
CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES

SECTION 37.6: REIMBURSEMENT FOR SERVICES

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37.6 REIMBURSEMENT FOR SERVICES

Overview

Introduction	This Section describes the methodologies that Medicaid uses to reimburse for prescribed drug services.
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In This Section	This Section contains:
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- Reimbursement Methodology
- Usual and Customary Charges
- Drug Estimated Acquisition Cost (EAC)
- Multiple Source Drugs
- Co-payments for Prescription Services
- Medicare Crossover Claims
- Third Party Liability Claims

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37.6.1 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:

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

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

National Drug
Code (NDC)

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

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

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

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

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Maximum Allowable
Overhead Cost
(Dispensing Fee)

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

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

Provider Fee

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

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

37.6.2 USUAL AND CUSTOMARY CHARGES

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

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

37.6.3 DRUG ESTIMATED ACQUISITION COST

"Estimated Acquisition Cost" (EAC) means the **modified** Average Wholesale Price of the drug dispensed and identified by the manufacturer number, product number, and package number usually purchased by a provider from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. EAC for drug products supplied through repackaging into smaller quantities by chain drugstore central purchasing shall be based on the package size purchased by the central purchasing unit. Supporting documentation (invoices) shall be made available to the agency or its designee upon request. This limitation includes drug products which are repackaged or relabeled by the manufacturer or third party under any type of purchase

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contract or agreement. Bulk purchase practices which result in price reductions not generally available to all pharmacies shall also be subject to this limitation. If the package size is larger than the largest size listed by Medicaid of Louisiana, then EAC will be based on the largest size listed in the American Druggist Blue Book or other national compendia utilized by the State to update the Medicaid Management Information System (MMIS).

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

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

37.6.4 MULTIPLE SOURCE DRUGS

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

Federal Upper
Limits (FUL)
Regulations

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

Note: Refer to Appendix A-1 or www.lamedicaid.com for the current listing.

Louisiana Maximum
Allowable Cost
(LMAC) Regulations

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

Note: Refer to Appendix A-1 or www.lamedicaid.com for the current listing.

Override of
FUL or LMAC

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

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

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

- The certification must be in the prescriber's handwriting and signed;
- The certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription;
- The standard phrases written by the prescriber on the prescription should testify to the medical necessity of the brand name drug. The only acceptable phrases are **brand necessary** or **brand medically necessary**;
- **If multiple prescriptions are written on the same prescription blank, the prescriber must certify which drugs require the brand name product, indicating Brand Medically Necessary for each prescription which requires the branded product;**
- Phrases such as *do not substitute*, *no generics*, or *dispense as written* are not acceptable for overriding MAC limitations;
- **Providers should verify that the appropriate wording is properly documented at the time of dispensing;**
- Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable; and
- A handwritten statement transferred to a rubber stamp and then stamped on the prescription blank is unacceptable.

37.6.5 CO-PAYMENTS FOR PRESCRIPTION SERVICES

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

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Co-payment
Schedule

The following is the prescription co-payment schedule:

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

Co-payment
Exemptions

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

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

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

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**Other Co-payment
Policies**

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

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

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

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

**Other Co-Payment
continued**

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

37.6.6 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.

37.6.7 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.