAW</b>	Dispense As Written
<b>DEA</b>	Drug Enforcement Administration
<b>DESI</b>	Drug Efficacy Study and Implementation
<b>DME</b>	Durable Medical Equipment
<b>DMERC</b>	Durable Medical Equipment Regional Carrier
<b>DHH</b>	Department of Health and Hospitals
<b>DRA</b>	Deficit Reduction Act of 2005
<b>DSM</b>	Disease State Management

**ACRONYMS**

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<b>DUR</b>	Drug Utilization Review
<b>DW/W</b>	Disabled Widows/Widowers
<b>EAC</b>	Estimated Acquisition Cost
<b>e-CDI</b>	Electronic Clinical Data Inquiry
<b>EFT</b>	Electronic Funds Transfer
<b>EOB</b>	Explanation of Benefits
<b>EOMB</b>	Explanation of Medicare Benefits
<b>EPSDT</b>	Early Periodic Screening Diagnosis Treatment Program
<b>ERA</b>	Electronic Remittance Advice
<b>ESRD</b>	End Stage Renal Disease
<b>EW/W</b>	Early Widows/Widowers
<b>FDA</b>	Food and Drug Administration
<b>FFP</b>	Federal Financial Participation
<b>FPL</b>	Federal Poverty Level
<b>FQHC</b>	Federally Qualified Health Center
<b>FUL</b>	Federal Upper Limits
<b>HCFA</b>	Health Care Financing Administration (see CMS)
<b>HCPCS</b>	HCFA Common Procedural Coding System
<b>HHS</b>	Department of Health and Human Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996
<b>HRSA</b>	Health Resources and Services Administration
<b>ICD-9-CM</b>	International Classification of Diseases, Ninth Revision, Clinical Modification
<b>ICF-MR</b>	Intermediate Care Facility for the Mentally Retarded
<b>ICN</b>	Internal Control Number
<b>IDPN</b>	Intradialytic Parenteral Nutrition Therapy

**ACRONYMS**

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<b>LAC</b>	Louisiana Administrative Code
<b>LaCHIP</b>	Louisiana Children's Health Insurance Program
<b>LADUR</b>	Louisiana Retrospective Drug Utilization Review
<b>LAPRIMS</b>	Louisiana Pharmacy Rebate Information Management System
<b>La. R.S.</b>	Louisiana Revised Statute
<b>LIFC</b>	Low Income Families with Children
<b>LMAC</b>	Louisiana Maximum Allowable Cost
<b>LMPBM</b>	Louisiana Medicaid Pharmacy Benefits Management
<b>LTC</b>	Long Term Care
<b>MAC</b>	Maximum Allowable Cost
<b>MAPIL</b>	Medical Assistance Program Integrity Law
<b>MEVS</b>	Medicaid Eligibility Verification System
<b>MMA</b>	Medicare Prescription Drug, Improvement and Modernization Act of 2003
<b>MMIS</b>	Medicaid Management Information System
<b>MNIES</b>	Medically Needy Income Eligibility Standard
<b>NCPDP</b>	National Council for Prescription Drug Program
<b>NDC</b>	National Drug Code
<b>NPI</b>	National Provider Identifier
<b>OBRA</b>	Omnibus Budget Reconciliation Act
<b>OTC</b>	Over-the-Counter (drugs)
<b>PACE</b>	Program of All Inclusive Care for Elderly
<b>P&amp;T</b>	Pharmaceutical and Therapeutics Committee
<b>PA</b>	Physician's Assistant OR Prior Authorization
<b>PAU</b>	Prior Authorization Unit

**ACRONYMS**

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<b>PBM</b>	Pharmacy Benefits Management
<b>PCP</b>	Primary Care Provider
<b>PDL</b>	Preferred Drug List
<b>PHI</b>	Protected Health Information
<b>PHS</b>	Public Health Service
<b>POS</b>	Point of Sale
<b>PPBP</b>	Provider Peer Based Profiling
<b>PRN</b>	As needed
<b>QDWI</b>	Qualified Disabled and Working Individuals
<b>QI</b>	Qualified Individuals
<b>QMB</b>	Qualified Medicare Beneficiary
<b>RA</b>	Remittance Advice
<b>REOMB</b>	Recipient's Explanation of Medical Benefits
<b>REVS</b>	Recipient Eligibility Verification System
<b>SLMB</b>	Specified Low Income Medicare Beneficiary
<b>SSA</b>	Social Security Administration
<b>SSI</b>	Supplemental Security Income
<b>SURS</b>	Surveillance and Utilization Review Subsystem
<b>TPL</b>	Third Party Liability
<b>TPN</b>	Total Parenteral Nutrition
<b>UCF</b>	Universal Claim Form
<b>ULM</b>	University of Louisiana at Monroe
<b>MOLINA</b>	United Information Systems Corporation
<b>UNIDUR</b>	Molina Prospective Drug Utilization Review



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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES  
SECTION: 37 FREQUENT CONTACT INFORMATION**

<b>DEPARTMENT</b>	<b>TELEPHONE NUMBER</b>
Blue Cross/Blue Shield of Arkansas (Medicare Part B Carrier)	1-800-462-9666
Community Care Hotline	1-800-359-2122
Direct Deposit Problems	225-216-6370
Lock-In Unit	225-216-6245
Medicaid Eligibility	1-888-342-6207 or 1-877-242-2447
Medicaid Pharmacy Benefits Management Section	1-800-437-9101 or 225-342-9768
Medicaid Program Integrity Fraud Hotline	1-800-488-2917
Myers and Stauffer Helpdesk (LMAC Rate Questions)	1-800-591-1183
CIGNA(DMERC)	1-866-238-9652
Pharmacy Point of Sale (POS)	1-800-648-0790 or 225-216-6381 (After hours please call REVS line)
Provider Enrollment	225-216-6370
Recipient Eligibility Verification System (REVS)	1-800-776-6323 or 225-216-7387
TPN Prior Authorization Unit (Molina)	1-800-488-6334 225-928-5263
ULM Drug Prior Authorization Unit	1-866-730-4357 or 1-866-797-2329(fax)
Molina Provider Relations	1-800-473-2783 or 225-924-5040
Molina Webmaster	1-877-598-8753

To download Appendix A – List of Drugs Payable on Drug file, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: APPENDIX A-1 – LIST OF DRUGS WITH LMAC AND FUL RATES**

To download Appendix A-1 – List of Drugs with LMAC and FUL Rates, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX B – LIST OF DESI DRUGS BY NATIONAL  
DRUG CODE (NDC)**

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To download Appendix B – List of DESI Drugs by National Drug Code (NDC), visit  
[www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX C – MEDICAID DRUG FEDERAL REBATE**

**PARTICIPATING PHARMACEUTICAL COMPANIES**

To download Appendix C – Medicaid Drug Federal Rebate Participation Pharmaceutical Companies, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX D – POINT OF SALE USER GUIDE**

To download Appendix D – Point of Sale User Guide, visit [www.lamedicaid.com](http://www.lamedicaid.com)  
Provider Manual link.

To download Appendix E-1 – Products with Quantity Limits, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX E-2 PRODUCTS WITH MAXIMUM DAILY DOSAGES**

To download Appendix E-2 – Products with Maximum Daily Dosages, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.



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**SECTION: APPENDIX F RXPA FORM**

To download Appendix F – RXPA Form, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX G – UNIVERSAL CLAIM FORM**

**AND INSTRUCTIONS**

To access an example of Appendix G – Universal Claim Form and Instructions, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**  
**SECTION: APPENDIX H – FORM 211 – DRUG ADJUSTMENT/VOID FORM**

To download Appendix H – Form 211 – Drug Adjustment/Void Form, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX I – PA01 FORM – TPN PRIOR**

**AUTHORIZATION FORM**

To download Appendix I – PA01 Form – TPN Prior Authorization Form, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**SECTION: APPENDIX J – CMS 1500 FORM**

To download Appendix J – CMS 1500 Form, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

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**CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES**

**SECTION: APPENDIX K– FORM 213 – TPN ADJUSTMENT/VOID FORM**

To download Appendix K – Form 213 – TPN Adjustment/Void Form, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.

To download Appendix L – Table of Tamper Resistant Prescription Criteria and Examples, visit [www.lamedicaid.com](http://www.lamedicaid.com) Provider Manual link.