PHARMACY BENEFITS MANAGEMENT SERVICES MANUAL

Chapter Thirty-Seven of the Medicaid Services Manual

Issued December 1, 2005

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

PHARMACY BENEFITS MANAGEMENT SERVICES

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OVERVIEW

The Pharmacy Program within the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) is responsible for the development, implementation and administration of the Medicaid Pharmacy Program, and is charged with the responsibility of assuring quality pharmacy services while developing efficiencies in operation, service and cost.

Other responsibilities include the daily operations for outpatient pharmacy prescription services. Although total parenteral nutrition (TPN) is reimbursed through the Pharmacy Program, it is managed in collaboration with the Durable Medical Equipment (DME) Program through the prior authorization process.

This provider manual chapter specifies the Medicaid benefits in the Pharmacy Program and the policies related to those benefits. This chapter is intended to explain covered pharmacy services and limits, how to file claims, Medicaid reimbursement, and other relative Medicaid pharmacy program policies and procedures. For various reference contacts and tools, refer to Appendices A through E.

All Food and Drug Administration (FDA) approved legend drugs that meet the Omnibus Budget Reconciliation Act (OBRA) '90 and OBRA '93 criteria are covered with a few exceptions. The Pharmacy Program determines the reimbursement methodology for both the drug ingredient cost and the professional dispensing fee for covered drugs.

The Pharmacy Program is responsible for the following components:

- Policy;

- Program development and implementation;

- Network development;

- Program coverage;

- Preferred drug list development and implementation and prior authorization for certain therapeutic classes;

- Federal upper limit (FUL) for multiple source drugs;

- Claims management;

- Annual provider recertification;

- Clinical interventions;

- Prospective and retrospective drug utilization review (DUR);

- Federal and state supplemental pharmaceutical manufacturer rebates;

- Pharmacy provider desk audits;

- Recipient Lock-In program;

- Provider help desk;

- Recipient help desk;

- Provider relations; and

- Provider education for prescribers and pharmacists.

The Pharmacy Program:

- Initiates policy development;

- Implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and Medicare/Medicaid pharmacy claims crossovers;

- 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 Pharmacy Program directs an extensive network of pharmacy providers and is also responsible for the integrity of several subsystems, including the drug file component of reference subsystem, the DUR subsystem and the drug portion of the Surveillance Utilization Review Subsystem (SURS).

Medicaid Management Information System

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

LDH contracts with a fiscal intermediary who operates the federally approved MMIS which is consistent with the Centers for Medicare and Medicaid Services (CMS) and LDH requirements. The fiscal intermediary (FI) 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);

- Educational articles - *Provider Update* newsletter article;

- Lock-In Program;

- DUR Board coordination;

- Preferred Drug List and prior authorization system;

- Monthly prescription limit system; and

- Electronic Data Inquiry/Clinical Drug Inquiry System (e-CDI).

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COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

This section provides the terms and conditions under which prescription services will be paid by the Medicaid Program and a description of the authorized benefits for eligible recipients.

Terms and Conditions

Licensed Prescribers

Payment will be made for prescription services only when issued by a licensed prescribing practitioner who has an active Medicaid prescriber number. (Refer to Section 37.5.6 - Prescribers for detailed information about prescribers).

Eligible Recipients

The Medicaid Program 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. (Refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on Medicaid eligibility).

Rebate Agreements

In accordance with Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Medicaid Program will pay only for those drug products for which the pharmaceutical company has entered into a federal rebate agreement with the U.S. Department of Health and Human Services (DHHS).

NOTE: The listing of Medicaid drug federal rebate participating pharmaceutical companies can be accessed by the below link. This listing is updated periodically and is posted on the Louisiana Medicaid website. **Providers should take note of the effective dates of the labeler codes.**
www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf

Coverage will be provided for those drug products labeled by the pharmaceutical companies that have entered into a rebate agreement. As new pharmaceutical companies enter into rebate agreements, labeler codes will be added.

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The therapeutic categories, e.g., cough and cold preparations, anorexics and cosmetic drugs, will remain non-payable.   The *Medicaid Drug Federal Rebate Participation Pharmaceutical Companies* listing and additional information can be accessed by the below link or by visiting Section 37.5.1 of this manual chapter.

www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf

Medically Accepted Indications

A drug must be medically necessary and prescribed for medically accepted indications to be eligible for reimbursement.

As defined by Section 1927(k)(6) of the Social Security , the term "medically accepted indication" means any use for a covered outpatient drug which is approved by the Food and Drug Administration (FDA) 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: *American Hospital Formulary Service Drug Information, United States Pharmacopeia – Drug Information* (or its successor publications), and *DRUGDEX Information System.*

Drug Utilization Review

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 not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug review, and an educational program. (Refer to Section 37.5.12 - Patient Counseling, Drug Utilization Review (DUR) for detailed information regarding DUR).

Patient Counseling Requirement

The Louisiana Board of Pharmacy's regulations require patient counseling, patient profiles, and prospective drug review, in accordance with OBRA '90.

Patient Counseling Documentation

Section 1927(g)(2)(ii)(I) of OBRA '90 requires that the pharmacist offer to discuss with each Medicaid recipient or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in his/her professional judgment, the pharmacist deems significant. Such counseling is subject to standards for counseling in accordance with the Louisiana Board of Pharmacy Regulations at LAC, 46:LIII, §517. Such counseling is to be provided unless refused by the recipient or caregiver. The Pharmacy Program will require counseling documentation for all prescriptions reimbursed by Louisiana Medicaid. According to the patient counseling standards in the OBRA'90, patient counseling begins with, and focuses on providing information related to the immediately prescribed drug. The only documentation required is a "yes" or "no" checked on the form next to the patient's signature to indicate whether he or she accepted the offer to provide this information. Counseling records must be retained in the pharmacy for five years from the date of payment and must be readily retrievable upon audit.

NOTE: Refer to Section 37.5.12 of this manual chapter for detailed information.

Pharmacy Signature and Delivery Logs

Pharmacy providers must obtain a signature from the patient or caregiver confirming the receipt of the prescription(s). This applies to all prescription pick-ups, home and facility deliveries. Claim submission is not proof that the prescription(s) or prescription order was actually furnished.

Pharmacy Pick-up

- The signature log documentation should include the prescription number(s) and the date the prescription was picked up. If multiple prescriptions are being picked up at one time, a single signature will be sufficient for all of the patient's prescriptions.

- Electronic signatures for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy.

- Obtaining a signature to confirm receipt of prescription(s) can be part of a counseling log.

- The signature confirmation must be maintained by the dispensing pharmacy for five years from the date of payment and must be retrievable upon audit.

Facility Delivery

- A signature is required at the time of delivery.

- The signature documentation must also include the list of prescription number(s) and date the medication(s) was/were delivered. A single signature will be sufficient for all the medication in the delivery.

- Electronic signatures for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit.

- A waiver signature form is not an acceptable practice and such forms will not serve as confirmation of delivery.

- Confirmation of the delivery must be maintained by the pharmacy for five years from the date of payment and must be retrievable on audit. Delivery industry tracking receipts that contain a signature (e.g., FedEx, UPS, and USPS) qualify as a signature for receipt of delivery.

Home Delivery

- If a pharmacy provider chooses to have a pharmacy representative deliver prescription(s) to a recipient' s home, the pharmacy should inform the recipient or designee of the pharmacy's delivery schedule, verify the date and location for the delivery, and notify the recipient or designee that a signature will be required at the time of delivery.

- The pharmacy representative will obtain a signature from the recipient or their designee confirming the delivery. A waiver signature form is not an acceptable practice, and such forms will not serve as confirmation of delivery. Delivery confirmation must be maintained by the pharmacy for five years from the date of payment and must be retrievable upon audit. Electronic signatures for receipt are permitted only if retrievable and kept on file by the pharmacy.

Prescription Duration

Scheduled narcotic prescriptions must be filled within six months of the date issued excluding Schedule II narcotic prescriptions. Schedule II narcotic prescriptions will expire 90 days after the date of issue in accordance with the Louisiana Board of Pharmacy regulations. Prescriptions for

non-controlled substances expire after 11 authorized refills or one year after the date prescribed, whichever comes first.

Prescription Transfers

The transfer of prescriptions, including those for Schedule III-V narcotics, must be in accordance with the Louisiana Board of Pharmacy regulations.

Date of Service

Claims shall be submitted for the date of service the prescription was dispensed.

Prescription Refills

Prescription refills can be provided if they are authorized specifically by the prescribing practitioner. Prescriptions for non-controlled substances have a one-year expiration and an 11-refill maximum from the date prescribed, whichever comes first.

Refills for Scheduled III-V narcotics have a six month expiration and a five refill maximum from the date prescribed, whichever comes first.

No refills are allowed on Schedule II prescriptions.

National Drug Code

In order to be reimbursed for a pharmacy claim, prescribed items must have an assigned National Drug Code (NDC).

Prescriptions Received via Telecommunication

Most prescriptions are acceptable when received by telephone or other telecommunication device in accordance with state and federal regulations. Providers must file and log prescriptions received via telecommunication as they would any other written or electronic prescriptions.

Tamper Resistant Prescription Policy

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

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The "Transitional Medical Assistance (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 electronic medical record (EMR), 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 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: The *Table of Tamper Resistant Prescription Criteria and Examples* can be accessed in Section 37.5.12 by the below link.
www.lamedicaid.com/Provweb1/manuals/App_L_Tamper_Res_Prescription.pdf

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.

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.

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.

Authorized Benefits

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

NOTE: Refer to "Quantity Limitations" in this section and Section 37.3 - Reimbursement Services for detailed information regarding authorized benefits.

Legend Drugs

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." Medicaid reimbursement is available for most legend drugs that are dispensed in outpatient settings.

NOTE: Refer to "Non-Covered Services" in this section for detailed information regarding legend drugs.

Legend Vitamin and Mineral Products

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

Vitamin B 12 preparations	Vitamin E preparations	Pediatric vitamin preparations
Vitamin A preparations	Vitamin K preparations	Legend prenatal vitamins for pregnant and lactating recipients
Vitamin B preparations	Calcium replacement	Magnesium salt replacement
Vitamin B1 preparations	Folic Acid preparation	Prescription strength fluoride as a single entity
Vitamin B6 preparations	Geriatric vitamin preparations	Urinary pH modifiers (Phosphorus)
Vitamin C preparations	Multivitamin preparations	
Vitamin D preparations	Niacin preparations	

Injectable Drugs

Reimbursement is provided for most injectable drugs for outpatient recipients when supplied by community pharmacies, long-term care (LTC) pharmacies, and home infusion pharmacies that are enrolled as Medicaid providers.

Some antibiotic and oncologic injections administered in practitioners offices and clinics are reimbursed through the Professional Services Program.

Non-Legend Drugs

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. **Providers must bill the NDC from the actual package dispensed**. **Also, the drug manufacturer must participate in the federal rebate program.**

The following non-legend drugs are covered when an authorized prescriber has written a prescription:

- Insulin;

- Sodium chloride solution for inhalation therapy;

- Contraceptives, topical;

- Urinary pH modifiers; and

- Other non-legend drugs that have Pharmacy Program approval.

Non-Legend Items and Supplies

Only a limited number of non-legend items and supplies can be reimbursed by the Medicaid Program. In order to receive Medicaid reimbursement, these items and supplies must be prescribed by licensed practitioners. **Providers must bill the NDC from the actual package dispensed.**

- 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;

- Disposable needles and syringes used to administer insulin;

- 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 Pharmacy Program approval.

Total Parenteral Nutrition

Total Parenteral Nutrition (TPN) and associated supplies and equipment are covered services in the Pharmacy Program. (Refer to Section 37.5.10 - Total Parenteral Nutrition for additional information).

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. (Refer to Section 37.5.11 - Medication Administration for detailed information).

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Non-Covered Services

Drugs Excluded From Coverage

The following drugs and/or therapeutic categories are excluded from coverage:

- Anorexics – Medicaid does not reimburse for anorexics with the exception of orlistat;

- 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;

- 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

- Vaccines covered in other programs.

Durable Medical Equipment/Supplies Excluded

Durable medical equipment (DME) and supplies, other than those included in this section , are not covered in the Pharmacy Program. These items are covered in the Home Health Program and must

be billed to that program. (Refer to Chapter 18 - Durable Medical Equipment of the *Medicaid Services Manual* for specific information covered through the DME program).

Prior Authorization and Single Preferred Drug List

The Medicaid Program administers a prior authorization process for pharmacy services. This process utilizes a single preferred drug list (PDL) for selected therapeutic classes. Drugs included on the PDL are preferred. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.

PDL Provider Notification

Lists of covered drug products, including those that require prior authorization, will be posted on the Louisiana Medicaid website.

Prior Authorization Process General Information

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

Prior Authorization and Single PDL Information Site

The *Louisiana Medicaid Single Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)* and the *Louisiana Uniform Prescription Drug Prior Authorization Form* and its instructions can be accessed by the below link or by visiting Section 37.5.5 of this manual chapter.

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 prior authorization by telephone, facsimile or mail. Refer to the Section 37.5.4 – Contact Information for access to additional information on prior authorization. In addition, refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

The Prior Authorization Unit's hours of operation are 8:00 am to 6:00 pm Central Time, Monday through Saturday.

NOTE: If a prescribing practitioner does not have an individual prescriber number, refer to Section 37.5.6 - Prescribers for detailed information.

Prior Authorization Request Form

The Louisiana Uniform Prescription Drug Prior Authorization Form must be used by the prescriber to request a prior authorization. The form and its instructions can be accessed by the below link or by visiting Section 37.5.5 of this manual chapter.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a three 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 (RxPA) 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 RxPA Unit is closed (Sundays; Monday – Saturday before 8:00 am and after 6:00 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 determines the prescription is an emergency, the pharmacist must indicate "Emergency by Pharmacist" on the hard copy prescription.

NOTE: The Point of Sale (*POS) User Guide* can be accessed by the below link or by visiting Section 37.5.1 for detailed claim submission and processing information.

www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

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

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

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". 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 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 three-day supply, and refills for the dispensing of the non-preferred products are not permitted. The recipient's practitioner must contact the RxPA 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.

Recipients with Retroactive Eligibility

Drugs that are not on the PDL are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations. Pharmacy providers will be reimbursed for these claims when the date of service falls within the recipients' retroactive time period. The 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 recipient file. Pharmacy providers shall submit these claims electronically.

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Important Facts

When a recipient elects to self-pay for an original prescription which requires prior authorization, attempts to have Medicaid pay for the refill of this prescription will result in the pharmacy claim being denied.

If an approved prior authorization exists in the system, the pharmacy claim will bypass the prior authorization 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 a recipient's 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 Medicaid Eligibility Verification System (MEVS) or Recipient Eligibility Verification System (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.

Clinical Authorization

There are certain medications that require clinical authorization. Clinical authorization is a prescriber initiated request for authorization on a selected number of drugs.

Prescribers must complete the *Louisiana Uniform Prescription Drug Prior Authorization Form* in full. The clinical authorization criteria can be used as a reference when completing the form. Clinical authorization requests should be faxed or mailed to the RxPA Unit. (Refer to Section 37.5.4 – Contact Information in this manual chapter for contact information).

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

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http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

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Monthly Service Limit

Limit

Medicaid reimburses up to four 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.

Exceptions to Limit

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

- Persons under 21 years of age;

- Persons who are residents of long-term care institutions, such as nursing homes and Individuals with Intellectual Disabilities (ICF/IID) facilities; and

- Recipients who are pregnant.

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 on the hard prescription, by telephone or other telecommunications device:

- "Medically necessary override; and

- A valid diagnosis code that directly relates to each drug prescribed that is over the four prescription limit (an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM, or its successor) literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry (e-CDI) in his/her clinical assessment of the recipient's disease state or medical condition and the current drug regimen before making a determination that more than four prescriptions per calendar month is required by the recipient. (Refer to Section 37.5.4 for details on how to access the e-CDI).

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

An acceptable statement and diagnosis code are required for each prescription in excess of four for each calendar month.

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

NOTE: Refer to Section 37.5.1 to access the *POS User Guide* to obtain detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Drugs with Special Payment Criteria/Limitations

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

NOTE: Refer to Section 37.5.8 - Claim Submission for detailed override information as well as Section 37.5.1 to access the *POS User Guide* for detailed billing instructions, where applicable.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Age and Gender Restricted Drugs

Certain drugs have age and gender restrictions placed on them.   For further assistance, providers should contact the Molina Provider Helpdesk (Refer to Section 37.5.4 for contact information).

Acne Agents

Pharmacy claims for all acne agents will be reimbursed for recipients less than 21 years of age with an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Allergen Extracts

Pharmacy claims for the following allergen extracts are subject to physician prescriber requirements and an auto-injectable epinephrine prescription requirement for reimbursement:

- Timothy Grass Pollen Allergen Extract (Grastek®);

- Short Ragweed Pollen Allergen Extract (Ragwitek®); and

- Grass Mixed Pollens Allergen Extract (Oralair®).

Physician Prescriber Requirements for Allergen Extracts

Prescribers of allergen extracts must have a specialty of 1) Allergy, 2) Otology, Laryngology, Rhinology, or 3) Ophthalmology, Otology, Laryngology, Rhinology for reimbursement.

Auto-Injectable Epinephrine Requirement for Allergen Extracts

Pharmacy claims for allergen extracts require a pharmacy claim for an auto-injectable epinephrine product within the last year for reimbursement.

Anti-Anxiety Drugs

Pharmacy claims for solid oral dosage forms of alprazolam IR (Xanax®), chlordiazepoxide (Librium®), lorazepam (Ativan®), oxazepam (Serax®), clonazepam (Klonopin®), clorazepate (Tranxene®), and diazepam (Valium®) have quantity limits of 90 units per rolling 30 days.

Quantity limits will be bypassed for clonazepam (Klonopin®), clorazepate (Tranxene®), and diazepam (Valium®) when an acceptable diagnosis code is submitted.

Acceptable diagnosis codes that will bypass the edit are:

ICD-10-CM Diagnosis Code	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Alprazolam ER (Xanax XR®) and Alprazolam ODT (Niravam®)

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) are subject to the following for reimbursement:

- Age Restriction; and

- Diagnosis Code Requirements.

Pharmacy claims for alprazolam ER (Xanax XR®) also have quantity limits.

Age Restriction

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) will deny at POS for recipients 17 years old or younger on the date of service.

Diagnosis Code Requirements

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) require a diagnosis code. The diagnosis code must be documented by the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Acceptable diagnosis codes for alprazolam ER (Xanax XR®) are:

ICD-10-CM Diagnosis Code	Description
F40.01	Panic Disorder with Agoraphobia
F41.0	Panic Disorder without Agoraphobia

Acceptable diagnosis codes for alprazolam ODT (Niravam®) are:

ICD-10-CM Diagnosis Code	Description
F41.1	Generalized Anxiety Disorder

ICD-10-CM Diagnosis Code	Description
F40.01	Panic Disorder with Agoraphobia
F41.0	Panic Disorder without Agoraphobia

Quantity Limits

There is a quantity limit of 30 units per rolling 30 days for alprazolam ER (Xanax XR®).

Analeptics: Armodafinil (Nuvigil®) and Modafinil (Provigil®)

Age Restriction

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when the recipient is 16 years of age or younger**.**

Diagnosis Code Requirements

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) require an appropriate diagnosis code documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.by the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis is required for claim submission. The appropriate diagnosis codes are listed in the chart:

ICD-10-CM Diagnosis Code(s)	Diagnosis
G47.33	Obstructive sleep apnea (OSA)
G47.26	Circadian rhythm sleep disorder, shift work type
G47.4*	Narcolepsy

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Therapeutic Duplication

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the recipient's file for either armodafinil (Nuvigil®) or modafinil (Provigil®).

Therapeutic Duplication with Stimulants

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the recipient's file for other stimulants or atomoxetine (Strattera®).

Concurrent Use with Sedative Hypnotics

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the recipient's file for a sedative hypnotic.

If in the professional judgment of the prescriber a determination is made which necessitates therapy with modafinil (Provigil®) or armodafinil (Nuvigil®) and a sedative hypnotic, the pharmacist may override this edit. After consultation with the prescriber to verify the necessity of both agents, the pharmacist must document on the hardcopy prescription the prescriber's reason for concurrent therapy. The reason for service code, professional service code and result of service code used in submitting the claim must also be documented on the hardcopy prescription or in the pharmacy' electronic recordkeeping system.

Agalsidase Beta (Fabrazyme®)
Pharmacy claims for agalsidase beta (Fabrazyme®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code	Diagnosis Description
E75.21	Fabry (-Anderson) Disease

Alglucosidase (Lumizyme®)

Pharmacy claims for alglucosidase (Lumizyme®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code	Diagnosis Description
E74.02	Pompe Disease

Amikacin Inhalation Suspension (Arikayce®)

Pharmacy claims for amikacin inhalation suspension (Arikayce®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code	Diagnosis Description
A31.0, A31.2	Mycobacterium avium complex

Anticoagulants

Prescriptions for select anticoagulants are subject to the following clinical edits for reimbursement:

- Quantity limits; and

- Duration of therapy.

Quantity Limits

The quantity limits for anticoagulant agents are listed in the chart.

Generic	Representative Brand	Dosage Form	Quantity Limit
Apixaban	Eliquis®	Tablet	60 units/30 days
Apixaban Starter Pack	Eliquis® Starter Pack	Tablet Dose Pack	1 unit/365 days
Dabigatran Etexilate Mesylate	Pradaxa®	Capsule	60 units/30 days
Dalteparin Sodium	Fragmin®	Vial/Syringe	60 units/30 days
Edoxaban Tosylate	Savaysa®	Tablet	30 units/30 days
Enoxaparin Sodium	Lovenox®	Vial/Syringe	60 units/30 days
Fondaparinux Sodium	Arixtra®	Syringe	30 units/30 days
Rivaroxaban 2.5mg	Xarelto®	Tablet	60 units/30 days
Rivaroxaban 10mg, 15mg & 20mg	Xarelto®	Tablet	30 units/30 days
Rivaroxaban Starter Pack	Xarelto® Starter Pack	Tablet Dose Pack	1 unit/365 days

Duration of Therapy

The duration of therapy for select anticoagulant agents are listed in the chart.

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Generic	Representative Brand	Maximum Duration of Therapy*
Dalteparin	Fragmin®	35 days
Enoxaparin	Lovenox®	35 days
Fondaparinux Sodium	Arixtra®	35 days

*Maximum 35-day course of therapy within a 90-day period

Antidepressant Medications

Prescriptions for antidepressant medications will require an approved clinical authorization for recipients under 6 years of age. Pharmacy claims for antidepressant medications will be checked for therapeutic duplication.

Therapeutic Duplication

Pharmacy claims for a tricyclic antidepressant will deny if there is an active claim on the recipient's file for a tricyclic antidepressant.

Pharmacy claims for selective serotonin reuptake inhibitors (SSRIs) will deny if there is an active claim on the recipient's file for a SSRI.

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.

Therapeutic Duplication

Pharmacy claims for first and/or second generation antihistamines and antihistamine-decongestant products will deny if there is an active claim on the recipient's file for another first and/or second

generation antihistamine or antihistamine-decongestant product. A change in therapy from an antihistamine to an antihistamine-decongestant or the reverse will have override provisions.

Exclusions

Claims for diphenhydramine, hydroxyzine HCL, and hydroxyzine pamoate are excluded from the therapeutic duplication.

After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recordkeeping system the following:

- The reason the prescribing provider chose to override the therapeutic duplication; and

- The National Council for Prescription Drug Program (NCPDP) DUR override codes used in submitting the claim.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in this section for policy regarding first and second generation antihistamines and combination agents included in the therapeutic duplication edit.

Antiretroviral Agents
Pharmacy claims for select antiretroviral agents require a diagnosis code for reimbursement.
The following chart lists acceptable diagnosis codes.

ICD-10-CM Diagnosis Code	Diagnosis Description
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B w/o delta-agent and without hepatic coma
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent
B19.1	Unspecified viral hepatitis B
B19.10	Unspecified viral hepatitis B without hepatic coma

ICD-10-CM Diagnosis Code	Diagnosis Description
B19.11	Unspecified viral hepatitis B with hepatic coma
B20	Human immunodeficiency virus [HIV] disease
B97.35	Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
W46.0XXA	Contact with hypodermic needle (initial enc.)
W46.0XXD	Contact with hypodermic needle (subsequent enc.)
W46.1XXA	Contact with contaminated hypodermic needle (initial enc.)
W46.1XXD	Contact with contaminated hypodermic needle (subsequent enc.)
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.6	Contact with and (suspected) exposure to HIV
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
Z22.51	Carrier of viral hepatitis B
Z72.5	High risk sexual behavior
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.21	Contact with and (suspected) exposure to potentially hazardous body fluids
Z77.9	Other contact with and (suspected) exposure hazardous to health

Antisense Oligonucleotides: Nusinersen sodium (Spinraza®) and Eteplirsen (Exondys 51®)

Pharmacy claims for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) will be subject to the following for reimbursement:

- Clinical authorization; and

- Diagnosis code requirements.

Clinical Authorization Requirement

Pharmacy claims for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) require an approved clinical authorization.

Diagnosis Code Requirement

The acceptable diagnosis codes for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) are listed in the chart.

Medication	Diagnosis	ICD-10-CM Diagnosis Code
Nusinersen Sodium (Spinraza®)	Spinal Muscular Atrophy	G12.0; G12.1
Eteplirsen (Exondys 51®)	Duchenne Muscular Dystrophy	G71.0

* -- any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Antipsychotic Agents

Pharmacy claims for antipsychotic medications are subject to the following clinical edits:

- Diagnosis Code Requirement;

- Age and Dosage Limits; and

- Therapeutic Duplication.

Diagnosis Code Requirement on All Antipsychotic Medications

Prescriptions for antipsychotic agents require appropriate diagnosis codes documented on all prescriptions.

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The numeric diagnosis code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for antipsychotic medications that have a missing or invalid diagnosis code will deny at POS.

NOTE: The ICD-10-CM Diagnosis Codes can be accessed by the below link to the Louisiana Medicaid Single PDL for Fee-for-Service and Managed Care Organizations or by visiting Section 37.5.1 of this manual chapter.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the recipient cannot wait to receive the medication, the pharmacy provider may override the denial. The pharmacist must document "Emergency" on the hard copy prescription or in the pharmacy's electronic recordkeeping system and the reason for the emergency.

Antipsychotic agents are also subject to prospective drug utilization reviews when a third antipsychotic agent is submitted for payment.

Age and Dosage Limits

Pharmacy claims for selected antipsychotic medications will be subject to age and dosage limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Quantity Limits

Pharmacy claims for selected antipsychotic medications have quantity limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Therapeutic Duplication

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Pharmacy claims for a recipient with an active oral antipsychotic prescription on file will deny when an additional pharmacy claim for a second oral antipsychotic prescription is submitted.

Pharmacy claims for a recipient with an active injectable antipsychotic prescription on file will deny when an additional pharmacy claim for a second injectable antipsychotic prescription is submitted.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)Agents

Prescriptions for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD agents will require an appropriate diagnosis code for reimbursement. ADD/ADHD will be checked for therapeutic duplication.

The numeric diagnosis code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for ADD and ADHD medications that have a missing or invalid diagnosis code will deny at POS.

When recipients are established on ADD/ADHD medications, but the diagnosis codes submitted are not included in the table of covered diagnoses, prescribing providers may call the RxPA Unit (Refer to Section 37.5.4 for contact information.)

NOTE: Refer to the link to access the *POS User Guide* for detailed billing instructions. www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Therapeutic Duplication

Pharmacy claims for ADD/ADHD medications will be subject to a therapeutic duplication.

An incoming pharmacy claim for a short-acting ADD/ADHD medication will deny when there is an active claim on file for another short-acting ADD/ADHD medication. An incoming claim for a long-acting ADD/ADHD medication will deny when there is an active claim on file for another long-acting ADD/ADHD medication.

An incoming pharmacy claim for an ADD/ADHD medication will deny when there is an active claim on file for another ADD/ADHD medication written by a different prescriber.

Behavioral Health Medications for Recipients Less Than 6 Years of Age

Pharmacy claims for behavioral health medications for recipients less than 6 years of age require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.1 to access the *POS User Guide* to obtain detailed billing
instructions and override procedures.
         www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Clinical Authorization for ADD/ADHD Medications for Recipients Less Than 6 years of Age

Pharmacy claims for ADD/ADHD medications for recipients less than 6 years of age require an
approved clinical authorization for reimbursement.

**Buprenorphine and Buprenorphine/Naloxone Agents (Bunavail, Suboxone®, and
Zubsolv®)**

Prescriptions for buprenorphine and buprenorphine/naloxone agents (i.e. Bunavail®, Suboxone®,
and Zubsolv®) are only reimbursed when the following criteria are met:

- The prescriber is a physician;

- The physician has an X Drug Enforcement Administration (DEA) number;

- The prescriber is licensed to prescribe buprenorphine and buprenorphine/naloxone
  agents (i.e. Bunavail®,Suboxone®, and Zubsolv®) 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;

- Concurrent prescriptions for opioid analgesics and/or benzodiazepines are only
  reimbursed when written by the same physician who prescribed the buprenorphine
  or buprenorphine/naloxone;

- Recipients must be sixteen years of age or older;

- Prescriptions for Suboxone® (buprenorphine/naloxone) are allowed a maximum
  daily dose of 24mg/day (based on buprenorphine);

- Prescriptions for buprenorphine agents are allowed a maximum daily dose of
  24mg/day; and

- Prescriptions for Zubsolv® are allowed a maximum of up to 17.1 mg/day (based
  on buprenorphine) per recipient for an initial 90 consecutive day period. After the
  initial 90 day period, a maximum daily dose of up to 11.4 mg/day (based on
  buprenorphine) is allowed per recipient.

Diagnosis Code Requirement

Prescriptions for buprenorphine agents require an appropriate 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 diagnosis codes are as follows:

ICD-10-CM Diagnosis Code(s)	Description
F11.2*	Opioid Type Dependence

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Buprenorphine Agents are also subject to prospective drug utilization reviews when concurrent opioid analgesics (i.e. Suboxone, and Zubsolv®) are written by the same physician.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication" in this section for further policy as well as the *POS User Guide* accessed by visiting Section 37.5.1 for detailed billing information.

　　　　www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

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Quantity Limits on Buprenorphine-Naloxone Products

The quantity limits for buprenorphine/naloxone products are listed in the following chart:

Product	Dose Form Route	Buprenorphine/Naloxone Strength		Quantity Limit (units/day)
Bunavail®	Film Buccal	2.1mg	0.3mg	1
		4.2mg	0.7mg	2
		6.3mg	1mg	2
Buprenorphine/Naloxone	Tablet Sublingual	2mg	0.5mg	1
		8mg	2mg	2
Suboxone®	Film Sublingual	2mg	0.5mg	1
		4mg	1mg	1
		8mg	2mg	2
		12mg	3mg	2
Zubsolv®	Tablet Sublingual	1.4mg	0.36mg	1
		2.9mg	0.71mg	1
		5.7mg	1.4mg	1
		8.6mg	2.1mg	2
		11.4mg	2.9mg	1

Concurrent Opioid Analgesic and/or Benzodiazepine Therapies

- Concurrent opioid analgesic, benzodiazepine, and/or any buprenorphine containing agent prescriptions written by a different prescriber for recipients on a buprenorphine agent will deny. There are no override provisions through the POS system using NCPDP service codes;

- Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for any buprenorphine containing agent on the recipient's file. There are no override provisions through the POS system using NCPDP service codes; and

- When a recipient has an active prescription for any opioid analgesic and/or any buprenorphine containing agent by the same prescriber, the incoming prescription will deny as a therapeutic duplication. The pharmacist must contact the physician for his/her authorization to assure the physician wants concurrent therapy before overriding the denial edit and filling the incoming prescription.

Buprenorphine Buccal Film (Belbuca®)

Prescriptions for buprenorphine buccal film (Belbuca®) will be reimbursed when:

- A valid diagnosis code is entered at claims submission; and
- The maximum daily dose limit of 1800 mcg/day is not exceeded.

All diagnosis codes are acceptable **EXCEPT** for the following:

ICD-10-CM Diagnosis Code(s)	Description
F11.2*	Opioid Type Dependence

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Buprenorphine Extended-Release Injection (Sublocade®)

Buprenorphine extended-release injection (Sublocade®) will be reimbursed when the following criteria is met:

- Prescriber requirements;
- Age requirements;
- Diagnosis code requirements;
- Quantity limits; and
- Therapeutic duplication.

Prescriber Requirements

The prescriber is:

- A physician;
- Has an XDEA number; and
- Is licensed to prescribe buprenorphine extended-release injection (Sublocade®) and has provided a copy of his/her current Controlled Substance Registration Certificate indicating XDEA number and a copy of a Provider Enrollment File Update form to Provider Enrollment.

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Age Requirements

- The patient must be 18 years of age or older.

Diagnosis Code Requirements

Prescriptions for buprenorphine agents require an appropriate diagnosis code entered at claim submission. The diagnosis code may be documented on the hard copy prescription or by the pharmacist after written or verbal consultation with the physician.

ICD-10-CM Diagnosis Code (s)	Description
F11.2*	Opioid Type Dependence

Quantity Limits

Buprenorphine extended-release injection (Sublocade®) have a quantity limit of one pre-filled syringe per rolling 30 days.

Therapeutic Duplication

When a patient has an active prescription for any opioid analgesic (including buprenorphine) written by the same prescriber, the incoming buprenorphine prescription will deny as a therapeutic duplication.   **Override provisions are available.** The pharmacist will have to contact the physician for his/her authorization to verify the physician wants concurrent therapy.

Concurrent opioid analgesic and/or benzodiazepines prescriptions written by a different prescriber for patients on buprenorphine will deny. **There are no provisions for overrides.**

Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for buprenorphine agents on the recipient's file. **There are no provisions for overrides.**

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Buprenorphine Implant Kit (Probuphine®)

Buprenorphine implant kit (Probuphine®) will be reimbursed when the following criteria is met:

- Prescriber requirements;
- Age requirements;
- Diagnosis code requirements;
- Quantity limits; and
- Therapeutic duplication.

Prescriber Requirements

The prescriber is:

- A physician;
- Has an XDEA number; and
- Is licensed to prescribe buprenorphine implant (Probuphine®) and has provided a copy of his/her current Controlled Substance Registration Certificate indicating XDEA number and a copy of a Provider Enrollment File Update form to Provider Enrollment.

Age Requirements

- The patient must be 16 years of age or older.

Diagnosis Code Requirements

Prescriptions for buprenorphine agents require an appropriate diagnosis code entered at claim submission. The diagnosis code may be documented on the hard copy prescription or by the pharmacist after written or verbal consultation with the physician.

ICD-10-CM Diagnosis Code (s)	Description
F11.2*	Opioid Type Dependence

Quantity Limits

Buprenorphine implant kits (Probuphine®) have a quantity limit of two implant kits per 720 rolling days.

Therapeutic Duplication

When a patient has an active prescription for any opioid analgesic (including buprenorphine) written by the same prescriber, the incoming buprenorphine prescription will deny as a therapeutic duplication. **Override provisions are available.** The pharmacist will have to contact the physician for his/her authorization to verify the physician wants concurrent therapy.

Concurrent opioid analgesic and/or benzodiazepines prescriptions written by a different prescriber for patients on buprenorphine will deny. **There are no provisions for overrides.**

Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for buprenorphine agents on the recipient's file. **There are no provisions for overrides.**

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.
              www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Buprenorphine Transdermal Patches (Butrans®)

Pharmacy claims for Buprenorphine Transdermal Patches (Butrans®) require an appropriate 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. Refer to prescribing information. Each patch is intended to be worn for seven days.

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

Cariprazine (Vraylar®) and Cariprazine (Vraylar®) Therapy Pack

Dose Limit for cariprazine (Vraylar®)

Recipients 15 Years of Age or Younger

All pharmacy claims for any strength of cariprazine (Vraylar®) for recipients 15 years of age or younger will deny.

Recipients 16 – 17 Years of Age

Pharmacy claims for cariprazine (Vraylar®) for recipients 16 – 17 years of age, with a dose greater than 4.5mg/day, will deny. Overrides will be addressed by faxing a Rx PA16 to the RXPA Unit.

Recipients 18 Years of Age or Older

Pharmacy claims for cariprazine (Vraylar®) for recipients 18 years of age or older, with a dose greater than 6 mg/day, will deny.

After consultation with the prescriber to verify the necessity of exceeding 6mg/day for recipients 18 years of age and older, the pharmacist may override the denial. The reason for service code, professional service code and result of service code used in submitting the claim must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: The *POS User Guide* can be accessed by the below link or by visiting Section 37.5.1 for detailed billing instructions and override procedures.
        www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Age Limit for Cariprazine (Vraylar®) Therapy Pack

Recipients 15 Years of Age or Younger

All pharmacy claims for any strength of cariprazine (Vraylar®) therapy pack will deny for recipients 15 years of age or younger. There are no override provisions through the POS system using NCPDP service codes.

Quantity Limit for Cariprazine (Vraylar®) Therapy Pack

Pharmacy claims for cariprazine (Vraylar®) therapy pack will have a quantity limit of one package per recipient (not to exceed one package per 18 months). There are no override provisions through the POS system using NCPDP service codes.

Diagnosis Requirement for Cariprazine (Vraylar®) and Cariprazine (Vraylar®) Therapy Pack

Pharmacy claims for cariprazine (Vraylar®) and cariprazine (Vraylar®) therapy pack require a valid diagnosis code submitted at POS. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system
Prescribing providers may call Louisiana Medicaid RxPA Unit for guidance when recipients are established on antipsychotic medications but the diagnosis codes submitted are not included in the table of covered diagnoses.

When the diagnosis code written on the prescription is not included in the list of covered diagnoses, and when the pharmacist cannot reach the prescriber or when the RxPA Unit is closed, the pharmacist, using his/her professional judgment, may deem the filling of the antipsychotic prescription to be an "emergency". In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and may override the diagnosis code requirement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Carisoprodol

Pharmacy claims for carisoprodol will deny when the quantity exceeds 90 tablets per rolling 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**.

Codeine

Pharmacy claims for products containing codeine have an age limit for reimbursement. The acceptable age limits are listed in the chart.

Description	Age (Y=Year)

| Codeine (Single Ingredient) | >18 Y |
| Codeine Combination Product | >12 Y |

Collangenase Topical (Santyl®)

Prescriptions for collagenase topical (Santyl®) will have a quantity limit of seven (7) 90 gram tubes per prescription, for a total of 630 grams.

Contraceptive Agents

Drospirenone/Ethinylestradiol/Levomefolate Calcium (Beyaz®)

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

Etonogestrel (Nexplanon®)

Pharmacy claims for Etonogestrel (Nexplanon®) will be limited to one implant every two years.

If the prescriber chooses to exceed the quantity limit for Etonogestrel (Nexplanon®), the pharmacist may override the limit after consultation with the prescribing practitioner. The pharmacist must document the NCPDP override codes and reason for the override on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Etonogesetrel/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 day 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; and

- 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: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Oral Contraceptive Agents

Oral contraceptive agents will have an age limit of 12-55 years of age per program policy for legacy Medicaid.

Pharmacy claims for oral contraceptive agents are subject to an **educational alert** encouraging the submission of a diagnosis code at POS. The acceptable diagnosis codes for oral contraceptives as a family planning benefit or for menstrual disorders are listed in the chart.

ICD-10-CM Diagnosis Code	Diagnosis Description
Z30*	Encounter for oral contraceptive management
F32.81	Premenstrual dysphoric disorder
N92*	Excessive, frequent and irregular menstruation

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code.

Medroxyprogesterone Acetate Injectable

Prescription claims for Medroxyprogesterone Acetate injectable for female recipients billed with a quantity of one and a days' supply less than 84 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 female recipients, billed with a quantity of 0.65 and a days' supply less than 84, will 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.

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

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Norelgestromin /Ethinyl Estradiol Transdermal Patches (Ortho-Evra) ®)

Reimbursement of these contraceptive transdermal patches when dispensed using the package size of three 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.

Cytokine and Cell-Adhesion Molecule (CAM) Antagonists

Prescriptions for cytokine and cell-adhesion molecule (CAM) antagonists will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Deferasirox (Exjade ®)

Pharmacy claims for deferasirox (Exjade®) are subject to diagnosis code requirements and age limitations.

Recipients 2 years of age and less

Pharmacy claims for deferasirox (Exjade®) will deny for recipients 2 years of age or less.

Recipients 2-9 years of age

Pharmacy claims for deferasirox (Exjade®) require a diagnosis code of chronic iron overload due to blood transfusions for payment for recipients 2-9 years of age. The diagnosis code must be documented on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Recipients 10 years of age and older

Pharmacy claims for deferasirox (Exjade®) require a valid numeric diagnosis code for reimbursement.

The appropriate diagnosis codes for deferasirox (Exjade®) are listed in the chart:

Covered Indications at POS	ICD-10-CM Diagnosis Code
2 years and up	
Chronic iron overload due to blood transfusion	E83.111
10 years and up **Chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndromes**	
β-thalassemia intermedia	D56.1
Hemoglobin E/β-thalassemia	D56.5
Hemoglobin S/β-thalassemia	D57.4*
10 years and up **Chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndromes**	
Hemoglobin C/ β-thalassemia	D56.8
α-thalassemia intermedia [hemoglobin H disease]	D56.0

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Diabetic Testing Supplies

The 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 durable medical equipment regional carrier (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 facility 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 37.5.7 - Medicare Prescription Drug Coverage for detailed information.

Eculizumab (Soliris®)

Pharmacy claims for eculizumab (Soliris®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code*	Diagnosis Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis Optica Spectrum Disorder (NMOSD)
G70.0	Myasthenia Gravis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Epinephrine Injection (Generic, EpiPen®, and EpiPen Jr®)

Prescriptions for epinephrine injection have the following quantity limits for reimbursement.

Medication	Quantity Limit
Epipen® (Brand and Generic) Epipen Jr® (Brand and Generic)	4 boxes of 2 syringes (8 syringes total) per rolling 365 days

Esketamine Intranasal (Spravato®)
Pharmacy claims for esketamine intranasal (Spravato®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

<div align="center">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</div>

Elagolix (Orilissa ®)

Pharmacy claims for elagolix (Orilissa®) require an approved clinical authorization for reimbursement.

Fertility Agents

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.

Galcanezumab Injection (Emgality®)

Prescriptions for galcanezumab-gnlm (Emgality®) 100 mg single-dose
pen/syringe will have a quantity limit of one (1) carton of three (3) single-dose syringes per 30 days.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

Granulocyte Colony Stimulating Factor Agents (GCSF)

The GCSF agents are listed in the following chart.

Granulocyte Colony Stimulating Factor (GCSF) Agents
Filgrastim (Neupogen®)
Filgrastim-aafi (Nivestym®)
Filgrastim-sndz (Zarxio®)
Pegfilgrastim (Neulasta®)
Pegfilgrastim-jmdb (Fulphila®)
Sargramostim (Leukine®)

Granulocyte Colony Stimulating Factor (GCSF) Agents
Tbo-filgrastim (Granix®)

Prescriptions for Granulocyte Colony Stimulating Factor agents will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
<div align="center">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</div>

Growth Hormone

Prescriptions for Growth Hormone will be reimbursed when:

- The prescriber has obtained an approved clinical authorization; and

- An acceptable diagnosis code has been submitted with the pharmacy claim.

Diagnosis Code Requirement

Pharmacy claims for Growth Hormone will require an acceptable diagnosis code for reimbursement.
NOTE: **NOTE:** Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
<div align="center">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</div>

Hepatitis C Virus Direct-Acting (DAA) Antiviral Agents

Hepatitis C Direct Acting Antiviral Agent(s) may be subject to clinical edits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
<div align="center">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</div>

Hereditary Angioedema (HAE) Agents
Pharmacy claims for Hereditary Angioedema agents require an approved clinical pre-authorization for reimbursement. The select HAE agents are as follows:

- C1 Inhibitor, Human Injection (Berinert®)
- C1 Inhibitor, Human Injection (Cinryze®)

- C1 Inhibitor, Human Injection (Haegarda®)
- C1 Inhibitor (Recombinant) Injection (Ruconest®)
- Ecallantide Injection (Kalbitor®)
- Icatibant Acetate Injection (Firazyr®)
- Lanadelumab Injection (Takhzyro®)

Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hydroxyprogesterone Caproate (Makena®)

Hydroxyprogesterone Caproate (Makena®) is a covered pharmacy and medical benefit.

Prescriptions for hydroxyprogesterone caproate (Makena®) require the following for reimbursement:

- The prescriber has submitted an acceptable diagnosis code of O09.21* Pregnancy with a history of pre-term labor.

- The acceptable diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code may be communicated to the pharmacist from the prescriber (or prescriber's agent) electronically, via telephone, or facsimile.

- The acceptable diagnosis code must be submitted at POS.

When the prescriber does not indicate a diagnosis code on the prescription and the prescriber cannot be reached, a denial for a missing diagnosis code may be overridden by the pharmacist. The pharmacist must also document "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.

www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Incretin Mimetic/Enhancers

Prescriptions for incretin mimetic/enhancer will be reimbursed when:

- There is prior use of metformin or another incretin mimetic/enhancer; and

- The maximum daily dose limit is not exceeded.

Prior Use of Metformin Required

An incoming pharmacy claim for an incretin mimetic/enhancer will require evidence of previous use of metformin or a paid claim for the requested medication or another medication within the same therapeutic class.

An incoming claim for an incretin mimetic/enhancer will deny if there is no evidence of a paid claim(s) for at least 90 days of metformin therapy OR there is no evidence of at least 60 days of paid claims for the requested medication (or another incretin mimetic/enhancer).

Maximum Daily Dose Limit

The maximum dose for select incretin mimetic/enhancers are listed in the chart.

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Medication (Brand Name Example)	Maximum Dose
Alogliptin (Nesina®)	25mg/day
Alogliptin/Metformin (Kazano®)	25mg/2000mg per day
Alogliptin/Pioglitazone (Oseni®)	25mg/45mg per day
Dulaglutide (Trulicity®)	1.5mg/week
Exenatide (Bydureon®, Bydureon® BCise™)	2mg/week
Exenatide (Byetta®)	20mcg/day
Linagliptin (Tradjenta®)	5mg/day
Linagliptin/Metformin (Jentadueto®, Jentadueto XR®)	5mg/2000mg per day
Liraglutide (Victoza®)	1.8mg/day
Lixisenatide (Adlyxin®, Adlyxin® Starter Kit)	20mcg/day
Pramlintide (Symlin®)	Type 1 diabetes: 60mcg SQ immediately prior to each major meal
	Type 2 diabetes: 120mcg SQ immediately prior to each major meal
Saxagliptin (Onglyza®)	5mg/day
Saxagliptin/Metformin ER (Kombiglyze XR®)	5mg/2000mg per day
Semaglutide (Ozempic®)	1mg/week
Sitagliptin (Januvia®)	100mg/day
Sitagliptin/Metformin (Janumet®, Janumet XR®)	100mg/2000mg per day

*Authorization at POS is required to exceed maximum doses.

Isotretinoin

Isotretinoin capsules will be covered only if a handwritten prescription signed by the prescribing practitioner, with no provisions for refills, is submitted.

Ivacaftor (Kalydeco®)

Pharmacy claims for Ivacaftor (Kalydeco®) require an approved clinical authorization for reimbursement.

NOTE: **NOTE:** Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Ketorolac

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

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures.
        www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

L-glutamine oral powder (Endari®)

Pharmacy claims for l-glutamine oral powder (Endari®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
        http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Linezolid (Zyvox®)

Prescriptions for linezolid (Zyvox®) injections, tablets, and oral suspension will only be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
        http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lipotropics: Lomitapide (Juxtapid®), Mipomersen (Kynamro®), Alirocumab (Praluent®), and Evolocumab (Repatha®)

Prescriptions for lomitapide (Juxtapid®), mipomersen (Kynamro®, alirocumab (Praluent®), and evolocumab (Repatha®) will be reimbursed when:

- The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lumacaftor/Ivacaftor (Orkambi®)

Clinical Authorization

Pharmacy claims for lumacaftor/ivacaftor (Orkambi®) will be reimbursed at POS when the prescriber has obtained an approved clinical authorization.

Override provisions should be addressed through the Clinical Authorization process.

Diagnosis Code Requirements

Pharmacy claims for lumacaftor/ivacaftor (Orkambi®) require a valid ICD-10-CM diagnosis code. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The following table lists the acceptable diagnosis code for lumacaftor/ivacaftor (Orkambi®).

Diagnosis	ICD-10-CM Diagnosis Code(s)
Cystic fibrosis	E84.*

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Lumacaftor/ivacaftor (Orkambi®) claims submitted at POS without a valid diagnosis code will deny.

Prescribing providers may call the RxPA Unit for guidance when recipients are established on medications but the ICD-10-CM diagnosis code(s) submitted are not included in the covered diagnoses.

When the diagnosis code written on the prescription is not included in the list of covered diagnoses AND when the pharmacist cannot reach the prescriber OR when the RxPA Unit is closed, the pharmacist, using his/her professional judgment, may deem the filling of the prescription to be an "emergency". In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system AND may override the diagnosis code requirement.

Monoclonal Antibodies (Respiratory): Benralizumab Injection (Fasenra®), Mepolizumab Injection (Nucala®), Omalizumab (Xolair), and Reslizumab Injection (Cinqair®)

Benralizumab Injection (Fasenra®), Mepolizumab Injection (Nucala®), Reslizumab Injection (Cinqair®)

Prescriptions for benralizumab injection (Fasenra®), mepolizumab injection (Nucala®), and reslizumab injection (Cinqair®) will only be reimbursed when the prescriber has obtained an approved clinical authorization.

Omalizumab (Xolair®)

Prescriptions for omalizumab (Xolair®) will be reimbursed when the following criteria are met:

- The prescriber has obtained prior authorization for the recipient to receive the omalizumab or the recipient has an existing prior authorization for omalizumab; and

- The recipient is 12 years of age or older on the date of service.

The following are acceptable diagnoses for omalizumab claims submitted for prior authorization:

Diagnosis Description
Allergic (extrinsic) asthma
Allergic (extrinsic) asthma unspecified
Allergic (extrinsic) asthma with status asthmaticus
Allergic (extrinsic) asthma with acute exacerbation
Chronic Idiopathic Urticaria

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Pimavanserin (Nuplazid®)

Prescriptions for pimavanserin (Nuplazid®) are subject to:

- An approved clinical authorization;

- Diagnosis code requirement; and

- Quantity limit.

Diagnosis Code Requirement

Pharmacy claims for pimavanserin (Nuplazid®) will require a diagnosis code of G20 (Parkinson's disease).

Quantity Limit

Pharmacy claims for pimavanserin (Nuplazid®) have a quantity limit of 60 (17mg) tablets or 30 (34mg) capsules per rolling 30 days.

Mosquito Repellents

Prescriptions for mosquito repellents are covered to decrease the risk of exposure to the Zika virus. Mosquito repellent coverage will be limited to Medicaid recipients:

- Who are pregnant; or

- Of childbearing years (women and men 14-44 years of age) who are trying to conceive.

A prescription will be required to cover one of the following products:

Product Name	Ounces	Bill As
Cutter Backwoods 25 percent Spray	6 oz.	170 g
Cutter Skinsations 7 percent Spray	6 oz.	177 mL
OFF! Family Care 15 percent Spray	2.5 ounces	71 g
OFF! Deep Woods Dry 25 percent Spray	4 ounces	113 g

Product Name	Ounces	Bill As
OFF! Deep Woods 25percent Spray	6 ounces	170 g
OFF! Active 15 percent Spray	6 ounces	170 g
Repel Sportsmen 25 percent Spray	6.5 ounces	184 g
Repel Sportsmen Max 40 percent Spray	6.5 ounces	184 g
Natrapel 20 percent Picaridin	5 ounces	177 mL
Sawyer Insect Repellent 20 percent Picaridin	4 ounces	118 mL

Quantity Limit

One bottle of mosquito repellent will be covered every rolling 30 days.

Age Restriction

Pharmacy claims for mosquito repellents have an age limit of 14 to 44 (of childbearing) years of age.

Multiple Sclerosis (MS) Treatment Agents

Prescriptions for Multiple Sclerosis treatment agents will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
　　　　　　　　　　　http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Naloxone

Pharmacy claims for naloxone have a quantity limit requirement for reimbursement. Refer to the chart below.

Description	Dosage Form	Strength	Units per 90 Rolling Days	Representative Brand
Naloxone	Injectable Solution	0.4mg/ml	2	Naloxone

Description	Dosage Form	Strength	Units per 90 Rolling Days	Representative Brand
Naloxone	Injectable Solution Cartridge	0.4mg/ml	2	Naloxone
Naloxone	Injectable Solution Prefilled Syringe	1mg/ml	2	Naloxone
Naloxone	Injectable Solution (5ml, 10ml, 20ml)	1mg/ml	1	Naloxone
Naloxone	Injectable Solution (10ml)	0.4mg/ml	1	Naloxone
Naloxone	Injectable Solution Auto-Injector	0.4mg/0.4ml	2	Evzio®
Naloxone	Nasal Liquid	4mg/0.1ml	2	Narcan®

Nicotine Transdermal Patches, Gum and Spray

Nicotine transdermal patches, nicotine polacrilix 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.

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 physician-supervised 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.

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.

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;

LOUISIANA MEDICAID PROGRAM

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REPLACED: 07/01/19

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- Patient is 12 years of age or older;

- The prescription is an original—no refills are allowed;

- The prescription is for a maximum of 90 capsules **and** 30 days' supply;

- The recipient has a documented current body mass index (BMI) of 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;

- The recipient has other risk factors warranting the use of Orlistat and the prescriber has identified an approved diagnosis code in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription; and

- There are 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-10-CM **numeric codes only**, are acceptable:

ICD-10-CM Code	Description
E11.*	Type II Diabetes
R73.02	Impaired Glucose Tolerance
E15, E16.1	Hyperinsulinemia
E78.0-E78.5	Dyslipidemia
I10, I11.*, I12.*, I13.*, I15.*	Hypertension
I21.*, I22.*, I24.*, I25.*	Ischemic Heart Disease
I70	Atherosclerosis
I73	Other peripheral vascular diseases
K21.0, K21.9	Gastric Reflux Disease
M16.*, M17.*	Osteoarthritis of Hips/Knees
G47.30	Sleep Apnea
I60.*, I61.*, I62.*, I63.*, I65.*, I66.*, I67.*, I68.*, I69.*	Cerebrovascular Disease

ICD-10-CM Code	Description
G93.2	Pseudotumor cerebri
I83.2	Varicose Veins of the lower extremities with ulcer and inflammation
I80.0	Phlebitis & Thrombophlebitis of the superficial vessels of the lower extremities
I80.1	Phlebitis & Thrombophlebitis of the femoral vein
I80.2	Phlebitis & Thrombophlebitis of other deep vessels
I80.3	Phlebitis & Thrombophlebitis of lower extremities, unspecified
I83.0	Varicose veins of lower extremities, with ulcer
I83.1	Varicose veins of lower extremities, with inflammation
I83.9	Varicose veins of lower extremities, without mention of ulcer & inflammation

The prescriber identified 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.

Onasemnogene Abeparvovec Injection (Zolgensma®)

Pharmacy claims for onasemnogene abeparvovec injection (Zolgensma®) require a clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Palivizumab (Synagis®)

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

- The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

<div align="center">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</div>

Respiratory Syncytial Virus Season

Louisiana's respiratory syncytial virus (RSV) activity may be followed during the RSV season by frequently accessing the Center for Disease Control's website. (Refer to Section 37.5.4 for web address.) The RSV season in Louisiana begins November 1st and ends March 31st.

Age Restriction

Palivizumab claims for recipients who are 24 months of age or younger on November 1st of the current RSV season meet the POS age requirement.

Early Refill

Palivizumab claims will only process for payment every 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.

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 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.

Medical Reconsideration for Palivizumab (Synagis®)

Medical reconsideration of a denied clinical authorization decision may be requested by the prescribing practitioner. Medical reconsideration requires completion of the Palivizumab Request for Reconsideration Form.

Palivizumab Criteria ICD-10-CM Code and Medication List

NOTE: Any accepted diagnosis code listed on the Palivizumab Clinical Authorization Form must have supporting documentation attached. Supporting documentation is supplemental information submitted to support the patient meeting the criteria and may include copies of progress notes, hospital discharge notes, pediatric cardiologist consult notes, chart notes, pharmacy profiles, etc.

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Neuromuscular Disorders

Acceptable ICD-10 codes include:

ICD-10-CM Code	Description
A80.0-A80.39	Infantile paralysis
G31.9	Cerebral degenerations
G25.3	Myoclonus
G11.1, G11.4	Spinocerebellar disease
G12.0	Werdnig-Hoffman disease (Infantile spinal muscular atrophy)
G12.1, G12.8, G12.9	Spinal muscular atrophy
G12.2*	Motor neuron disease

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
G80*	Cerebral palsy
G40.3*	Generalized convulsive epilepsy
G40.4*	Grand mal seizures
G40*	Epilepsy
Q05*	Spina bifida
P90	Newborn seizures
R56*	Infantile seizures

Congenital Abnormalities of the Airways

Acceptable ICD-10 codes include:

ICD-10-CM Code	Description
G47.35	Congenital central alveolar hypoventilation syndrome
Q32.0, Q32.1	Other diseases of the trachea and bronchus, not elsewhere classified (Must specify Tracheomalacia or tracheal stenosis)
Q31.1, Q31.5, Q32.1, Q32.4	Other anomalies of larynx, trachea, and bronchus (Must specify congenital tracheal stenosis, subglottic stenosis, atresia of trachea, laryngomalacia, or absence or agenesis of bronchus, trachea)
Q33.0	Congenital cystic lung
Q33.3, Q33.6	Agenesis, hypoplasia, and dysplasia of the lung
Q33.4	Congenital bronchiectasis
Q38.2	Macroglossia
Q38.5	Uvula anomaly
J98.6	Diaphragmatic paralysis
Q87.3	Beckwith-Wiedemann syndrome

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
Q33.9	Anomaly of lung, unspecified
Q33.1, Q33.8	Other anomaly of the lung

Chronic Lung Disease

Acceptable ICD-10 code:

ICD-10-CM Code	Description
P27*	Chronic respiratory disease arising in the perinatal period (CLD/BPD/Interstitial pulmonary fibrosis of prematurity/Wilson-Mikity syndrome)

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
J05.0	Croup
J06*	URI
J20*	Bronchitis
J21*	Bronchiolitis
J45*	Asthma
R06.2	Wheezing

Congenital Heart Diseases

Per AAP guidelines, prophylaxis with palivizumab in children with chronic heart disease (CHD) should be made on the degree of cardiovascular compromise. CHD that is deemed hemodynamically insignificant will not meet criteria. Documentation must specifically support CHD being hemodynamically significant (e.g. medications, etc.).

Acceptable ICD-10 codes include:

Acyanotic CHD

ICD-10-CM Code	Description
Q23.0	Aortic stenosis
I37.0, I37.1, I37.2, Q22.1, Q22.2	Pulmonary valve disorders (incompetence, insufficiency, regurgitation, and stenosis)

ICD-10-CM Code	Description
I42*, I43	Cardiomyopathy (must be moderate to severe)
Q21.0	Ventricular septal defect
Q21.1	Atrial septal defect
Q21.2	Atrioventricular canal (endocardial cushion defect)
Q22.3	Anomalies of pulmonary valve congenital
Q22.1	Pulmonic stenosis
Q23.0	Congenital stenosis of aortic valve (congenital aortic stenosis) [Excludes: congenital subaortic stenosis; supravalvular aortic stenosis]
Q23.3	Congenital mitral insufficiency
Q25.0	Patent ductus arteriosus
Q25.1	Coarctation of the aorta
Q25.2, Q25.3	Atresia and stenosis of aorta (absence, aplasia, hypoplasia, stricture of the aorta) Supra (valvular)-aortic stenosis [Excludes: congenital aortic (valvular) stenosis or stricture; hypoplasia of aorta in hypoplastic left heart syndrome]

NOTE: Must currently be receiving medication to control congestive heart failure.

Cyanotic CHD

ICD-10-CM Code	Description
Q20.0	Truncus arteriosus
Q20.3	Transposition of the great vessels
Q21.3	Tetralogy of Fallot
Q22.0	Atresia, congenital
Q22.4	Tricuspid atresia and stenosis, congenital

ICD-10-CM Code	Description
Q22.5	Ebstein's anomaly
Q23.4	Hypoplastic left heart
Q22.6	Hypoplastic right heart
Q25.5	Pulmonary atresia
Q26.2	Total anomalous pulmonary venous return

NOTE: Does not require use of medication/must not have had or completed surgical correction.

Pulmonary Hypertension

ICD-10-CM Code	Description
I26.0*	Acute cor pulmonale
I27.0	Primary pulmonary hypertension
I27.2	Other chronic pulmonary heart disease (pulmonary hypertension, secondary)
P29.3	Persistent fetal circulation (persistent pulmonary hypertension/primary pulmonary hypertension of newborn)

 *any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Acceptable Medications Used in CHD

Digoxin	ACE Inhibitors	Supplemental oxygen
Beta Blockers	Nitroglycerin	Diuretics
Calcium Channel Blockers	Anti-Coagulants	

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits", and as well as the *POS User Guide* accessed by the below link or by visiting Section 37.5.1 for detailed claims filing information.

www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Pyrimethamine (Daraprim®)

Prescriptions for pyrimethamine (Daraprim®) will be reimbursed when:

- The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

Schedule II Narcotic Agents

All prescriptions for Schedule II narcotic agents require a 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 "Prospective Drug Utilization Policies/Limits/Edits" in this section for further information.

Fentanyl Buccal and Sublingual Agents

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

Acceptable diagnosis codes are as follows:

ICD-10-CM Code Range	Description
C00.*-C96*	Cancer

Buccal and sublingual agents are subject to prospective drug utilization reviews which address quantity limits.

Diagnosis Code Requirement

Pharmacy claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) require an appropriate diagnosis code documented on the hardcopy prescription by either the prescriber or pharmacist. The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Age Restriction

Claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) will deny when the recipient is 17 years of age or younger.

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.

Prescriptions for methadone will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

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 POS system for Morphine ER (Avinza®) when the maximum daily dosage is exceeded.

Oxycodone/Acetaminophen 7.5/325mg (Xartemis XR®)

Prescriptions for oxycodone/acetaminophen (Xartemis XR®) require an appropriate diagnosis code documented on the hard copy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Pharmacy claims for oxycodone/acetaminophen (Xartemis XR®) have a quantity limit of 30 units every 15 days within a 30-day period.

Paroxetine Mesylate (Brisdelle®)

Pharmacy claims for paroxetine mesylate (Brisdelle®) require submission of a valid diagnosis code at POS for reimbursement. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The following table lists the acceptable diagnosis codes for paroxetine mesylate (Brisdelle®).

Medication	ICD-10-CM Diagnosis Code*	Diagnosis Description
Paroxetine Mesylate (Brisdelle®)	E28.310	Moderate to severe vasomotor symptoms associated with menopause
	E89.41	
	N95.1	

Perampanel (Fycompa®)

Age Limit

Pharmacy claims for perampanel (Fycompa®) will deny for recipients under four years of age.

After consultation with the prescriber to verify the necessity of prescribing perampanel (Fycompa®) for a recipient under four years of age, the pharmacist may override the age restriction. The reason for service code, professional service code and result of service code used in submitting the claim must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
 www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Progesterone (Crinone® 4%)

Pharmacy claims for progesterone (Crinone® 4%) will require a diagnosis code for payment.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Progesterone micronized	Crinone® 4%	Secondary Amenorrhea	N91.1

*Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code.

Risankizumab Injection (Skyrizi®)

Pharmacy claims for risankizumab injection (Skyrizi®) require a clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
                    http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Roflumilast (Daliresp®)

Pharmacy claims for roflumilast (Daliresp®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.
                    http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Short-Acting Beta$_2$ Agonist Inhalers

Prescriptions for short- acting beta$_2$ agonist inhalers (SABAs) (i.e albuterol, levalbuterol, and pirbuterol):

- Require an appropriate diagnosis code; and

- Are subject to a maximum quantity of six short-acting beta$_2$ agonist inhalers per calendar year.

Diagnosis Code Requirement

The diagnosis code must be documented on the hardcopy prescription by either the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via

telephone or facsimile. Claims submitted with a diagnosis associated with chronic obstructive pulmonary disease, emphysema, or cystic fibrosis will bypass the edit.

Diagnosis codes which bypass the six inhaler limit are noted below:

ICD-10-CM Diagnosis Code(s)	Diagnosis Description
E84*	Cystic fibrosis
J40	Bronchitis, not specified
J44*	Obstructive chronic bronchitis
J43*	Emphysema
J44*	Chronic obstructive asthma
J44.9	Chronic airway obstruction

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Pharmacy claims that do not indicate a diagnosis code on the prescription and the prescriber cannot be reached; a denial for a missing diagnosis code may be overridden by the pharmacist entering the emergency override.

Quantity Limit

If the prescriber chooses to exceed the quantity limit, the prescriber must provide the reason why the limit needs to be exceeded. The pharmacist may override the limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record-keeping system the following:

- The prescriber's reason why the limit needs to be exceeded; and

- The NCPDP DUR override codes used in submitting the claim.

If the prescriber cannot be reached, the pharmacist may override the quantity limit by entering the emergency override. The pharmacist must document "Emergency" on the hardcopy prescription and the reason for entering the emergency override.

Therapeutic Duplication

Pharmacy claims billed for concurrent use of different SABAs will deny with a therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. This consultation is necessary to confirm that:

- The prescriber is aware of the current active SABA claim; and

- The addition of a different SABA is necessary (i.e., a change in therapy).

To bill concurrent therapy with different SABAs, the pharmacist must document on the hardcopy prescription or the pharmacy's electronic recordkeeping system the following:

- The reason why an additional SABA was requested by the prescriber; and

- The NCPDP DUR override codes used in submitting the claim.

NOTE: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy regarding short-acting beta$_2$ agonist inhalers.

Sildenafil (Revatio®) And Tadalafil (Adcirca®)

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

The following diagnosis codes are acceptable:

ICD-10-CM Code	Description
I27.0, I27.2, I27.89, P29.3	Pulmonary Arterial Hypertension

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combination Products

Prescriptions for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and combination products will be reimbursed when:

- The prescriber has obtained an approved clinical authorization.

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Prior Use of Metformin Required (SGLT2 Inhibitors Only)

An incoming pharmacy claim for a SGLT2 inhibitor will require evidence of previous use of metformin or a paid claim for the requested medication or another medication within the same therapeutic class.

An incoming claim for a SGLT2 inhibitor will deny if there is not a paid claim(s) for at least 90 days of metformin therapy OR there is no evidence of at least 60 days of paid claims for the requested medication (or another SGLT2 inhibitor).

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Sodium Oxybate (Xyrem®)

Clinical Pre-Authorization

Pharmacy claims for sodium oxybate (Xyrem®) will be reimbursed when the prescriber has obtained an approved clinical authorization. A diagnosis of narcolepsy or cataplexy must be submitted in the clinical authorization process.

Therapeutic Duplication

Pharmacy claims for sodium oxybate (Xyrem®) will deny when the recipient has an active claim on file for a CNS depressant. Claims for CNS depressants will deny when the recipient has an active claim on file for sodium oxybate (Xyrem®).

CNS depressant medications include the following agents, whether given as a single entity or as a component of a combination product:

Alprazolam	Dantrolene	Metaxalone	Quazepam
Baclofen	Diazepam	Methadone	Ramelteon
Buprenorphine	Dihydrocodeine	Methocarbamol	Remifentanil
Buspirone	Doxepin	Midazolam	Secobarbital
Butabarbital	Estazolam	Morphine	Sufentanil
Butalbital	Eszopiclone	Nalbuphine	Suvorexant
Butorphanol	Fentanyl	Opium	Tapentadol
Carisoprodol	Flurazepam	Orphenadrine	Tasimelteon
Chlordiazepoxide	Hydrocodone	Oxazepam	Temazepam
Chlorzoxazone	Hydromorphone	Oxycodone	Tizanidine

Clonazepam	Levorphanol	Oxymorphone	Tramadol
Clorazepate	Lorazepam	Paregoric	Triazolam
Codeine	Meperidine	Pentazocine	Zaleplon
Cyclobenzaprine	Meprobamate	Phenobarbital	Zolpidem

The therapeutic duplication edit for sodium oxybate (Xyrem®) and CNS depressants can be overridden in emergency circumstances. These claims will require consultation and approval from the prescribing provider to override the therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication with the emergency override. The pharmacist must document "**Emergency**" on the hardcopy prescription and the reason why the prescribing provider choose to override the therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Somatropin

Pharmacy claims for Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, and Zorbtive®) require an appropriate diagnosis code for reimbursement. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile.

There are no overrides for this edit. However, the pharmacist may contact the prescriber for a valid diagnosis code and resubmit the claim.

The following chart addresses acceptable diagnosis code(s) which are in accordance with the reimbursement criteria for somatropin.

ICD-10-CM Diagnosis Code(s)	Diagnoses
N25.0	Growth failure in children associated with: • Renal insufficiency or chronic kidney disease
Q87.1	• Noonan Syndrome
Q87.1	• Prader-Willi Syndrome
Q96	• Turner Syndrome
P05.1	• Small for gestational age at birth (fetal growth retardation) who fail to manifest catch-up growth or with no catch-up growth
R62.52	Short Stature in children (idiopathic or SHOX deficiency)

	• Short stature • Lack of expected normal physiological development in childhood
E23.0	Pituitary dwarfism
E23.0	Panhypopituitarism
ICD-10-CM Diagnosis Code(s)	**Diagnoses**
E23.1, E89.3	Iatrogenic pituitary disorders
K90.2, K91.2	(Zorbitive® only) Short Bowel Syndrome in patients receiving specialized nutritional support: • Blind Loop Syndrome • Other unspecified post-surgical nonabsorption
R64	(Serostim® only) HIV-associated cachexia or wasting

Suvorexant (Belsomra®)

Pharmacy claims for suvorexant (Belsomra®) are subject to a maximum daily dosage limit of 20 mg/day.

Tasimelteon (Hetlioz®)

Prescription claims for tasimelteon (Hetlioz®) will have the following clinical edits:

- Clinical Authorization;

- Maximum Daily Dose; and

- Therapeutic Duplication.

Clinical Authorization for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will be reimbursed at POS when the prescriber has obtained an approved clinical authorization.

Override provisions should be addressed through the Clinical Authorization process.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Maximum Dose for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) have a maximum daily dose of 20mg/day.   There are no override provisions through the POS system using NCPDP service codes.

Therapeutic Duplication for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will deny at POS if there is an active claim for another sedative-hypnotic agent.

After consultation with the prescriber to verify the necessity of the therapeutic duplication, the pharmacist may override the therapeutic duplication.

The pharmacist must document the override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Tazarotene (Tazorac®)

Pharmacy claims for Tazarotene (Tazorac®) require an appropriate diagnosis code for reimbursement. The prescribing provider must document the diagnosis code on the hard copy prescription or may communicate the diagnosis code to the pharmacist electronically, via telephone, or facsimile.

The acceptable diagnosis codes are:

ICD-10-CM Code	Description
L40*	Psoriatic Arthritis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Pharmacy providers may direct questions to the Provider Help Desk concerning overrides for this edit. (Refer to Section 37.5.4 for contact information).

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
        www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Tedizolid Phosphate (Sivextro®)

Prescriptions for tedizolid phosphate (Sivextro®) will be reimbursed when:

- The prescriber has obtained an approved clinical pre-authorization.

Tezacaftor/Ivacaftor (Symdeko®)

Prescriptions for tezacaftor/ivacaftor (Symdeko®) will only be reimbursed when the prescriber has obtained an approved Clinical Pre-Authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Tobramycin/Nebulizer (Kitabis Pak®)

Pharmacy claims for tobramycin (Kitabis Pak®) will require a diagnosis code for payment.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Tobramycin Nebulizer	Kitabis Pak® 4%	Cystic Fibrosis with Pseudomonas	E84*

*Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10_CM diagnosis code.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Tramadol

Pharmacy claims for tramadol containing products have an age limit for reimbursement. The acceptable age limits are listed in the chart.

Description	Age (Y=Year)
Tramadol	≥17 Y
Tramadol Combination Product	≥17 Y

Triptans

Pharmacy claims for triptans for recipients under 18 years of age will require a valid diagnosis code for reimbursement. Triptans are identified in the following chart:

Generic Name	Representative Brand(s)
Almotriptan	Axert®6
Eletriptan	Relpax®
Frovatriptan	Frova®
Naratriptan	Amerge®
Rizatriptan	Maxalt®, Maxalt MLT®
Sumatriptan	Alsuma®, Imitrex®, Sumavel®, Zecuity®
Zolmitriptan	Zomig®, Zomig ZMT®

The acceptable ICD-10-CM diagnosis codes for triptans in recipients less than 18 years of age are as follows:

Descripton	ICD-10-CM Diagnosis Codes
Migraine diagnosis	G43.0*, G43.1*, G43.7*

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Prescriptions for Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors: deutetrabenazine (Austedo®), tetrabenazine (Xenazine®), and valbenazine (Ingrezza®) will be reimbursed when:

- The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

Diagnosis Code Requirement for Selected Medications

Prescriptions for selected medications require a diagnosis code for reimbursement for both FFS Medicaid and the MCOs. The diagnosis code should be documented on the hardcopy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code on the hardcopy prescription or in the pharmacy's electronic recordkeeping system after electronic or verbal consultation with the prescribing practitioner.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions.

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Prospective Drug Utilization Policies/Limits/Edits

Prospective drug utilization review (UniDUR) consists of criteria set forth by the state-established 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 recipient's condition, recipient's historical drug prescription records on file and the current medications prescribed for them.

Professional judgment 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 37.5.12 for an overview of Patient Counseling, Drug Utilization Review (DUR).

Duration of Therapy Limits

H$_2$ Antagonists & Sucralfate

The program utilizes a duration of therapy module for H$_2$ antagonists, and sucralfate for recipients who are 16 and older. Acute dosage guidelines for these drugs are monitored. H$_2$ antagonists have a duration of therapy limit of 180 days in a rolling 365 days. Sucralfate has a duration of therapy limit of 90 days per calendar year. Acute dosing of H$_2$ antagonists and sucralfate requires documentation of an appropriate diagnosis code. When authorized by the prescriber, claims beyond the duration of therapy limit can be processed through the POS system at the pharmacy. The chronic use of these agents at full therapeutic dosage is generally not indicated.

The acute dosage schedules of these drugs are as follows:

H$_2$ Antagonists & Sucralfate		
Generic Description	**Acute mg/day dose**	**Duration of Therapy**
Ranitidine HCl	300	180 days
Cimetidine	1200	180 days
Nizatidine	300	180 days
Famotidine	40	180 days
Sucralfate	4000	90 days

Maintenance dose drug therapy will continue to be payable after the duration of therapy has been exceeded with prescriber authorization.

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

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Select diagnosis codes which may justify the long-term usage of sucralfate are listed below.

ICD-10-CM Diagnosis Code(s)	Diagnosis
B96.81	*H. pylori*
C96.2	Malignant Mast Cell Tumors
D44.0, D44.2, D44.9	Multiple Endocrine Adenomas
E16.4	Zollinger-Ellison Syndrome
K20.9	Esophagitis, Unspecified
K21.0	Reflux Esophagitis
K20.8	Abscess of Esophagus
K22.1*	Ulcer of Esophagus with or without bleeding
K22.7*	Barrett's Esophagus
K25.*	Gastric Ulcer
K26.*	Duodenal Ulcer
K27.*	Peptic Ulcer
K29.*	Gastritis/Duodenitis
K30	Gastric Hyperacidity
K21.9	Gastroesophageal Reflux Disease (GERD)
K50.*	Crohn's Disease

LOUISIANA MEDICAID PROGRAM

ISSUED: 02/06/20
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ICD-10-CM Diagnosis Code(s)	Diagnosis
K86.0, K86.1	Chronic Pancreatitis
K92.2	Gastrointestinal Hemorrhage

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Select diagnosis codes which may justify the long-term usage of H_2 antagonists are listed below.

ICD-10-CM Diagnosis Code(s)	Diagnosis
C96.2*	Malignant Mast Cell Tumors
D44.0, D44.2, D44.9	Multiple Endocrine Adenomas
E16.4	Zollinger-Ellison Syndrome
K20.9	Esophagitis, Unspecified
K21.0	Reflux Esophagitis
K20.8	Abscess of Esophagus
K22.1*	Ulcer of Esophagus with or without bleeding
K22.7*	Barrett's Esophagus
K25.*	Gastric Ulcer
K26.*	Duodenal Ulcer
K27.*	Peptic Ulcer
K29.*	Gastritis/Duodenitis
K30	Gastric Hyperacidity
K21.9	Gastroesophageal Reflux Disease (GERD)
K50.*	Crohn's Disease
K86.0, K86.1	Chronic Pancreatitis
K92.2	Gastrointestinal Hemorrhage

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Proton Pump Inhibitors (PPIs)

Prescriptions for Proton Pump Inhibitors have a duration of therapy of 180 days in a rolling 365 days.

Diagnosis Codes Exempt from the Duration of Therapy Limit for PPIs

Select diagnosis codes are exempt and bypass the duration of therapy edit for PPIs. (See the following chart for the listing.)

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Diagnosis	ICD-10-CM Diagnosis Code(s)
Abscess of Esophagus	K20.8
Angiodysplasia of Stomach and Duodenum (with OR without Mention of Hemorrhage)	K31.81*
Atrophic Gastritis with Hemorrhage	K29.41
Barrett's Esophagus	K22.7*
Cerebral Palsy (*new Aug 2019)*	G80*
Chronic Pancreatitis	K86.0, K86.1
Congenital Tracheoesophageal Fistula	Q39.1, Q39.2
Cystic Fibrosis	E84.*
Eosinophilic Esophagitis	K20.0
Eosinophilic Gastritis	K52.81
Gastrointestinal Hemorrhage	K92.2
Gastrointestinal Mucositis (Ulcerative)	K92.81
Malignant Mast Cell Tumors	C96.2*
Multiple Endocrine Adenomas	D44.0, D44.2, D44.9
Tracheoesophageal Fistula	J86.0
Ulcer of Esophagus with OR without Bleeding	K22.1*
Zollinger-Ellison Syndrome	E16.4

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Claims for recipients under six years of age are excluded from the PPI duration of therapy module. In addition, claims for recipients receiving pancreatic enzymes are excluded from the PPI duration of therapy module as well.

Early Refill

The Medicaid Program denies pharmacy claims for early refills if the patient has requested the same medication at the same pharmacy prior to 85 percent of medication being utilized. This translates into a five day window based on a 30-day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication had been utilized. This translates into a two day window based on a 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 judgment.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a recipient'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: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
         www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Duplicate Drug Therapy

A claim denial will occur if the recipient 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, recipient 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. Pharmacy claims submitted with an override code are subject to the pharmacy audit process.

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

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
                www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Pregnancy and FDA Category X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category 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.

Pregnancy and FDA Category D Drugs

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

Prior Drug Use

Pharmacy claims for select drugs will require prior use of other drug(s) before reimbursement.

Olmesartan/amlodipine/hydrochlorothiazide (Tribenzor®) and
amlodipine/valsartan/hydrochlorothiazide (Exforge HCT®) will require prior drug use of two drug therapies from these select drug classes: calcium channel blockers, angiotensin receptor blockers, and/or diuretics. If previous claims for drugs in two of these three drug classes (calcium channel blockers, angiotensin receptor blockers, and/or diuretics) are not identified, the pharmacy claim will deny.

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
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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.

First Generation Antihistamine

> Brompheniramine Maleate
> Carbinoxamine Maleate
> Clemastine Fumarate
> Cyproheptadine HCL

If a first generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Second Generation Antihistamine

> Cetirizine HCL
> Desloratadine
> Fexofenadine HCL
> Levocetirizine Dihydrochloride
> Loratadine

If a second generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

First Generation Antihistamine-Decongestant

> Pseudoephedrine HCL /Brompheniramine
> Pseudoephedrine HCL /Triprolidine HCL
> Phenylephrine/Diphenhydramine
> Pseudoephedrine HCL/Chlorpheniramine

If a first generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, he claim will deny due to a therapeutic duplication.

Second Generation Antihistamine-Decongestant

Cetirizine HCL/Pseudoephedrine
Fexofenadine/Pseudoephedrine
Loratadine/Pseudoephedrine
Desloratadine/Pseudoephedrine

If a second generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Claims for diphenhydramine, hydroxyzine HCl, and hydroxyzine pamoate are not included in the antihistamine edits for therapeutic duplication.

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	Fosinopril Sodium
Fosinopril/Hydrochlorothiazide	Ramipril
Lisinopril	Trandolapril

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

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Eprosartan/Hydrochlorothiazide	Telmisartan
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/Antihyperlipemia Agent Combination

Amlodipine/Atorvastatin Calcium

Potassium Replacement

Potassium Acetate	Potassium Bicarbonate / Citric Acid
Potassium Chloride	Potassium Citrate

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 recipient to receive a third antipsychotic agent.

Note: Refer to "Drugs with Special Payment Criteria/Limitations" in this section for further policy regarding antipsychotic agents.

Typical Antipsychotic Agents

Chlorpromazine	Pimozide
Fluphenazine	Thioridazine
Haloperidol	Thiothixene
Loxapine	Trifluoperazine
Molindone	
Perphenazine	

Atypical Antipsychotic Agents

Aripiprazole	Lurasidone
Asenapine	Olanzapine
Brexpiprazole	Paliperidone
Cariprazine	Quetiapine
Clozapine	Risperidone
Iloperidone	Ziprasidone

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 diagnosis codes are:

ICD-10-CM Diagnosis Code(s)	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Sedative Hypnotic Agents

Estazolam   Temazepam
Eszopiclone   Triazolam
Flurazepam HCl   Zaleplon
Quazepam   Zolpidem Tartrate

Attention Deficit Disorder (ADD) Agents

Armodafinil   Guanfacine
Atomoxetine   Lisdexamfetamine
Dexmethylphenidate   Methylphenidate
Dextroamphetamine   Modafinil
Dextroamphentamine/amphetamine

An incoming pharmacy claim for any of the above ADD 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	Ibuprofen	Meloxicam
Diclofenac Potassium	Ibuprofen/Hydrocodone Bitartrate	Nabumetone
Diclofenac Sodium	Ibuprofen/Oxycodone	Naproxen
Diclofenac Sodium/Misoprostol	Indomethacin	Naproxen Sodium
Diflunisal	Ketoprofen	Naproxen/Lansoprazole
Etodolac	Ketorolac Tromethamine	Oxaprozin
Fenoprofen Calcium	Meclofenamate Sodium	Piroxicam
Flurbiprofen	Mefenamic Acid	Sulindac
		Tolmetin Sodium

Short-Acting Beta$_2$ Agonist Inhalers

Albuterol
Pirbuterol
Levalbuterol

Pharmacy claims billed for concurrent use of different short-acting beta$_2$ agonist inhalers (SABAs) will deny with a therapeutic duplication.

Note: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy regarding short-acting beta₂ agonist inhalers.

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 Ciltrate Buccal	Oxymorphone
Pentazocine/APAP	Propoxyphene/APAP
Pentazocine/Naloxone	Tramadol HCl
Propoxyphene HC1	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 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed by the below link or by visiting Section 37.5.1 for detailed billing information.

www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Drug/Drug Interaction

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 recipient 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.

Unnecessary Drug Therapy

Selective Cox-2 Inhibitor

Pharmacy claims for the selective COX-2 inhibitor, celecoxib (Celebrex®) will deny for "drug use not warranted" if they are not submitted with an appropriate diagnosis code and reason for treatment documented on the hard prescription.

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.

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- 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 recipients, the prescribing practitioner must include:

- The condition being treated with the COX-2 selective agent by indicating the diagnosis code of the treated condition 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 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 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 recipient will only process without an override when the following conditions are met:

- A diagnosis code indicating the reason for treatment is documented and submitted; and

- When one of the following conditions exists:

  - Recipient has current prescription for H2 receptor antagonist;

  - Recipient has current prescription for proton pump inhibitor;

  - Recipient has current prescription for warfarin;

  - Recipient has current prescriptions indicating chronic use of oral steroids; or

  - Recipient is 60 years of age or older.

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 POS submission of the claim and have the information recorded on the hardcopy.

NOTE: Refer to Section 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed by the below link or by visiting Section 37.5.1 for detailed billing information.

www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Maximum Dosage

Atypical Antipsychotic Agents

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

NOTE: Refer to Antipsychotic Agents of this section for the age limits and dosage schedules for antipsychotic agents.

The prescriber may choose to override an age or dosage limit for an antipsychotic medication. Overrides for antipsychotic medications can be addressed by the provider contacting the RxPA Unit. When the pharmacist cannot reach the prescriber or the RxPA Unit is closed, the pharmacist, using his/her professional judgment, may deem the filling of the antipsychotic prescription to be an "emergency." In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and override the age or dosage limit.

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 judgment to determine an appropriate days' supply based upon the directions noted by the prescriber.

Suspending Agents

Pharmacy claims for the following select suspending agents are reimbursable.

Generic Name	Trade Name1
Compounding Vehicle Suspension No. 19	Mx-Sol Blend; Ora Blend
Compound Vehicle Suspension SF No. 20	Ora Plus
Compounding Vehicle No. 8	Ora Sweet
Compound Vehicle Sugar Free No. 9	Ora Sweet SF

Sedative Hypnotic Agents

Pharmacy claims which exceed the maximum daily dosage limit for selected sedative hypnotic agents will deny at POS.

The maximum daily doses for the selected sedative hypnotic agents are as follows:

Generic Name	Brand Name	Maximum Dose Per Day
Doxepin (sedative-hypnotic only)	Silenor®	6 mg/day
Estazolam	Prosom®	2 mg/day
Eszopiclone	Lunesta®	3 mg/day
Flurazepam	Dalmane®	30 mg/day
Quazepam	Doral®	15 mg/day
Ramelteon	Rozerem®	8 mg/day
Temazepam	Restoril®	30 mg/day
Triazolam	Halcion®	0.5 mg/day

Generic Name	Brand Name	Maximum Dose Per Day
Zaleplon	Sonata®	20 mg/day
Zolpidem IR tablet	Ambien®	10 mg/day
Zolpidem SL tablet	Edluar®	10 mg/day
Zolpidem oral spray	Zolpimist®	10 mg (2sprays)/day
Zolpidem ER tablet	Ambien CR®	12.5 mg/day
Zolpidem SL tablet	Intermezzo®	1.75mg/day (female)
Zolpidem SL tablet	Intermezzo®	3.5 mg/day (male)

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Tapentadol (Nucynta®)

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 or in the pharmacy's electronic recordkeeping system the reason for service code, professional service code and result of service code with the POS submission.

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:

Generic Name	Maximum Dose per Day	Age

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 POS submission.

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Botulinum Toxins OnabotulinumtoxinA (Botox®) and IncobotulinumtoxinA (Xeomin®)

Quantity Limit

Pharmacy claims for onabotulinumtoxinA (Botox®) will have quantity limits of 6 units every rolling 84 days for the 100 unit vial and 3 units every rolling 84 days for the 200 unit vial. Pharmacy claims for incobotulinumtoxinA (Xeomin®) will have quantity limits of 400 units every rolling 84 days.

Diagnosis Code Requirement

Prescriptions for onabotulinumtoxinA (Botox®) and incobotulinumtoxinA (Xeomin®) require an appropriate diagnosis code documented on the hard copy prescription by either the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Acceptable Diagnosis Codes for OnabotulinumtoxinA (Botox®)

ICD-10-CM Diagnosis Code(s)	Description
L74.510	Axillary Hyperhidrosis
G24.5	Blepharospasm
G24.3	Cervical Dystonia
G43.7*	Chronic Migraine (Prophylaxis)
N32.81	Overactive Bladder
H49*, H50*, H51*	Strabismus
G35	Upper or Lower Limb Spasticity Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper or Lower Limb Spasticity Associated with Cerebral Palsy
G81.1*	Upper or Lower Limb Spasticity Associated with Spastic Hemiplegia
G82.53	Upper or Lower Limb Spasticity Associated with Complete Quadriplegia
G82.54	Upper or Lower Limb Spasticity Associated with Incomplete Quadriplegia
G83.0	Upper Limb Spasticity Associated with Diplegia of Upper Limb
G83.1*, G83.2*, G83.3*	Spasticity Associated with Monoplegia of Upper or Lower Limb
I69.•31, I69.•32, I69.•33, I69.•34, I69.•39, I69.•41, I69.•42, I69.•43, I69.•44, I69.•49	Spasticity Associated with Monoplegia of Upper or Lower Limb due to Late Effects Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper or Lower Limb Spasticity Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
S14.0*, S14.1•5*, S14.1•6*, S14.1•7*	Upper or Lower Limb Spasticity Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury
N36.44, N31.9	Urinary Incontinence (Detrusor Overactivity Associated with Neurological Disease)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code

• - any ONE number or letter of a valid ICD-10-CM diagnosis code

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Acceptable Diagnosis Codes for IncobotulinumtoxinA (Xeomin®)

ICD-10-CM Diagnosis Code(s)	Description
G24.5	Blepharospasm
G24.3	Cervical Dystonia
K11.7	Chronic Sialorrhea
G35	Upper Limb Spasticity (ULS) Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper Limb Spasticity (ULS) Associated with Cerebral Palsy
G81.1*	Upper Limb Spasticity (ULS) Associated with Spastic Hemiplegia
G82.53	Upper Limb Spasticity (ULS) Associated with C5-C7 Complete Quadriplegia
G82.54	Upper Limb Spasticity (ULS) Associated with C5-C7 Incomplete Quadriplegia
G83.0	Upper Limb Spasticity (ULS) Associated with Diplegia of Upper Limb
I69.●●39	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb due to Late Effects of Cerebrovascular Disease
I69.●●59	Upper Limb Spasticity (ULS) Associated with Hemiplegia due to Late Effects of Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper Limb Spasticity (ULS) Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
G83.2*	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb
S14.0*, S14.1●●5, S1●●5	Upper Limb Spasticity (ULS) Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury (C5-C7)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code

● - any ONE number or letter of a valid ICD-10-CM diagnosis code

Hydrocodone Containing Agents

Prescriptions for hydrocodone containing drugs will be limited to:

- 45 units per 15 days for hydrocodone/acetaminophen;

- 30 units per 15 days for hydrocodone bitartrate capsule ER 12 hour;

- 15 units per 15 days for hydrocodone bitartrate tablet ER 24 hour; and

- 30 units per 15 days for hydrocodone/ibuprofen within a 30-day period.

If a prescriber chooses to exceed the 15-day quantity limit for hydrocodone, he/she must submit a Rx PA16 to the RxPA Unit.

NOTE: All Schedule II prescriptions require a valid diagnosis code to process. Hydrocodone claims will not be subject to the 15-day quantity limit when one of the diagnosis codes below is submitted.

ICD-10 Diagnosis Code(s)	Diagnosis
C00.*-C96.*	Cancer
Z51.5	Palliative Care

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

NOTE: The *POS User Guide* can be accessed by the below link or by visiting Section 37.5.1 for detailed billing instructions and override procedures.
     www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Lidocaine Patches (Lidoderm®)

Pharmacy claims for lidocaine patches (Lidoderm®) have a quantity limit of 30 patches every rolling thirty days.

Naltrexone Injection (Vivitrol®)

Pharmacy claims for naltrexone injection (Vivitrol® are subject to the following for reimbursement:

- Diagnosis code requirement;
- Age Limit;
- Quantity Limit; and
- Drug-Drug Interaction.

Diagnosis Code Requirement

The acceptable diagnosis code(s) for naltrexone injection (Vivitrol®) are listed below.

Medication	Diagnosis Description	ICD-10-CM Diagnosis Code
Naltrexone Injection (Vivitrol®)	Alcohol Dependence	F10.2*
	Opioid Dependence	F11.2*

* any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Age Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a minimum age requirement of 18 years old and older.

Quantity Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a quantity limit of 1 unit (380mg/vial dose kit) per 28 rolling days.

Drug-Drug Interaction

Pharmacy claims for naltrexone injection (Vivitrol®) prescriptions will deny if there is an active claim on the recipient's file for an opioid.   Pharmacy claims for opioid prescriptions will deny if there is an active claim on the recipient's file for naltrexone injection (Vivitrol®).

Opioids

Opioid prescription drugs have the following clinical edits:

- Diagnosis code requirement for all Schedule II narcotics;

- 15-day quantity limit for select opioids;

- 7-day quantity limit for select opioids for opioid naïve recipients;

- Maximum of 90 Morphine Milligram Equivalent (MME) per day; and

- Prior drug use required for long-acting opioids.

Opioid 15-day Quantity Limit

Pharmacy claims for opioids will be subject to a 15-day quantity limit. The opioid quantity limits per 15-days are listed in the chart below.

Opioid Quantity Limits, Units per 15 Days Supply within a 30 day period			
Description	**Dosage Form**	**Units / 15 days**	**Representative Brand**
Hydrocodone Bitartrate, Hydrocodone/Ibuprofen	Capsule ER 12 hr, Tablet	30 units	Zohydro ER®, Vicoprofen®
Hydrocodone Bitartrate	Tablet ER 24 hr	15 units	Hysingla ER®
Hydrocodone/Acetaminophen	Short Acting Tablet/Capsule	45 units	Lortab®, Vicodin®
Hydromorphone HCl	Short Acting Tablet	45 units	Dilaudid®
Hydromorphone HCl	Tablet ER 24 hr	15 units	Exalgo®
Meperidine	Tablet	45 units	Demerol®
Methadone	Tablet	45 units	
Morphine Sulfate	Tablet	45 units	
Morphine Sulfate	Capsule ER 24 hr	15 units	Avinza®
Morphine Sulfate	Capsule SR Pellet, Tablet SA	30 units	Kadian®, MS Contin®
Morphine Sulfate	Tablet ER	60 units	Arymo ER ®
Morphine Sulfate/Naltrexone	Capsule SR Pellet	30 units	Embeda®

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Opioid Quantity Limits, Units per 15 Days Supply within a 30 day period			
Description	**Dosage Form**	**Units / 15 days**	**Representative Brand**
Oxycodone HCl, Oxycodone, Oxycodone/Acetaminophen	Tablet SR 12 hr, Capsule ER 12 hr Tablet ER 12 hr	30 units	Oxycontin® Xtampza ER® Xartemis XR®
Oxycodone HCl, Oxycodone/Acetaminophen, Oxycodone/Aspirin	Tablet/Capsule	45 units	Roxicodone®, Endocet®, Percocet®, Roxicet®
Oxycodone/Ibuprofen	Tablet	14 units	
Oxymorphone HCl	Tablet	45 units	Opana®
Oxymorphone HCl	Tablet SR 12 hr	30 units	Opana ER®
Tapentadol	Tablet	45 units	Nucynta®
Tapentadol	Tablet ER 12 hr	30 units	Nucynta ER®
Tramadol HCl	Tablet	45 units	Ultram®
Tramadol HCl	Tablet ER 24 hr Capsule ER 24 hr	15 units	Ultram ER® ConZip®
Tramadol/Acetaminophen	Tablet	40 units	Ultracet®

Fentanyl Transdermal Patch Quantity Limits- Units per 30 Rolling Day Period					
Description	**Dosage Form**	**Route**	**Strength**	**Units/30 Rolling Days**	**Representative Brand**
Fentanyl	Patch	Transdermal	12, 25, 37.5, and 50 mcg/hr	10 units	Duragesic®
Fentanyl	Patch	Transdermal	62.5, 75, 87.5, and 100 mcg/hr	20 units	Duragesic®

NOTE: The *POS User Guide* can be accessed by the below link or by visiting Section 37.5.1 for detailed billing instructions and override procedures.
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Short-Acting Opioid 7-Day Quantity Limit (Opioid Naïve Recipients)

Short-acting opioids will be limited to a 7-day supply for opioid-naïve recipients. For this edit, opioid-naïve recipients are defined as those who have not had an opioid claim paid within the last 90 days. The following chart lists short-acting opioids and corresponding quantity limits for opioid-naïve recipients.

Description	Dosage Form	Units/7 days	Representative Brand
Codeine/Acetaminophen	Tablet	28	Tylenol® with Codeine
Hydrocodone/Acetaminophen	Tablet	28	Lortab®, Vicodin®
Hydrocodone/Ibuprofen	Tablet	28	Vicoprofen®
Hydromorphone HCl	Tablet	28	Dilaudid®
Meperidine	Tablet	28	Demerol®
Morphine Sulfate	Tablet/Capsule	28	
Oxycodone		28	Roxicodone®
Oxycodone/Acetaminophen		28	Endocet®, Percocet®, Roxicet®
Oxycodone/Aspirin		28	
Oxycodone/Ibuprofen	Tablet	28	
Oxymorphone HCl	Tablet	28	Opana®
Tapentadol	Tablet	28	Nucynta®
Tramadol	Tablet	28	Ultram®
Tramadol/Acetaminophen	Tablet	28	Ultracet®

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
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Morphine Milligram Equivalent (MME) Limit

The Morphine Milligram Equivalent (MME) per day for all active opioid prescriptions for a recipient will be calculated. For each recipient, the cumulative daily MME for all active opioid prescriptions will be limited to a maximum of 90 MME per day.

Buprenorphine products for the treatment of Substance Use Disorder (SUD) will not be included in the MME limit.

NOTE: The *POS User Guide* can be accessed by the below link or by visiting
 Section 37.5.1 for detailed billing instructions and override procedures.
                www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Long-Acting Opioid Prior Use Requirement

Pharmacy claims for an incoming prescription for a long-acting opioid will deny if there is not a paid claim for either a short-acting or long-acting opioid medication within the previous 90 days.

Opioid Quantity and MME Limit Exemptions

All Schedule II opioid prescriptions require a valid diagnosis code to process. There are exemptions to the edits for quantity limits and maximum daily MME limits for opioids. Pharmacy claims for opioid products will not be subject to the opioid quantity limits or 90 MME per day limit when the recipient has a diagnosis of burn, sickle cell crisis, cancer and/or palliative care. The exemptions to the opioid quantity and MME limit are listed in the chart.

ICD-10-CM Diagnosis Code	Description
T20.2*	Burn of second degree of head, face, and neck
T20.3*	Burn of third degree of head, face, and neck
T20.6*	Corrosion of second degree of head, face, and neck
T20.7*	Corrosion of third degree of head, face, and neck
T21.2*	Burn of second degree trunk
T21.3*	Burn of third degree trunk
T21.6*	Corrosion of second degree of trunk
T21.7*	Corrosion of third degree trunk
T22.2*	Burn of second degree of shoulder and upper limb, except wrist and hand
T22.3*	Burn of third degree of shoulder and upper limb, except wrist and hand

ICD-10-CM Diagnosis Code	Description
T22.6*	Corrosion of second degree of shoulder and upper limb, except wrist and hand
T22.7*	Corrosion of third degree of shoulder and upper limb, except wrist and hand
T23.2*	Burn of second degree of wrist and hand
T23.3*	Burn of third degree of wrist and hand
T23.6*	Corrosion of second degree of wrist and hand
T23.7*	Corrosion of third degree of wrist and hand
T24.2*	Burn of second degree of lower limb, except ankle and foot
T24.3*	Burn of third degree of lower limb, except ankle and foot
T24.6*	Corrosion of second degree of lower limb, except ankle and foot
T24.7*	Corrosion of third degree of lower limb, except ankle and foot
T25.2*	Burn of second degree of ankle and foot
T25.3*	Burn of third degree of ankle and foot
T25.6*	Corrosion of second degree of ankle and foot
T25.7*	Corrosion of third degree of ankle and foot
D57.0	Hb-SS disease with crisis
D57.00	Hb-SS disease with crisis, unspecified
D57.01	Hb-SS disease with acute chest syndrome
D57.02	Hb-SS disease with splenic sequestration
D57.21	Sickle-cell/Hb-C disease with crisis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
D57.212	Sickle-cell/Hb-C disease with splenic sequestration
D57.219	Sickle-cell/Hb-C disease with splenic sequestration
D57.41	Sickle-cell thalassemia with crisis
D57.411	Sickle-cell thalassemia with acute chest syndrome
D57.412	Sickle-cell thalassemia with splenic sequestration
D57.419	Sickle-cell thalassemia with crisis, unspecified
D57.81	Other sickle-cell disorders with crisis
D57.811	Other sickle-cell disorders with acute chest syndrome

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ICD-10-CM Diagnosis Code	Description
D57.812	Other sickle-cell disorders with splenic sequestration
D57.819	Other sickle-cell disorders with crisis, unspecified
C00.*-C96.*	Cancer
Z51.5	Palliative Care

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code.

Opioid (Oral) Liquids

Prescriptions for opioid oral liquids will have a quantity limit of 180 mls or a 7-day supply, whichever is less.

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 30 days. Unless otherwise specified, quantity limits apply to all strengths of an agent.

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

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Almotriptan Maleate	Tablet	12 units
Eletriptan HBr	Tablet	6 units
Frovatriptan Succinate	Tablet	9 units
Naratriptan HCl	Tablet	9 units
Rizatriptan Benzoate	Tablet, Tablet rapid dissolve	12 units
Sumatriptan Succinate (Nasal)	Exhaler Powder	1 kit* (package size = 16)
Sumatriptan Succinate/ Naproxen Na	Tablet	9 units
Sumatriptan Succinate	Tablet	9 units

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
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 or in the pharmacy's electronic record keeping system the reason for service code, professional service code and result of service code with the POS submission.

Quantity Limitations

Prescriptions payable under the Medicaid Program are limited as follows:

Maximum Allowable Quantities

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

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.

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 10-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.

- "PRN" prescriptions are those prescriptions that patients utilize on an "as needed" basis. For "prn" prescriptions, thirty units or a 10-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.

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Co-Payment Exemption

Long-term care recipients are exempt from co-payments and monthly prescriptions limits.

NOTE: Refer to Chapters 26: Intermediate Care Facilities for Individuals with Intellectual Disabilities and 34 – Nursing Facilities of the *Medicaid Services Manual* for detailed information regarding recipients in LTC facilities.

Over the Counter Drugs

LTC facilities are responsible for providing all over the counter (OTC) drugs to Medicaid recipients. OTC drugs are part of the per diem for LTC recipients.

Over the Counter Drugs for Preventive Care

Select OTC agents for preventive care will be reimbursed when:

- The prescribing practitioner issues the recipient a prescription for the preventive care OTC agent; and

- The recipient meets the criteria to obtain the preventive care OTC agent.

OTC Drug	Medicaid Recipient	Preventive Care
Aspirin 81 mg	Women greater than 12 years of age Men greater than 44 years of age	Cardiovascular disease, colorectal cancer, and preeclampsia prevention
Folic Acid 0.4mg and 0.8mg	Women ages 12-54	Pregnancy planning
Vitamin D 400 IU	Women and men greater than 64 years of age	Fall prevention

Age Restriction

Pharmacy claims submitted for recipients outside of the age limits listed above will deny at POS.

Days' Supply

Quantities of 100 units with 100 days' supply will be allowed to process for payment.

Copayment

Pharmacy claims for the select preventive care OTC agents listed above will be exempt from copayment.

Coverage for aspirin 81 mg will be continued for recipients greater than 79 years old; however, these pharmacy claims will be subject to copayment.

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 "Drugs with Special Payment Criteria/Limitations; Diabetic Testing Supplies" in this section 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.

Emergency Kits

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

Outpatient Drugs Covered by Medicare Part B

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 37.5.7 Medicare Prescription Drug Coverage for detailed information on drugs covered by Medicare Part B.

Drug Services for Hospice Recipients

"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 recipient'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.
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 provider 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 *Medicaid Services Manual* for detailed information.

PHARMACY PROVIDER ENROLLMENT AND PARTICIPATION GUIDELINES

This section describes pharmacy provider qualifications, enrollment and provider records, how the provider can make changes to the provider record, Internal Revenue Services (IRS) reporting, provider rights and responsibilities, record keeping requirements, billing agents, and point of sale (POS) enrollment.

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on provider enrollment and requirements, including general standards for participation. (See Appendix N for information on accessing Chapter 1.)

Provider Qualifications

A provider must be enrolled in the Medicaid Program and meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement through the Louisiana Medicaid Program.

The Medicaid Program reimburses pharmacies, not individual pharmacists, for the provision of prescribed drugs.

A pharmacy is a facility licensed in accordance with 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."

To enroll in the Medicaid Program, 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:LIII.1301 and §1701.

Administering Pharmacists

Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy may administer the influenza vaccine. Pharmacists who have this authority are

required to obtain a Medicaid provider number in order for the enrolled pharmacies to be reimbursed for the administration of this vaccine. (Refer to Section 37.14 Medication Administration of this manual chapter for detailed information on medication administration, including vaccinations.)

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 as a dispensing physician with the Louisiana Board of Medical Examiners;

- 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. (Refer to Section 37.6 Reimbursement for Services of this manual chapter for detailed information on reimbursement.)

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; and

- A provider cannot deny services to a recipient solely due to the presence of third party insurance coverage or the recipient's inability to pay a Medicaid co-payment.

Medical Assistance Program Integrity

The Louisiana Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.1-46 and 440.3, imposes terms and conditions on Medicaid providers. See Chapter 1 of the *Medicaid Services Manual*, Section 1 for information concerning the terms and conditions.

Prescription Provider Fee

A prescription fee shall be paid by each pharmacy and dispensing physician for each outpatient 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 the Medicaid Program.

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

Professional Dispensing Fee Survey

All pharmacy providers must complete the professional dispensing fee surveys. These surveys are conducted periodically to determine the accuracy of the maximum allowable overhead cost (professional dispensing fee).

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.

Solicitation

In accordance with R.S. 46:438.2, 46:438.4 and 42 U.S.C.1320a-7b, it is unlawful to 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.

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.

All medical and billing records must be made available to official representatives of the Medicaid Program upon request. The representative making the request must possess proper identification.

Health Insurance Portability and Accountability Act

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations 42 CFR 447.202.

LDH is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and is exempt from the HIPAA privacy regulations regarding records for any claims for which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. The 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.

Record Keeping Requirements

The provider must retain all medical, fiscal, professional, and business records on all services provided to all Medicaid recipients for a period of six years from the date of service. The records must be accessible, legible and comprehensible. If the provider is being audited, records must be retained until the audit is complete, even if six years is exceeded.

These records may be paper, film, or electronic, except as otherwise required by law or Medicaid policy.

Types of Records That Must be Retained

The following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):

- Medicaid claim forms and any documents that are attached;

- Professional records, such as patient treatment plans and patient records;

- Prior authorization and service authorization information;

- Prescription records for Medicaid and other third party payors (including Medicare, private pay and cash);

- Business records, such as accounting ledgers, financial statements, purchase/acquisition records, invoices, inventory records, check registers, canceled checks, sales records, etc.;

- Tax records, including purchase documentation; and

- Provider enrollment documentation.

Requirements for Prescription Record

A patient record must be maintained 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.

All records must be maintained in accordance with the Louisiana Board of Pharmacy regulations.

Right to Review Records

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records without prior notice. This includes, but is not limited to, the following governmental authorities: LDH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services (DHHS). Providers must allow access to all Medicaid recipient records and other information that cannot be separated from the records.
If requested, providers must furnish, at the provider's expense, legible copies of all Medicaid related information to LDH, federal agencies or their representatives.

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.

Prohibition of Reassignment of Provider Claims

Medicaid payments cannot be reassigned to a factor. A factor is defined as 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.

Out-Of-State Providers

Enrollment Criteria

In accordance with LAC 50:I.701 (B), out-of-state pharmacies may enroll as providers in the Louisiana Medicaid Program to secure reimbursement for a specific claim or claims **only** under the following circumstances:

- When an emergency arises from an accident or illness;

- When the health of the individual would be endangered if he/she undertook travel or if care and services are postponed until his/her return to Louisiana;

- When it is general practice for residents of a particular locality to use medical resources in the medical trade 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.

If services are provided to a Medicaid recipient in accordance with the criteria detailed above, enrollment will be allowed to obtain a Medicaid provider number to secure payment of the claim. However, this Medicaid provider number will only be active to finalize the claim at issue, not to allow the out-of-state pharmacy to maintain continuous and active enrolled provider status.

In no event can an out-of-state Medicaid provider number be active for 12 months from the date of service to secure payment of a single claim.

Medicare Crossover Claims

Out-of-state pharmacy providers will be allowed continuous Medicaid enrollment for crossover claims only. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in Louisiana's Medicaid Program. When enrolling in the Medicaid Program, the out-of-state pharmacy must indicate that crossover billing is requested and submit a copy of their Medicare certification letter.

Enrollment Forms

Enrollment for the payment of a claim or claims meeting the above-referenced criteria, or for the payment of Medicare crossover claims, providers need to complete the "Basic Provider Enrollment Packet for Entities/Businesses" and the provider type-specific packet "26 Pharmacy". (See Appendix N for information regarding provider enrollment).

Recipients Out of the Country

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

Provider Enrollment

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

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 the *Medicaid Services Manual*, Chapter 18 Durable Medical Equipment for detailed information.

Medicare Enrollment

Pharmacies must contact the Medicare regional carrier to enroll as a Medicare provider. (See Appendix N for contact information.)

Refer to Section 37.7 Medicare Prescription Drug Coverage of this manual chapter for detailed information on Medicare prescription drug coverage.

Enrollment Process

The provider must submit a completed Medicaid enrollment package to the Medicaid fiscal intermediary (FI). The provider will be notified in writing by the FI when enrollment is complete. Refer to Appendix N for information on how to obtain provider enrollment forms.

The enrollment packet must include the following documents:

- 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 (located in provider type-specific packet 26-Pharmacy);

- Copy of a voided check from the account where funds are to be electronically deposited (deposit slips are not accepted); and

- Copy of pharmacy license from the Louisiana Board of Pharmacy.

NOTE: If the request is for retroactive coverage, the license must be submitted that covers the retroactive period of coverage.

Out-of-State Pharmacy

When a pharmacy is located out-of-state and mails or delivers drugs to the state of Louisiana, the Louisiana Board of Pharmacy permit must be submitted along with the provider's Board of Pharmacy permit from their home state.

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.

Effective Date of Enrollment

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.

Providers shall not bill Medicaid prior to receipt of confirmation that they are successfully enrolled. Reimbursement will not be provided prior to the provider's effective date of enrollment.

Licensure and Permits

Prescribed drug services providers must submit complete and legible copies of the required licenses and permits with the enrollment applications.

National Provider Identifier (NPI)

As a provision of the Health Insurance Portability and Accountability Act (HIPAA), providers must obtain and use their NPI number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e., non-emergency transportation, case management, and some home and community-based waiver services). Although HIPAA regulations address only electronic transactions, the Medicaid Program requires both the NPI number and the legacy seven-digit Medicaid provider number on hard copy claims.

Termination

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.

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

A provider must submit a new application, provider agreement, and other required forms to the fiscal agent to request reinstatement after a termination or suspension period. 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.

Point of Sale Enrollment

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 with a response to the pharmacy within seconds of submission that indicates the recipient's eligibility, and whether the claim is payable or rejected.

Application Forms

Providers must obtain authorization to submit claims via POS by completing the required forms included in the provider enrollment packet:

- Medicaid Pharmacy POS Provider Certification;

- Medicaid POS Agreement; and

- Pharmacy Provider Enrollment Amendment POS Enrollment.

Annual Re-certification

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

Provider Record

A provider record is created by the Medicaid FI for each provider based on the information from the initial enrollment application.

Provider Identification (ID) Number

A seven-digit provider number is assigned by the FI when the provider has been approved for enrollment in the Medicaid Program. The provider ID number is used to identify the provider for billing and correspondence purposes. The provider ID number must be included on all correspondence to the FI or the Medicaid office.

Reporting Changes

All changes must be reported promptly to the FI. Information in a provider's record can only be changed by submitting a written, signed and dated request on the provider's letterhead stationery to the FI. (See Appendix N for contact information for Provider Enrollment).

NOTE: All correspondence must include the Medicaid provider number.

Change of Address

The provider must notify the FI 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 of the change.

Medicaid correspondence is sent to the billing address listed on the provider record.

Change in Telephone Number

The provider must notify the FI of any 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.

Change in Electronic Funds Transfer

The provider must notify the FI in writing **at least 60 days in advance of any change in financial institutions or accounts**. Failure to do so may result in lack of payment.

Change in Federal Tax ID/ Social Security Number

A new provider enrollment application must be completed if a provider's federal tax identification/social security number changes.

Provider No Longer Accepts Medicaid

The provider must notify the FI should the pharmacy no longer accept Medicaid for any reason, including closing the business.

Change of Ownership

The provider must notify the FI immediately of a change in ownership. Failure to do so may result in departmental review. (See the *Medicaid Services Manual*, Chapter 1, Section 1.1, for a full description of Change in Ownership.)

The Pharmacy Program defines change of ownership based on the Louisiana Board of Pharmacy's definition. Therefore, if a new Board of Pharmacy permit is issued due to a 50 percent or more shift in ownership, the provider is required to obtain a new Medicaid provider number. The provider is also required to obtain a new NPI to be used with the new Medicaid provider number.

Reporting to the IRS

Federal law requires Medicaid to report to IRS all payments made during the calendar year to any provider under a tax ID number.

REIMBURSEMENT FOR PHARMACY SERVICES

This section describes the methodologies that Medicaid uses to reimburse for prescribed drugs.

Reimbursement Methodology

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:

- National Drug Acquisition Cost (NADAC) plus the professional dispensing fee;

- If NADAC is not available, use the Wholesale Acquisition Cost (WAC) plus the professional dispensing fee;

- Federal Upper Limit (FUL) plus the professional dispensing fee; or

- Providers' usual and customary charge to the general public.

340B Purchased Drugs

Payment for self-administered drugs that are purchased by a covered entity through the 340B program shall be made at the 340B actual acquisition cost, which can be no more than the 340B ceiling price, plus the professional dispensing fee.

National Drug Code (NDC) System

Drugs are identified by the National Drug Code (NDC). The NDC is an 11-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 11-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, a violation of Medicaid policy and may be recouped.

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

Medicaid uses ingredient costs that are supplied and updated each week by a nationally recognized compendia.

Professional Dispensing Fee

The pharmacy provider will be reimbursed at the appropriate ingredient cost plus the professional dispensing fee or the usual and customary charge, whichever is less.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid enrollees will not exceed $10.99 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid enrollees and obtained through the Public Health Service 340B Program will be $10.99 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

Provider Fee

All pharmacy providers and dispensing physicians are responsible for a ten cent (10¢) provider fee on **all** prescriptions they fill. The Medicaid professional dispensing fee does not include the provider fee mandated under state law.

Usual and Customary Charges

Federal regulations governing the Medicaid Program require that participating providers agree to charge no more for services to eligible beneficiaries than they charge for similar services to the general public.

In implementing this regulation, the Medicaid Program states that providers in the Pharmacy Program may not charge a higher professional dispensing fee, on the average, for Medicaid beneficiary's' prescriptions than is charged for non-beneficiary's' prescriptions. 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.

Federal Upper Limits (FUL) Regulations

Federal Upper Limit 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.

When a prescriber indicates the brand name product is medically necessary for a particular beneficiary, and certifies that in his professional judgment the generic equivalent is not indicated, 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 unless the prescription is submitted electronically;

- The certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription or submitted electronically with prescriber approval;

- The standard phrases written by the prescriber on the prescription shall 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;

- 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; and

- Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable.

Co-Payments for Prescription Services

The co-payment will be paid by the beneficiary 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 beneficiary 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.

Co-payment Schedule

The following is the prescription co-payment schedule:

Monthly Income	Copay
When 5% of family's monthly income is spent on copays	$0
Medication Cost	**Copay**
$10.00 or less	$0.50
$10.01 - $25.00	$1.00
$25.01 - $50.00	$2.00
$50.01 or more	$3.00

Co-payment Exemptions

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

- Family planning services and supplies;

- Emergency services;

- Individuals younger than 21 years old;

- Pregnant women;

- Individuals who are inpatients in long-term care facilities or other institutions;

- Native Americans;

- Alaskan Eskimos;

- Women who are receiving services on the basis of breast and cervical cancer;

- Beneficiaries receiving preventive services such as the following:

  - Aspirin 81 mg for women ages 12-19 years of age and men ages 45-79 years of age;

  - Folic acid 0.4mg and 0.8mg for women ages 12-54 years of age; and

  - Vitamin D 400 IU for women and men ages 65 and older;
- Beneficiaries receiving hospice services; and

- Beneficiaries with waiver type cases.

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

Other Co-payment and 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 beneficiary'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 beneficiary's co-payment liability.

The pharmacy provider shall collect a co-payment for each drug dispensed 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 beneficiary. 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.

In accordance with CFR 447.56, co-payments of Medicaid household members are not to exceed five percent of the family income.

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

Medicare Crossover Claims

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.

Third Party Liability Claims

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.

PRESCRIBERS

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 and a National Provider Identifier (NPI) as a condition for prescription reimbursement by the program.

Qualified Prescribers

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 who are authorized to prescribe under state law and have prescriptive authority from his/her licensing board. A qualified prescriber must be an enrolled Medicaid provider.

Prescriber Numbers

The integrity of the Pharmacy Program is dependent upon utilizing accurate data.

Each Medicaid prescriber is required to have an individual NPI and a Medicaid provider/prescriber number when submitting pharmacy claims for payment. 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 identification number in the claim submission. The system will only allow claims to be submitted with a seven-digit individual prescribing practitioner Medicaid identification number.

Prescribing practitioners who deliver health care services in state-operated mental health clinics, developmental centers and public health clinics must also have an assigned individual prescriber identification number and a NPI in order for the prescription to be reimbursed by the Medicaid Program.

Individual prescriber identification numbers are issued to all interns, residents and fellows currently in training.

Prescribers Who Are Not Medicaid Program Providers

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

If a prescribing practitioner does not have an individual Medicaid provider number, he/she should contact the fiscal intermediary (FI) Provider Enrollment Unit. (See Appendix N for contact information.)

Sanctioned Prescribers

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

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.

Accessing Prescriber Numbers

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 Louisiana Medicaid website. This listing is updated monthly. (See Appendix N for information on accessing the website.)

Pharmacy providers may verify prescriber numbers by calling the Point of Sale (POS) Pharmacy Help Desk. (See Appendix N for contact information.)

MEDICARE PRESCRIPTION DRUG COVERAGE

This section describes the coordination of benefits between the Medicare Program and the Louisiana Medicaid Program for dual-eligibles.

Medicare

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.

For additional information concerning the Medicare Program, visit CMS' website. (See Appendix N for contact information.)

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.

Medicaid will only pay a crossover claim for recipients who are Qualified Medicare Beneficiaries (QMBs) when the service is covered by Medicaid. Other claims will deny as "non-covered".

Coinsurance and deductibles are reimbursed through the Point of Sale (POS) system for covered Medicare Part B drugs and supplies when a dual-eligible individual is enrolled in the 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.

Medicare Crossover Claims Submission

The provider must send claims for service provided to dual-eligible recipients to the Medicare carrier or intermediary for processing. Medicare will send the provider an explanation of

Medicare benefits after the claim is processed. 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 the 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 (Durable Medical Equipment Regional Carrier).

The provider may contact the National Supplier Clearinghouse. (See Appendix N for contact information.)

General Medicare Part B Crossover Reimbursement Policies

Provider Participation

A provider must be enrolled as a Medicaid provider in order to submit Medicare crossover claims.

Time Limits

The time limit for filing crossover claims with the Medicaid Program is six months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (12 months from the date of service).

Reimbursement

Payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the Average Sales Price (ASP).

Mandatory Assignment on all Drugs

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.

Assignment is an agreement between the provider and the recipient. The provider agrees to accept the Medicare-approved amount as full payment for covered items or services.

If the provider accepts assignment, the beneficiary pays only 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.

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.

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.

Coordination of Benefits with Part B

Pharmacy claim reimbursement must be coordinated with Medicare Part B and any private insurance plan in which a recipient is enrolled. Medicare may be primary or secondary to a private insurance plan. To determine whether Medicare is primary, contact Medicare. (See Appendix N for contact information.)

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.

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 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 the Healthcare Common Procedure Coding System (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 recipient 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 48-hour dosage regimen.

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

Medicare Part B covers diabetic supplies (lancets, lancet devices, glucose control solutions and blood glucose strips). Glucometers are covered in some instances.

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.

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 the state of Louisiana is Novitas Solutions, Inc. (See Appendix N for contact information.)

Medicare Part D Outpatient Drug Coverage

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.

Medicaid Coverage for Other 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 Part D eligibles, Medicaid will be required to cover the excluded drugs for full benefit dual-eligibles.

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

Prescription Drug Program (PDP) or Medicare Advantage Plan (MA PD) non-preferred drugs are not covered, as there is a Medicare appeal process to obtain these medications.

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

- 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;
    - Urinary pH modifiers (Phosphorus); and

- Nonprescription drugs:

    - Sodium Chloride inhalation agents;
    - Contraceptives, topical;
    - Urinary pH modifiers;
    - Antihistamines (Diphenhydramine only);
    - 2nd Generation Antihistamines; and
    - 2nd Generation Antihistamine – Decongestant Combinations.

The Medicaid Program 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 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 Part D excluded drugs that are covered by Medicaid.

THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

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

Third Party Liability

Federal regulations and applicable state laws require that third party resources be used before Medicaid is billed, as Medicaid by law, is intended to be the payor of last resort. Third party liability (TPL) 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.

Coordination of Benefits

Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale (POS) 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 maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

Pharmacy Providers' Roles

The provider should inquire if the recipient has private insurance coverage with prescription benefits. This information is entered in the recipient's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company(ies). 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 into the Louisiana Medicaid website to view the Medicaid Eligibility Verification System (MEVS). Providers may view the recipient's other insurance company and Medicaid carrier code number.

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 Louisiana Department of Health's TPL Unit with updated traditional Medicare insurance coverage (see Appendix N for contact information).

Urgent TPL requests are defined as the inability of a recipient to have a prescription filled or the inability of a recipient to access immediate care because of the incorrect third party insurance coverage.

Urgent private insurance and Medicare Advantage Plan update requests for recipients enrolled in a Healthy Louisiana plan for pharmacy and medical benefits must be submitted to the recipient's Healthy Louisiana plan.

Urgent private and urgent Medicare Advantage Plan update requests for recipients whose Pharmacy benefit is paid by Fee-for-Service Medicaid (Legacy) must be submitted to Louisiana Department of Health's TPL contractor, HMS.

NOTE: See Appendix D, POS User Guide of this manual chapter for claim submission details.

Coordination of Benefits Exemptions

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 individuals under age 21; and

- Pharmacy claims are deemed preventive care for pregnant women.

NOTE: Documentation of court ordered medical child support or preventative care on the hard copy prescription or in the pharmacy's electronic recordkeeping system by the pharmacist is required for the above circumstances.

Exemptions to Medicaid Program Restrictions

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.

Claims for Recipients with Multiple Insurance Coverage

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.

Override Capabilities and Codes

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

NOTE: See Appendix D, POS User Guide of this manual chapter for detailed billing information.

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

Override codes should be used under the following conditions:

- 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 the pharmacy with other insurance information; or

  - 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 the claim 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;

  - Recipient has court ordered medical child support;

  - Preventative care for a recipient under the age of 21 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; or

- Recipient has insurance coverage, but the pharmacy and/or physician is out of the insurance company's network.

CLAIM SUBMISSION

This section describes:

- Claim submission requirements, including expression of drug quantities;

- Overrides;

- Time limits for claim submission; and

- Methods of claim submission.

National Drug Code

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an 11-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.

Use of NDCs

The provider must enter the entire 11-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.

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 may contact the Pharmacy Benefits Management (PBM) Help Desk and request that the drug be added. Drugs may be added in accordance with program policy and/or manufacturer participation in the federal drug rebate program. (See Appendix N for contact information.)

Drug Quantities and Unit of Measurement

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;
- Milliliter (ml); or
- Gram (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).

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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; and

- 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/her 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).

Billing Questions

Billing questions regarding the correct unit type should be directed to the fiscal intermediary (FI) from 8:00am to 5:00pm, Monday through Friday. (See Appendix N for contact information.)

Prescriber Numbers

Prescription claims must indicate a valid individual Louisiana Medicaid prescriber number or National Provider Identifier (NPI) until only the NPI is required. Group practice numbers, hospital numbers and clinic numbers are not acceptable.

NOTE: See Section 37.4 Prescribers of this manual chapter for detailed prescriber policy.

Diagnosis Codes

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

NOTE: See Section 37.5 Covered Services, Limitations and Exclusions of this manual chapter for specific program policy involving diagnosis codes.

Overrides

Listed below are the detailed policies regarding overrides. Refer to Appendix D POS User Guide for details regarding claims submission requiring overrides.

Federal Upper Limits /Louisiana Maximum Allowable Cost Limitations

A prescriber may certify that a specified brand is medically necessary for a particular recipient. The Federal upper limit (FUL) or Louisiana Maximum Allowable Cost (LMAC) limitations for that medication will not apply.

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 continued in the prescriber's handwriting. The only acceptable phrases are "brand necessary" or "brand medically necessary".

NOTE: See "Multiple Source Drugs" in Section 37.6 Reimbursement for Services of this manual chapter for detailed information.

Prescriptions Limit

The Medicaid Program has a four prescription monthly limit. The 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"; and

- • A valid numeric diagnosis code that directly relates to each drug prescribed that is over the four prescription limit. (A literal description is not acceptable in lieu of a diagnosis code.)

Early Refills

If the recipient has requested the same medication at the same pharmacy five or more days early for a 30-day supply, or prior to 85 percent of medication being utilized, a claim is denied for

early refill.   Narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication has been utilized.   This translates into a two-day window based on a 30-day supply.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a recipient'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 POS User Guide for detailed claims filing instructions.

Ingredient Duplication

A claim denial will occur as the recipient 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, recipient 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.

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

Duration of Therapy

The Pharmacy Program has duration of therapy modules for the H2 antagonists, proton pump inhibitors (PPIs), sucralfate and Hepatitis C medications.

NOTE: See Section 37.5 Covered Services, Limitations and Exclusions and Appendix D Point of Sale User Guide of this manual chapter for detailed information.

Therapeutic Duplication

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 active prescriptions on file to deny for therapeutic duplication.

- First and second generation antihistamines and first 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 to be 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: See Section 37.5 Covered Services, Limitations and Exclusions and Appendix D the POS User Guide of this manual chapter for detailed claims filing instructions.

Unnecessary Drug Therapy

The Pharmacy Program has an unnecessary drug therapy module for the use of celecoxib (Celebrex®), armodafinil (Nuvigil®), and modafinil (Provigil®).

A valid diagnosis code is required, as well as a valid condition, warranting the COX-2 selective agent, celecoxib (Celebrex®), and armodafinil (Nuvigil®, and modafinil (Provigil®). 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: See "Prospective Drug Utilization Policies/Limits/Edits" in Section 37.5 Covered Services, Limitations and Exclusions of this manual chapter for detailed information.

Drug/Drug Interaction

A valid 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 POS claim.

Coordination of Benefits

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

NOTE: See "Override Capabilities and Codes" in Section 37.8 Third Party Liability/Coordination of Benefits of this manual chapter 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: See Appendix D POS User Guide of this manual chapter for detailed claims filing instructions.

Age and Gender Overrides

Some drugs have age and/or sex restrictions.

Pharmacy providers should contact the Pharmacy Program to address questions regarding age or sex restrictions. (See Appendix N for contact information.)

NOTE: See "Drugs with Special Payment Criteria/Limitations" in Section 37.5 Covered Services, Limitations and Exclusions for other criteria and Appendix D POS User Guide for detailed billing information.

Maximum Dosage

Selected medications have maximum dosage limits.   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.

Quantity Exceeds Program Maximum

Pharmacy claims for selected medications used in the management of pain are subject to maximum quantities.   Quantity limits are cumulative, based on a rolling days' supply and apply to all strengths of an agent.   Selected medications may be eligible for an override with prescriber authorization and documentation.   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 or in the pharmacy's electronic recordkeeping system.   The pharmacist should reference the POS User Guide for detailed claims filing instructions.

Most prescriptions for recipients who have confirmed diagnosis of cancer are exempt from quantity limits for pain medications.   All prescriptions for Schedule II narcotic agents require a 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 (PA) Emergency

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

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a 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 prescription (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.

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.

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 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 three-day supply and refills for the dispensing of the non-preferred products are not permitted. The recipient's practitioner must contact the PA Unit to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Lock-In Emergency

This override is provided because the Louisiana Department of Health (LDH) recognizes that there may 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 the Lock-In provider. Payment will be made to any pharmacist enrolled in the Medicaid Program 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.

The notation "Emergency 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: See Section 37.17 Lock-In Program of this manual chapter for detailed information.

Types of Pharmacy Claims

Types of Claim Submissions

Providers can submit prescribed drug claims through the POS 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.

Point of Sale Claim Submission

Medicaid pharmacy providers can submit Medicaid claims through a LDH 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.

Features of POS

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

The POS system is available 24 hours per day, seven days per week, except for scheduled downtime for system maintenance.

Authorization to Use POS

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

NOTE: See "Point of Sale (POS) Enrollment" in Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines in this manual chapter for information on provider enrollment.

Electronic Claim Submission (BATCH)

Providers interested in using the NCPDP 1.2 Batch version must contact the POS Help Desk. Testing and approval are required. (See Appendix N for contact information)

Hard Copy Submission

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

Ordering the Claim Forms

NCPDP Universal Claim Forms may be purchased from Communi Form, LLC. (See Appendix N for contact information.)

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 to the FI.

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 Medicaid Management Information Systems within LDH 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. (See Appendix N for contact information.)

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.
"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: See Appendix G of this manual chapter for an example of the Universal Claim Form and billing instructions.

Claim Adjustments

From time to time some claims submitted and paid require adjustments. This can be done through the POS claim reversal process, which involves reversing the incorrect claim and resubmitting a new, corrected claim via POS. 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.

In some instances, it is necessary to submit a hard copy adjustment claim form.

NOTE: See Appendix D POS User Guide of this manual chapter for instructions for both types of claim adjustments.

NOTE: See Appendix H of this manual chapter for Form 211 Drug Adjustment Form and instructions for completion.

Time Limit for Submission of Medicaid Claims

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.

Twelve Month Filing Limit

A claim for services rendered must be received by the Department or its fiscal intermediary no later than 12 months from the date of service.

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 not the fault of the provider 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 12 months of the date of service.

The time limit for filing Medicare crossover claims to the Medicaid Program is six months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (12 months from the date of service).

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

- Proof of retroactive eligibility.

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.

Billing for Spend-Down Medically Needy Recipients

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.

CLAIMS PROCESSING/PAYMENTS

Claims for Medicaid reimbursement are processed by the Medicaid fiscal intermediary (FI). 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.

Claims Processing

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 the FI. (See Appendix N for contact information.)

Claim Adjudication

The system edits the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition of Claim

A claim disposition can be:

- Paid - payment is approved in accordance with program criteria; or

- 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.

Processing Time Frames

POS claims submitted by the end of the day on Thursday typically appear as adjudicated/pended on the provider's remittance advice (RA) the following Tuesday. Payments are made to the provider based upon the Louisiana Department of Health' (LDH) payment guidelines. Paper claims are processed for adjudication within 10 to 30 days.

POS Claims

Pharmacy claims are processed through a LDH approved switch vendor through the POS 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 POS processing.

NOTE: Refer to Appendix D of the POS User Guide of this manual chapter for comprehensive information.

Paper Claims

Paper claims are screened for completion. If information is missing, the claim will not be entered into the system and 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 RA. Paper claims should be resubmitted if the services meet the criteria for payment.

Remittance Advice

The RA plays an important communication role between the provider, the Medicaid Program, and the FI. Aside from providing a record of transactions, the RA 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 an adjudicated claim.

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 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

Internal Control Number

At the end of each claim line is the 13-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 13-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 FI internal purposes

Positions 9-11:   Sequence Number - for FI internal purposes

Positions 12-13:   Number of Lines within Claim

                    00 = First line
                    01 = Second line
                    02 = Third line, etc.

Copies of the five most current weeks' RAs are available on the Louisiana Medicaid website's password-protected section, "Weekly Remittance Advices".

Electronic Remittance Advice

The Electronic Media Claims (EMC) Department 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 RAs transmitted from the FI and posted to accounts electronically. Further information may be obtained by calling the FI. (See Appendix N for contact information.)

Remittance Advice Breakdown

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, providers should look carefully at the heading under which the claims appear to assist with the reconciliation process.

Claims appearing under the heading, "Claims in Process", indicate claims that have been received by the FI, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims."

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.

When providers choose to submit adjustment/void forms for refunds, 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 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, Surveillance and Utilization Review Subsystem (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.);

- **Recoupment Bypassed by LDH**;

- **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. Messages include, but are not limited to the following:

- Updates to program policy;

- Changes in participating manufacturers in the federal rebate program; and

- Changes in the Federal Upper Limits (FULs) and Louisiana Maximum Allowable Costs (LMACs).

Help Desk

POS information is available to Pharmacy providers between 8:00 a.m. and 5:00 p.m. Monday through Friday by contacting the FI's POS Helpdesk. (See Appendix N for contact information.)

PUBLIC HEALTH SERVICES 340B DRUG PRICING PROGRAM

The Drug Rebate program was established in 1990. The Veterans Health Care Act of 1992 established the 340B Drug Pricing Program through the enactment of Public Law 102-585. The Veterans Health Care Act of 1992 is codified as Section 340B of the Public Health Services (PHS) Act.

Section 340B of the Public Health Services Act requires drug manufacturers that receive reimbursement from state Medicaid programs to supply drugs to the 340B Drug Pricing Program at a discounted rate. The Office of Pharmacy Affairs (OPA) of the Bureau of Primary Health Care at the Health Resources and Services Administration (HRSA) administers the program. This Federal program is run by Apexus' Prime Vendor Program, which negotiates discounted drug products for use by covered entities that are certified as 340B providers.

To participate in the 340B program eligible entities must register with HRSA. Recertification must be completed annually, and 340B drugs may only be dispensed by eligible organizations to eligible patients. Drug manufacturers and HRSA have the authority to audit covered entities for program compliance. Additional information may be found on the HRSA website. (See Appendix N for contact information.)

Reimbursement Methodology

Covered Entity

Self-administered drugs (ambulatory and retail medications) 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 plus a professional dispensing fee. 340B drug stock cannot be used in an inpatient setting.

Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing.

Contract Pharmacies

Covered entities that are not equipped to provide pharmacy services may contract with pharmacy providers. A "ship to, bill to" procedure is used in which the covered entity purchases 340B stock that is shipped directly to the contract pharmacy.
Claims billed to Medicaid by contract pharmacies are only excluded from Medicaid's drug rebate program if the contract pharmacy is listed in the HRSA Exclusion File. To be listed in the exclusion file, the pharmacy:

- Has attested to HRSA that all of its Medicaid claims are "carved-in" to the 340B program; and

- All of their Medicaid claims are dispensed from 340B stock, whether the claims were billed for the covered entity or as part of the pharmacy's regular retail business.

It is the responsibility of the covered entity to ensure their 340B program and any contract pharmacies are in compliance with HRSA requirements. Information on HRSA's guidelines for contract pharmacy agreements, responsibilities and requirements can be located on HRSA website. (See Appendix N for contact information.)

NOTE: Refer to Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines of this manual chapter for additional enrollment and participation information.

HRSA maintains a national 340B exclusion file for use by all state Medicaid programs during drug rebate invoicing. The file is available to the public for download. (See Appendix N for information on accessing the file.)

All 340B covered entities are required to determine whether their Medicaid claims are "carved-in" or "carved-out" of their 340B program. "Carved-in" means that all drug claims billed to Medicaid are dispensed from regular stock purchased through the 340B program. Each covered entity attests to its status to HRSA and only those that carve all Medicaid patients into their 340B programs are excluded from each state's drug rebate program.

Claims billed to Medicaid by contract pharmacies are only excluded from drug rebate invoicing if the contract pharmacy has attested to HRSA that all Medicaid claims are "carved-in" to the 340B program and all of their Medicaid claims are dispensed from 340B stock. The covered

entity's carved-in status does not apply to its network pharmacies. If the contract pharmacy bills Medicaid claims in its regular business, none of that pharmacy's claims will be excluded from drug rebate invoicing.

The Medicaid Program reviews the HRSA exclusion file quarterly with each invoicing cycle and removes providers from drug rebate invoicing according to the term dates provided by HRSA.

The Medicaid Program invoices drug manufacturers for fee-for-service Medicaid and managed care Medicaid claims. Claims billed by covered entities that are listed on the HRSA exclusion file are removed from invoicing for both fee-for-service and managed care Medicaid patients.

Questions regarding the 340B program should be directed to HRSA, Office of Pharmacy Affairs. (See Appendix N for contact information.)

Providers may also contact the Pharmacy Program.

TOTAL PARENTERAL NUTRITION

This section explains the Pharmacy Program's Total Parenteral Nutrition (TPN) therapy coverage, limitations, prior authorization, reimbursement methodology and claim submission.

Provider Enrollment

Refer to Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines for enrollment instructions.

Program Coverage

The program covers the following services, equipment and supplies when medical necessity and other program criteria are met:

- 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 recipient'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.

B.　Parenteral nutrition is considered to be medically necessary when any of the following conditions exist. 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;

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;

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;

4.   Has complete mechanical small bowel obstruction where surgery is not an option;

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 to3.4 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.

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.b 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);

7.   Mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula; or

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 luoroscopy. 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.

Parenteral nutrition would usually be non-covered 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; and

- 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 gastrointestinal (GI) system. There must be objective evidence supporting the clinical diagnosis.

Parenteral nutrition is not 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.

Intradialytic Parenteral Nutrition Therapy

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.

Equipment and Supplies

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 intravenous (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.

Prior Authorization

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; and

- 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).

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; and

- 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;
  - 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.

Prior Authorization Requests

The Prior Authorization (PA) request shall be submitted to the fiscal intermediary Prior Authorization Unit (PAU) where it will be considered for payment. Provider may contact the PAU (See Appendix N for contact information.)

Providers may complete and submit electronic PA forms. These forms may be accessed at www.lamedicaid.com. For more information contact the PAU.

NOTE: Refer to Appendix I for Form PA01 and instructions or providers may access this form at www.lamedicaid.com.

Once a PA 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.

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 PAU's 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.

Medicare Crossover Claims

Claims for Total Parenteral Nutrition and equipment reimbursed by Medicare do not require prior authorization from Medicaid when these claims cross over 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.

Reimbursement Methodology

The following is the Medicaid reimbursement schedule:

- Reimbursement for Total 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.

Claim Submission

Medicaid Claims

Claims for TPN should be submitted on the CMS-1500. (See Appendix F for information on how to access this form.)

Medicare Crossover Claims

Medicare claims will automatically cross over to Medicaid when the provider is enrolled as a Medicare provider.

NOTE: See Medicare Part B Crossover Claims in Section 37.7 Medicare Prescription Drug Coverage for additional 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 remittance advice from the private insurance company should be submitted with the claim to Medicaid.

Adjustments/Voids

Providers should complete Form 213 Adjustment/Void form for TPN services submitted that require adjustments or voids.

NOTE: Refer to Appendix K of this manual chapter for a copy of this form.

MEDICATION ADMINISTRATION

The Louisiana Board of Pharmacy has set minimum requirements regarding the administration of medications by licensed Louisiana pharmacists. Currently the Medicaid Program will reimburse enrolled pharmacies when these credentialed pharmacists administer the influenza vaccine.

Louisiana Board of Pharmacy

Pharmacists in Louisiana must be registered by the Louisiana Board of Pharmacy to administer medications. Louisiana Board of Pharmacy Regulations regarding Prescription Orders to Administer Medications may be found at LAC 46:LIII.521.

Pharmacist Provider Number

Authorized Pharmacists

Pharmacists who are registered with the Louisiana Board of Pharmacy and have the *"Authority to Administer"* must obtain a Medicaid pharmacist provider number in order to bill the Medicaid Program. To confirm or request enrollment, authorized pharmacists should contact the Provider Enrollment Unit. (See Appendix N for contact information.)

National Provider Identifier (NPI)

Pharmacists who have a National Provider Identifier (NPI) must report it to the fiscal intermediary and may include it in the claim submission.

Influenza Vaccine Administration by Pharmacist

Claim Requirements

The Medicaid Program will reimburse enrolled pharmacies when an immunization is given by a pharmacist who has a Louisiana Board of Pharmacy *"Authority to Administer"*. The administering pharmacist's Medicaid provider number or his/her NPI must be included on the claim.

When a prescription for the influenza vaccine is written by a prescribing practitioner, that practitioner's NPI or Medicaid number should be included the claim. When a prescription order does not exist, the vaccinating pharmacist shall enter his/her Medicaid provider number or NPI as the prescriber and submit the claim.

Vaccination Reimbursement

The Medicaid Program reimburses enrolled pharmacies for the administration and the cost of the influenza vaccine for Medicaid recipients who are 19 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 19. Only the administration fee will be reimbursed for these recipients.

Bypassed Editing

Claims for influenza vaccines will process without edits for the four prescription limit, requirements to bill other insurance and Lock-In.

Copayments

Recipients may not be charged co-payments for the influenza vaccines.

NOTE: See Appendix D, Point of Sale User Guide for detailed information regarding the submission of these claims.

Electronic Drug Clinical 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 on the Louisiana Medicaid website.

Vaccination Documentation

Pharmacists must document immunizations administered in the Louisiana Immunization Network for Kids Statewide (LINKS) registry. For additional information, see the Louisiana Department of Health's website. (See Appendix N for contact information.)

PATIENT COUNSELING AND DRUG UTILIZATION REVIEW (DUR)

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.

The Pharmacy Program 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 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:

- Recipient counseling;

- Prospective drug review;

- Retrospective drug use review;

- An educational program; and

- A state DUR Board.

Patient Counseling

Patient counseling must be offered and provided in accordance with the Louisiana Board of Pharmacy Regulations at LAC, 46:LIII, §517.

Components of Patient Counseling

In accordance with those regulations, the pharmacist, at a minimum, should be convinced that the recipient 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 recipient;

- 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.

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.

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 recipient or caregiver from declining patient counseling.

Prospective Utilization Review (UniDUR)

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).

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 Pharmacy Program. The events are based on extensive development research done by the program staff, contractors, fiscal intermediary (FI), 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 recipient'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 Pharmacy Program 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. Prescriptions are screened 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 recipients with certain known medical conditions;

- Disease-Drug Precaution – diseases where specified drugs are suggested for use to deter disease progression or complications; and

- Pregnancy Precaution – drugs with high risk of fetal harm dispensed to childbearing women.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in Section 37.5 Covered Services, Limitations, and Exclusions of this manual chapter for detailed policy information.

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, 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 recipient'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 recipient and checking the recipient'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 Point of Sale (POS) Help Desk for additional information on the UniDUR message. (See Appendix N for POS Help Desk contact number.)

NOTE: Refer to Appendix D, Point of Sale User Guide and Section 37.5 Covered Services, Limitations, and Exclusions of this manual chapter for detailed information and instructions on the Prospective Drug Utilization Review (UniDUR) feature of the LMPBM System.

Retrospective Drug Utilization Review

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 Pharmacy Program, through a contract with the FI, Molina, administers LaDUR as a component of its 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 recipients' 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 recipients' prescribers and pharmacists regarding their observations in an effort to identify prescription therapies and utilization patterns that correspond to specified therapeutic criteria.

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 recipient's prescription utilization to the examination of a recipient'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.

Drug Utilization Review Board

The federal OBRA '90 statute requires each state to establish a DUR Board. The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) has established a Drug Utilization Review Board to assist the agency in assessing its DUR Program.

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 BHSF 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 DUR Program in an advisory capacity; and

- Prepare an annual report.

LaDUR Board 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 percent, licensed and actively practicing physicians, and at least one third licensed and actively practicing pharmacists.

The committee shall be composed of at least eight members (or approved designees) appointed by the secretary of LDH.

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.

LOCK-IN PROGRAM

The Lock-In Program is designed to educate recipients who may be misusing program benefits and to ensure that program funds are used to provide optimum healthcare services for recipients. Recipients who misuse or over-utilize pharmacy and physician benefits may be restricted to the use of:

- One pharmacy and/or specialty pharmacy;

- One physician; and

- Up to three specialists, if needed, for Physician-Pharmacy Lock-In.

In addition, recipients may be restricted to one pharmacy and/or specialty pharmacy provider (for Pharmacy Only Lock-In). Claims written by dental prescribers are exempt from Lock-In edits.

Choosing a Lock-In Provider

A Medicaid recipient loses his/her freedom of choice of providers when selected for enrollment in the Lock-In program. A Lock-In recipient must choose the following as his/her Lock-in providers:

- One primary care physician provider;

- Up to three specialist(s) when warranted; and

- One pharmacy provider and/or specialty pharmacy if needed.

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 Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (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 the Lock-In Unit. If a provider chooses to no longer be a recipient's Lock-In provider, the provider should contact the Lock-In Unit. (See Appendix N for contact information.)

Specialist

The recipient may add up to three specialist providers when his/her medical condition warrants treatment by a specialist.

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.

Lock-In Emergencies

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 Prescription" or "Discharge Prescription" must be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist.

NOTE: Refer to Appendix D, (POS) User Guide of this manual chapter for detailed information regarding submission of these claims.

Referrals

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 or authorized by one of the recipient's Lock-In physicians. The pharmacist should submit these prescription claims with the authorizing Lock-In physician's Medicaid provider number.

MEDICAID FRAUD AND ABUSE

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, promulgated regulations and policies concerning fraud and abuse. It is the responsibility of the provider to become familiar with these laws and regulations.

In order for the Louisiana Department of Health (LDH) to receive federal funding for Medicaid services, federal regulations mandate that LDH perform certain program integrity functions. The primary functions of the Program Integrity Section are:

- Provider Enrollment;

- Fraud and Abuse Detection;

- Investigations;

- Enforcement;

- Administrative Sanctions; and

- Payment Error Rate Measurement (PERM).

Refer to Chapter 1 of the *Medicaid Services Manual*, Section 1.3 Program Integrity, to become 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.

To report Medicaid fraud and/or abuse, contact Program Integrity. (Refer to the Appendix N for contact information)

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 verify:

- They received a drug on that date of service;

- That the drug they received looks like the drug in the picture; and

- Confirm the amount of co-payment that they were asked to pay, if any.

All exceptions are investigated.

Surveillance Utilization Review Subsystem (SURS)

The fiscal intermediary, through its Surveillance Utilization Review Subsystem, can identify potential fraud and abuse situations by means of profile (SURS) reports. For detailed information concerning SURs and SURs profile reports refer to Title 50, Part I, Subpart 5, Chapter 41 – the Surveillance Utilization Review System (SURs) Rule.

Appeals

LDH provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Division of Administrative Law (DAL), Health and Hospitals Section 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 DAL.

Detailed information regarding the appeals procedure may be obtained from the DAL. (See Appendix N for contact information.)

PROVIDER AUDITS

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 Pharmacy Program is responsible for auditing Medicaid pharmacy providers. This section explains the audit program and provider responsibilities relative to audits.

Audit Purpose

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 Pharmacy Program policy.

Audit Authority

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations at 42 CFR 447.202.

The Louisiana Department of Health (LDH) is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Therefore, LDH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. 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.

Audit Overview and Process

Since the inception of Medicaid, the Pharmacy Program has complied with the federal audit mandate.

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.

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.

Provider Responsibilities

Each provider upon enrolling in the Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the approved Medicaid State Plans, administrative rules, *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 the Medicaid Program as stated in the provider enrollment form (PE 50) 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 (0-11);

- Date of dispensing;

- Recipient's name;

- Prescriber's name;

- 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.

MEDICAID DRUG REBATE PROGRAM

Rebate Programs

The Pharmacy Program administers the federally mandated drug rebate program and the State Supplemental Drug Rebate Program for Louisiana's Medicaid Program. The Pharmacy Program contracts with the University of New Orleans to operate both drug rebate programs.

Pharmacists must bill the actual national drug code (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 Pharmacy Program 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.

Federally Mandated Drug Rebate Program

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 (DHHS) for states to receive federal funding for outpatient drugs dispensed to Medicaid patients.

The drug rebate program is administered at the national level by the DHHS Centers for Medicare and Medicaid Services (CMS)' Center for Medicaid and State Operations (CMSO).

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State Supplemental Drug Rebate Program

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.

Effective October 1, 2004, CMS authorized the state 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 DHHS.

LOUISIANA MEDICAID WEBSITE

The Louisiana Medicaid website is available to Medicaid providers to assist them with information necessary to provide services to Medicaid recipients (See Appendix N for web address). The "Pharmacy and Prescribing Providers" link on this website contains information to assist pharmacy providers in obtaining the following commonly requested information.

Preferred Drug Lists

The Preferred Drug List is a reference for the most current listing of preferred drugs as well as those drugs requiring prior authorization.   This list is updated every 6 months.

For additional information, refer to the Prior Authorization and Preferred Drug List in Section 37.5 Covered Services, Limitations, and Exclusions of this manual chapter.

Clinical Drug Inquiries

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 e-CDI is available 24 hours a day and is updated on a daily basis. The e-CDI will provide clinical historical data on each Medicaid recipient for the current month, prior month, or prior 12 months. A copy of the displayed information can be printed in a print friendly version for the recipient's clinical chart.

Prescriber Numbers

A list of prescribing practitioner numbers and National Provider Identifier (NPI) numbers are available on the website. This listing is updated on a daily basis.

For additional information refer to the "Accessing Prescriber Numbers" in Section 37.4 Prescribers of this manual chapter for more detailed information.

Prior Approval Program

Details about the Prior Approval (PA) Program and process are available on the website along with contact numbers.

Recipient Eligibility

Medicaid Eligibility Verification System (MEVS)

MEVS is an electronic system used to verify Medicaid recipient eligibility and third party liability information. This electronic verification process expedites reimbursement, reduces claim denials, and helps to eliminate fraud. Eligibility information for a recipient, including third party liability, health plan linkages, service limits 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, 24 hours per day except for occasional short maintenance periods.

For additional information, refer to "Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Recipient Eligibility.

Recipient Eligibility Verification System (REVS)

A telephonic system is also available to providers to verify eligibility information. REVS may be accessed through touch-tone telephone equipment using the fiscal intermediary's toll-free telephone number. (See Appendix N for contact information)

For additional information, refer to "Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Recipient Eligibility.

Point of Sale User Guide

The Point of Sale (POS) User Guide details the required information for claim submittal. This helpful manual lists National Council for Prescription Drug Program (NCPDP) fields and instructions for proper usage.

Vendor Specifications Document for the POS System

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.

Drug Appendices

- Appendix A – a list of drugs payable on the drug file;

- Appendix A-1 – a list of drugs with the applicable average acquisition rates;

- Appendix B – a list of the Drug Efficacy Study Implementation (DESI) drugs by national drug code (These drugs are non-payable); and

- Appendix C – a list of pharmaceutical companies participating in the Federal Medicaid Drug Rebate Program.

Third Party Liability Carrier Code List

Private insurance companies are assigned a unique Louisiana carrier code. Pharmacy providers are asked to submit the third party liability (TPL) carrier code when coordinating claims for payment with a primary payor.

For additional information, refer to "Third Party Liability" in Chapter 1 of the *Medicaid Services Manual*, Section 1.4, General Claims Filing.

Provider Education and Communication

Other information that can be obtained from the website includes:

- ***Provider Update* and Remittance Advice (RA) Messages**

    The *Provider Update* is a newsletter that contains information of the latest Medicaid policy. Copies of the *Provider Update* may be accessed by month and year of publishing.

    The RA is the control document which informs the provider of the current status of submitted claims. It is posted weekly to the website 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.

- **Provider Notices**

    Selected provider correspondences are posted on this website.

- **Provider Training Packet**

    The provider training packet presents the latest policy changes that affect providers.

- **Provider Relations Services**

    Provider relation services includes a list by parishes served of fiscal intermediary field analysts who are available to provide onsite training to new providers and to assist with complex billing problems. There is also information about provider trainings that have been held.

FORMS AND LINKS

FORM	USE
PA01	Total Parenteral Nutrition providers are required to utilize this form to request prior authorization for TPN services.
CMS-1500	This form is submitted to receive reimbursement for Total Parenteral Nutrition services.
List of Drugs Payable on Drug File	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDA.pdf
List of Drugs with Average Acquisition Rates	http://www.mslc.com/Louisiana/
List of DESI Drugs by National Drug Code (NDC)	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDB.pdf
Medicaid Drug Federal Rebate Participation Pharmaceutical Companies	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf
Point of Sale User Guide	www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf
Single Preferred Drug List (PDL)	This link contains all forms in the clinical authorization and prior authorization process listed by drug. http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf
NCPDP Universal Claim Form and Instructions	http://www.lamedicaid.com/provweb1/billing_information/NCPDP_Billing_Instructions.pdf
Form 211 – Drug Adjustment/Void	www.lamedicaid.com/Provweb1/Forms/FINAL_drugadjustforminstruct_71803.pdf
PA01 Form – TPN Prior Authorization Form	www.lamedicaid.com/Provweb1/Forms/RevisedPA-010205052004WithInsts.pdf
Tamper Resistant Prescription Criteria and Examples	www.lamedicaid.com/Provweb1/manuals/App_L_Tamper_Res_Prescription.pdf
Diagnosis Code Chart	http://www.lamedicaid.com/provweb1/Pharmacy/mFFS_ICD-10_Conversion_Table_Condensed.xlsx

CLAIMS RELATED INFORMATION

Hard copy billing of total parenteral nutrition (TPN) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as required, situational or optional.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Paper claims should be submitted to:

> DXC Technology
> P.O. Box 91020
> Baton Rouge, LA 70821

NOTE: Electronic claims submission is the preferred method for billing. Claims are submitted on the 837P with the DME file extension. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form; and

- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

CMS 1500 (02/12) INSTRUCTIONS FOR PHARMACY TPN SERVICES

You must write "DME" at the top center of the claim form!

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "DME" at the top center of the Louisiana Medicaid claim form in LARGE letters.
1a	Insured's ID Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	**Situational** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Reserved For NUCC Use	Leave Blank.	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	

9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE
9b	Reserved For NUCC Use	**Leave Blank.**	
9c	Reserved For NUCC Use	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Other Claim ID (Designated by NUCC)	**Leave Blank.**	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	

14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	Other Date	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	**Required-** Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported. DN Referring Provider DK Ordering Provider Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.	If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider
17a	Other ID#	**Required –** Enter the 7 digit Medicaid ID number of the referring or ordering provider.	
17b	NPI #	**Required -** Enter the NPI number of the referring or ordering provider	The 10-digit NPI Number is required.
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Ind. Diagnosis or Nature of Illness or Injury	**Required –** Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required –** Enter the most current ICD diagnosis code.	The most specific diagnosis codes must be used. General codes are not acceptable.

		NOTE: ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
22	Resubmission and/or Original Reference Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization Number	**Required** – Enter the correct 9-Digit PA number in this field.	
24	Supplemental Information	Situational – DME Providers are required to enter 11-digit NDC codes on claim detail lines for enteral feeding products only.	DME providers must enter NDC information in the SHADED section of 24A – 24G of

		In addition to the procedure code, **the National Drug Code (NDC) is required** by the Deficit Reduction Act of 2005 and **shall be entered** in the shaded section of 24A through 24G. Claims for enteral feeding products must include the NDC from the label of the product administered. A list of the procedure codes and NDCs for products that currently require NDC information can be found on www.lamedicaid.com under the Fee Schedules directory link.	appropriate detail lines only. This information must be entered in addition to the procedure code(s). The NDC indicated on the claim must match the NDC on the Prior Authorization.
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either 6-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete is appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the applicable modifier in the appropriate field.	Where modifiers are required, the modifier(s) on the claim must match the modifier(s) on the Prior Authorization
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	

24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT / Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID#	**Leave Blank.**	
25	Federal Tax ID Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	
30	Reserved For NUCC Use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional.** The practitioner or the practitioner's authorized representative's original signature is no longer required. Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI #	**Optional.**	
32b	Other ID#	**Situational** – Complete if appropriate or leave blank.	

33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI#	**Required –** Enter the billing provider's 10-digit NPI number.	The 10-digit NPI Number <u>must</u> appear on paper claims.
33b	Other ID#	**Required –** Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier – Optional –** If possible, leave blank for Louisiana Medicaid claims.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

A sample form is on the following page

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SAMPLE CLAIM FORM

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.

- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.
When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

NOTE: DME must be written in large letters in the blank area at the top of the claim form.

A sample form is on the following page

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GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Pharmacy Program manual chapter.

Average Wholesale Price (AWP) – The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health responsible for the administration of the Medicaid Program.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the U.S. Department of Health and Human Services (DHHS) responsible for federal administration of the Medicare and Medicaid programs (Titles XVIII, XIX and XXI of the Social Security Act).

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Medicaid Program and other health and related services, including aging and adult services, public health, behavioral health, intellectual disabilities and addictive disorder services.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicare and Medicaid Programs and other public health programs.

Drug Efficacy Study Implementation (DESI) Drugs – Drugs the Food and Drug Administration (FDA) has proposed to withdraw from the market because they lack substantial evidence of effectiveness.

Dispense As Written (DAW) – 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.

Drug Utilization Review (DUR) – The quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.

Dual Eligible – Recipients who have Medicare and Medicaid coverage.

Eligible (For purposes of the Pharmacy Program) –An individual who has been determined to meet the Medicaid program's eligibility criteria and is enrolled in the program.

Estimated Acquisition Cost (EAC) – An estimate of the price generally, and currently, paid by

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providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

Federal Upper Limits (FUL) – 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 there are 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.

Fiscal Intermediary (FI) – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. The FI processes claims for Medicaid services provided under the Medical Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Full Benefit Dual Eligibles – A population of low-income elderly individuals 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 some prescription drugs.

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) – A public or private facility that provides health and rehabilitation services to people with intellectual disabilities. An ICF/ID has four or more beds and provides "active treatment" to the residents.

International Classification of Diseases, 10th Edition Clinical Modification (ICD-10-CM) (or its successor)– A standard 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.

Lock-In – An educational program administered by the Medicaid pharmacy program staff which restricts certain Medicaid enrollees to a specific physician and/or pharmacy.

Intradialytic Parenteral Nutrition Therapy – A parenteral therapy provided to an end stage renal disease (ESRD) recipient while the recipient is being dialyzed.

Intravenous Nutrition – Also referred to as Total Parenteral Nutrition (TPN) or hyperalimentation therapy.

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Long-Term Care – 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., individuals who are chronically ill, aged, have a physical, mental or intellectual disability) 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 facilities, homes for individuals with intellectual disabilities 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.

Medicaid – A joint federal and state program that helps with medical costs for some individuals with limited income and resources according to approved Medicaid State Plans pursuant to Title XIX and XXI of the Social Security Act.

Medicaid Eligibility Verification System (MEVS) – Louisiana Medicaid's electronic eligibility verification system accessed through a switch vendor.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the Department. (R.S. 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Medicare – The federal health insurance program which provides coverage to the aged and persons with disabilities under Title XVIII of the Social Security Act.

Medicare (Part A/Part B) – A U. S. health insurance program which provides hospital insurance (Part A) and supplemental medical insurance (Part B) 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 a kidney transplant 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.

Medicare Part D – Prescription drug coverage established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of, which is 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. **Full benefit dual eligible Medicaid recipients no longer receive their pharmacy benefits through the Louisiana Medicaid Pharmacy Program, with the exception of some drugs excluded from the Part D benefit.**

National Drug Code (NDC) – A national classification system for identification of drugs that is similar to the Universal Product Code (UPC).

National Provider Identifier (NPI) – A 10-digit number mandated by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers, which is a single provider identifier that replaces the multiple provider identifiers currently used to bill health plans.

Parenteral Nutrition Therapy – The introduction of nutrients by some means other than through the gastrointestinal tract, in particular intravenous, subcutaneous, intramuscular or intramedullary injection.

Over the Counter (OTC) – A drug product that does not require a prescription under federal or state law.

Point of Sale System (POS) – An electronic claims processing system which 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 payable, duplicated or rejected.

Preferred Drug List (PDL) – Drugs that do NOT require further prior authorization.

Prior Authorization – 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.

Provider/Provider Agency – An individual or agency enrolled with Medicaid under a provider agreement to furnish services to Medicaid recipients. Pharmacies or physicians may enroll with the state to prescribe/dispense prescriptions to Medicaid recipients.

Rebate – 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.

Recipient – An individual who has been certified for medical benefits by the Medicaid Program. A recipient certified for Medicaid home and community-based waiver services may also be referred to as a participant.

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Retrospective Review – Determination of medical necessity and/or appropriate billing practice for services already rendered.

Telecommunication Switch Vendor – A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.

Third Party Liability – 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.

UniDUR – As part of the Point of Sale system, claims are subjected to editing for prospective drug utilization review.

ACRONYMS

ASP	Average Sales Price
AWP	Any Willing Provider OR Average Wholesale Price
BMI	Body Mass Index
CDI	Clinical Drug Inquiry
CFR	Code of Federal Regulations
CMSO	Center for Medicaid and State Operations
COB	Coordination of Benefits
DME	Durable Medical Equipment
DSM	Disease State Management
EFT	Electronic Funds Transfer
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
HCPCS	HCFA Common Procedural Coding System
HRSA	Health Resources and Services Administration
ICN	Internal Control Number
IDPN	Intradialytic Parenteral Nutrition Therapy
LAC	Louisiana Administrative Code
LADUR	Louisiana Retrospective Drug Utilization Review

LAPRIMS	Louisiana Pharmacy Rebate Information Management System
R.S.	Louisiana Revised Statute
LMAC	Louisiana Maximum Allowable Cost
MAC	Maximum Allowable Cost
MAPIL	Medical Assistance Program Integrity Law
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
NCPDP	National Council for Prescription Drug Program
OBRA	Omnibus Budget Reconciliation Act
OTC	Over-the-Counter (drugs)
PA	Physician's Assistant OR Prior Authorization
PAU	Prior Authorization Unit
PBM	Pharmacy Benefits Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PHI	Protected Health Information
PHS	Public Health Service
PPBP	Provider Peer Based Profiling
PRN	As needed
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice

REOMB	Recipient's Explanation of Medical Benefits
REVS	Recipient Eligibility Verification System
SURS	Surveillance and Utilization Review Subsystem
TPN	Total Parenteral Nutrition
UCF	Universal Claim Form
ULM	University of Louisiana at Monroe

CONTACT INFORMATION

DXC Technology

Contact the Medicaid Program's fiscal intermediary, DXC Technology for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	DXC Technology (877) 598-8753
Electronic Media Claims (EMC) Electronic Claims sign up and testing	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) *After hours, please call REVS*
Prior Authorization Unit (PAU)	DXC Technology – Prior Authorization Phone: (800) 807-1320 E-PA Fax: 225-216-6481
Provider Enrollment Unit (PEU)	DXC Technology-Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit (PR)	DXC Technology – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)
Weekly Remittance Advice	https://www.lamedicaid.com/sitesearch/searchpura.aspx

Louisiana Department of Health (LDH)

TYPE OF ASSISTANCE	CONTACT INFORMATION
Bureau of Health Services Financing (BHSF) – Medicaid State Office	P.O. Box 91030 Baton Rouge, LA 70821 Hot Line: (888) 342-6207 (Toll Free) http://www.dhh.la.gov/index.cfm/subhome/1/n/331
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0128 Fax: (225) 5292 http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://ldh.la.gov/index.cfm/page/224
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (866) 758-5038 Fax: (225) 219-0202 E-mail: MedWeb@dhh.la.gov http://www.ldh.la.gov/index.cfm/subhome/12/n/7
Office of Behavioral Health (OBH)	P.O. Box 629 Baton Rouge, LA 70821-0629 Phone: 225-342-9500 Fax: 225-342-5568 Medicaid Customer Service (888) 342-6207 http://ldh.la.gov/index.cfm/subhome/10
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov http://www.ldh.la.gov/index.cfm/subhome/11/n/8
Pharmacy Program	(800) 437-9101
Take Charge Plus	Phone: (888) 342-6207

TYPE OF ASSISTANCE	CONTACT INFORMATION
Third Party Liability (TPL) Recovery and Premium Assistance Section	P. O. Box 3558 Baton Rouge, LA 70821 Phone: (225) 342-8662 Fax: (225) 342-1376

Fraud Hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://new.dhh.louisiana.gov/index.cfm/page/219

Appeals

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 225-342-0443 225-219-9823 (Fax)

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid Services	https://www.cms.gov/
Communi Form, LLS NCPDP Universal Claims Forms	Communi Form, LLC Phone: (877) 817-3676 https://www.ncpdp.org/Products/Universal-Claim-Forms

TYPE OF ASSISTANCE	CONTACT INFORMATION
Office of Pharmacy Affairs HSB/HRSA	5600 Fishers Lane Rockville, MD 20857 301-594-4353 800-628-6297 OpaStaff@hrsa.hhs.gov https://www.hrsa.gov/opa
340B Exclusion File	https://340bopais.hrsa.gov/medicaidexclusionfiles
Health Management Systems, Inc. (HMS) Urgent Private TPL and Urgent Medicare Advantage Plan Update Request	**Aetna Better Health** Mailbox-MBU-LA_Enrollment@AETNA.com **LHCC Healthcare Connections** OICRequest@centene.com **UHC Community Care Plan** PI_COB_research@uhc.com **Amerigroup** ccuohi@amerigroup.com **AmeriHealthCarnitas** 888-922-0007 **Fee-for-Service** Phone: (877) 204-1324 Fax: (877) 204-1325 E-mail: latpr@hms.com
Novitas Solutions, Inc. Medicaid Part B Carrier	P.O. Box 3097 Mechanicsburg, LA 17055-1815 (855) 252-8782
Office of Population Affairs (OPA) Clearinghouse	P.O. Box 30686 Bethesda, MD 20824-0686 Phone: (866) 640-7827 Fax: (866) 592-3299 E-mail: Info@OPAclearinghouse.org

TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Medicaid RxPA Operation ULM, School of Pharmacy To obtain clinical pre-authorization	1800 Bienville Drive Monroe, LA 71201-3765 Phone: (866) 730-4357 Fax: (866) 797-2329 http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/rxpaindex.htm
U.S. Department of Health and Human Services Sterilization and Consent Forms	https://www.hhs.gov/opa/title-x-family-planning/training-and-resources/documents-and-tools/index.html

TYPE OF ASSISTANCE	CONTACT INFORMATION
Pharmacy Help Desk Questions concerning pharmacy claims billing	
Aetna	CVS Health (855) 364-2977
AmeriHealth Caritas	PerformRx (800) 684-5502
Fee-for-Service	DXC Technology (800) 648-0790
Healthy Blue	Express Scripts (844) 367-6111
Louisiana Healthcare Connections	CVS Caremark (800) 311-0543
United Healthcare	Optum Rx (866) 328-3108

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 PREFERRED DRUG LIST (PDL)
FEE-FOR-SERVICE AND MANAGED CARE ORGANIZATIONS

LOUISIANA MEDICAID SINGLE PREFERRED DRUG LIST (PDL) FEE-FOR-SERVICE AND MANAGED CARE ORGANIZATIONS

To access the most current and complete listing of criteria, forms, and drugs in the Medicaid PDL, Prior Authorization (PA), and Clinical Pre-Authorization process, visit:

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

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