# Magellan Medicaid Administration, LLC

## Single Pharmacy Benefit Manager for Managed Care Program – Provider Manual

**Louisiana Department of Health**
**Bureau of Health Services Financing**

# Revision History

| Date | New Version # | Made By | Description of Change |
|---|---|---|---|
| 07/31/2023 | 0.1 | Heather Bonneville | Initial creation |
| | | Ashley Sipes/<br>Anita Martin | Peer review/document review |
| | | Bridgette Devine | Content review |
| 8/212023 | 0.2 | Anita Martin/<br>Ashley Sipes/<br>Bridgette Devine | Updates made based on feedback and walk through with LDH on 8/14/2023. |
| 8/28/2023 | 0.3 | Bridgette Devine | Accepted previous track changes and made updates to Sections 4.7.2 and 6.3.2 per request from LDH. |
| 9/12/2023 | 0.4 | Ashley Sipes | Updates made based on feedback from LDH. Removed Section 13.0 and corresponding subsections relating to FWA, Audit, Compliance (sent separately for review) following walk-through with LDH. |
| 9/13/2023 | | Bridgette Devine | Content review |
| 9/27/2023 | 0.5 | Ashley Sipes/<br>Rosalind Borders | Approved with comments; based on version 0.4 Review.<br>• Replaced language in Section 13.0. |
| | | Trena Wiggins-Hunter/<br>Bridgette Devine | Content review |
| 9/29/2023 | 0.6 | Bridgette Devine | Accepted previous track changes to provide clean version for LDH approval. |
| 9/29/2023 | 1.0 | Bridgette Devine | Received final approval from LDH. |

# Table of Contents

# 1.0 Introduction

Effective October 1, 2023, Magellan Medicaid Administration, LLC. (MMA) will be the single Pharmacy Benefits Manager (PBM) for the Louisiana Department of Health (LDH) Medicaid Managed Care Program. The program includes six Managed Care Organizations (MCOs), and all claims will follow the policies outlined in this manual. The Health Plans are:

- Aetna Better Health of Louisiana
- AmeriHealth Caritas Louisiana, Inc
- Healthy Blue
- Humana Healthy Horizons in Louisiana
- Louisiana Healthcare Connections
- UnitedHealthcare Community Plan

As the PBM, MMA will administer the point of sale (POS) system to process Medicaid MCO pharmacy claim transactions. The POS system will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted.

After submission, MMA will respond to the pharmacy provider with information about client eligibility, the plan-allowed total amount paid, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable rejection messages. ProDUR messages will be returned in the DUR response fields. Other important related information will appear in the free-form message area.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

Failure to comply with MMA's terms and conditions, including, but not limited to, those described in this manual, as revised, may result in full or partial financial recoupment or, with LDH approval, payment suspension, termination of participation in the Louisiana Medicaid MCO network, termination of the Agreement, and other remediation actions, as determined by MMA and permitted by applicable law.

## 1.1 Louisiana Medicaid Managed Care Pharmacy Program

This manual provides claims submission guidelines for the Louisiana Medicaid Managed Care Pharmacy Program administered by MMA. This manual is incorporated into the *Magellan Rx Management Participating Pharmacy Agreement*. All network pharmacies must comply with the terms and conditions of this manual, as revised, in providing Prescription Drug Services pursuant to such an Agreement.

Important plan coverage and reimbursement policies are available in this *MMA Single Pharmacy Benefit Manager for Managed Care Program – Provider Manual*. The MMA website contains a link to this document. Subsequent revisions to this document are available on the MMA Louisiana Medicaid MCO web portal at https://www.lamcopbmpharmacy.com.

Additional Louisiana Medicaid state policy information, including Fee-For-Service policies can be found at https://ldh.la.gov/page/1328.

# 2.0 Magellan Services Support Centers

MMA has a Pharmacy Support Center (PSC), Clinical Support Center (CSC), and Web Support Center to assist pharmacies, prescribers, and Beneficiaries. For additional contact information for MCO and provider relations, please refer to *Section 15.0 Appendix A- Directory.*

| Provider Services | Phone Number/Email/Web Address | Availability/Comments |
|---|---|---|
| MMA Pharmacy Call Center (will connect callers to both the PSC & CSC) | 1-800-424-1664 | Monday–Friday<br>7:00am to 7:00pm CT<br>After-hours support is available 24 hours a day, 7 days a week |
| MMA Pharmacy Call Center Fax Line | 1-800-424-7402 | Monday–Friday<br>7:00am to 7:00pm CT<br>After-hours support is available 24 hours a day, 7 days a week |
| MMA LA MCO Web Portal | 1-800-424-1664<br>https://www.lamcopbmpharmacy.com | Monday–Friday<br>7:00am to 7:00pm CT |
| Louisiana Department of Health Provider Enrollment | 1-833-641-2140<br>https://ldh.la.gov/page/4125 | Monday–Friday<br>8:00 a.m. to 5:00 p.m. CT |

## 2.1 Pharmacy and Clinical Support Centers

MMA provides a toll-free number for pharmacies available 7 days a week, 24 hours a day, and 365 days a year responding to questions on coverage, claims processing, and plan eligibility. Examples of concerns/issues addressed by the staff include:

- **Questions on Medicaid MCO Pharmacy Claims Processing Messages** – It is important to contact the PSC at the time of dispensing if a pharmacy needs assistance with alert or denial messages. MMA's staff are able to provide claim information on all error messages, including ProDUR messaging.
- **Clinical Issues** – To address these situations, the CSC will provide assistance with initiating clinical Prior Authorizations (PAs). A second level of assistance is available if a pharmacist's question requires a clinical response. The CSC is not intended to be a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist.

## 2.2 Magellan Website Pharmacy Portal

Announcements, provider forms, drug information, *Louisiana Medicaid Managed Care Provider Manual*, policies, and bulletins will be posted on the MMA Louisiana Medicaid MCO web portal, https://www.lamcopbmpharmacy.com. The pharmacy portal also hosts a searchable PDL and a pharmacy provider finder.

# 3.0 Program Setup

## 3.1 Beneficiary Identification Card

An ID card will show coverage for the eligible Beneficiary only. A Beneficiary's MCO will be responsible for providing ID Cards. Per the standard NCPDP, the ID card will contain the following for pharmacy claim billing:

- RxBIN
- RxPCN
- RxGRP
- Issuer (80840)
- Beneficiary ID
- Beneficiary Name
- Issue Date
- Other required information and instructions a pharmacy needs to accurately submit claims, including the Pharmacy Call Center phone numbers, etc.

Examples for each MCO Beneficiary ID Card can be found in *Section 15.0 Appendix B* of this document.

## 3.2 Claim Formats

MMA will accept claim submission by POS as well as mailed paper claims for the Louisiana Medicaid Managed Care Program. Batch claims are only allowed as needed for unique situations. The following standard formats are accepted:

| Billing Media | NCPDP Version | Accepted - Yes/No<br>Comments |
|---|---|---|
| POS | NCPDP D.0 | Accepted<br>• Up to four claims per transmission |
| Provider Submitted Paper | Universal Claim Form (UCF) | Accepted |
| Beneficiary Submitted Paper | | Accepted for scenarios regarding retrospective eligibility only. |
| Batch | NCPDP Batch 1.2 | Accepted as needed for unique situations |

## 3.3 Point of Sale – NCPDP Version D.0

As part of claims processing, MMA uses an online POS system to provide submitters with real-time online information on the following:

- Beneficiary eligibility
- Claim status
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the MMA online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure that their system is able to process in accordance with the payer specifications sheet.

### 3.3.1 Supported POS Transaction Types

A pharmacy's ability to use these transaction types depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1), reversals (B2), and re-bills (B3). Other transactions listed in the table below are also supported.

- **Original Claims Adjudication (B1)** – This transaction type captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
- **Claims Reversal (B2)** – This transaction type is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- **Claims Re-Bill (B3)** – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 103) is equal to B3.
- The following fields must match the original paid claim for a successful transmission of a B2 (Reversal) or B3 (Re-bill):
  - Service provider ID – National Provider Identifier (NPI) number
  - Prescription number
  - Date of service (date filled)
  - National Drug Code (NDC)

| NCPDP Version D.0 Transaction Types Supported | |
|---|---|
| **NCPDP D.0 Transaction Code** | **Transaction Name** |
| B1 | Billing |
| B2 | Reversal |
| B3 | Re-bill |
| E1 | Eligibility Verification |

### 3.3.2 Required Data Elements

A software vendor needs MMA's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The MMA claims processing system has program-specific field requirements (e.g., Mandatory, Situational, and Not Required). The table below lists abbreviations that are used throughout the payer specifications to depict field requirements. For additional information, refer to the *Payer Specification* document on the MMA LA MCO Web Portal.

| Definitions of Field Requirements Indicators Used in Payer Specifications | |
|---|---|
| **Code** | **Description** |
| M | MANDATORY<br>Designated as MANDATORY in accordance with the *NCPDP Telecommunication Implementation Guide Version D.0.* The fields must be sent if the segment is required for the transaction. |
| R | REQUIRED<br>Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction. |
| RW | QUALIFIED REQUIREMENT<br>"Required when" the situations designated have qualifications for usage ("Required if x," "Not required if y"). |

**Claims are not processed without all the required (or mandatory) data elements, and claims are edited for valid format and valid values on fields that are not required.**

If data are sent in fields that are not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks will result in claim denials.

- **Required Segments** – The transaction types implemented by MMA have NCPDP-defined request formats or segments.
- **Payer Specifications** – A list of transaction types and their field requirements are available online at https://lamcopbmpharmacy.com. These specifications list B1 and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by MMA.

- **Program Setup** – The table below lists required values unique to plan programs.

| Important Required Values for Program Set Up | | |
|---|---|---|
| **Fields** | **Description** | **Comments** |
| BIN# | 025986 | |
| Processor Control # | 1214172240 | |
| Group | LAMCOPBM | |
| Provider ID # | NPI | 10 bytes (numeric) |
| Cardholder ID # | Cardholder ID | Up to 20 bytes (numeric)<br><br>**Note:** CCN, Medicaid ID, or MCO ID may be used. |
| Prescriber ID # | NPI | 10 bytes (numeric) |
| Product Code | National Drug Code (NDC) | 11 digits |

## 3.4 Paper Claims

Providers are allowed to submit paper claims. Beneficiaries may also submit a request for reimbursement for scenarios regarding retrospective eligibility only. All paper claims must be submitted using the UCF. Please mail to:

Magellan Rx Claims,
Attn: LA MCO Paper Claims Department
11013 W. Broad St., Suite 500
Glen Allen, VA 23060

# 4.0 Program Specifications

## 4.1 Plan Co-Pays

The following table outlines the prescription co-payment schedule for Beneficiaries.

| Co-Payment Schedule | |
|---|---|
| **Monthly Income** | **Copay** |
| When 5% of family's household 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 |

- 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 excluding some pharmacy services/populations. 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.
- Violators of this policy will be subject to penalty such as termination from the program for one year.

### 4.1.1 Co-Pay Exemptions

The following pharmacy services are exempt from co-pay:

- Family planning services and supplies;
- Emergency services;
- Preventive medications as designated by the U.S. Preventive Services Task Force A and B Recommendations (see *Section 5.2.1 – Preventive Care OTC Products* for additional information);
- Vaccines; and
- Covid-19 Treatments and OTC at-home COVID tests.

The following populations are exempt from co-pay:

- Beneficiaries less than 21 years old;
- Pregnant women;
- LTC Beneficiaries;
- Hospice Beneficiaries;
- Native Americans;
- Alaska Natives;
- Women whose basis of Medicaid eligibility is breast or cervical cancer; and
- Beneficiaries with Home and Community based waiver eligibility.

## 4.2 Timely Filing Limits

Louisiana Medicaid Managed Care Pharmacy Providers are to submit all claims at the time of dispensing prescriptions. Claims that exceed the prescribed timely filing limit will deny and return *NCPDP error code* – 81 *"Timely Filing Exceeded."*

- POS Original Claims (NCPDP transaction 01-04/B1) 365 days
- POS Reversals (NCPDP transactions B2) 365 days from original DOS
- POS Re-bills (NCPDP transactions B3) 365 days from original DOS

## 4.3 Dispensing Limits/Claim Restrictions

The Louisiana Medicaid Managed Care Program may have dispensing limits/claim restrictions. Refer to the *Louisiana Medicaid Single Preferred Drug List* (PDL) listed at https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

In certain situations, when a pharmacy provider has communicated with the prescriber, overrides may be allowed at POS.

Please review the reject responses on the claim and contact the PSC at 1-800-424-1664 if further information is needed.

### 4.3.1 Dispensing Quantity Limitations

The following table provides information related to quantity and days' supply limitations.

| Description | Additional Notes |
|---|---|
| Quantity Per Day and Days' Supply | Refer to the Louisiana Medicaid Single PDL for additional information on drug/product specific quantity per day limitations. |
| Maximum Allowable Quantities | • For a non-maintenance drug, a maximum of 1 month's supply (31 days) is allowed.<br>• For a maintenance drug, a one month's supply, and *up to* a 90 days' supply is allowed. |
| Maintenance Medications | • A dispensing fee will not be returned if a claim for a maintenance medication is dispensed for less than a 30-day supply.<br>– A dispensing fee submitted for less than a 30-day supply may be reimbursed, when the pharmacy consults with the prescriber to verify the necessity of the short fill (quantity less than 30 days' supply) and enters a SCC of '47 – Shortened Days' Supply Fill.<br>– If the SCC is not entered, the claim will pay the ingredient cost, but not a dispensing fee, and will return the following message: *"One dispensing fee per 30 days for maintenance medications."*<br>• **Note**: If the product is on the Maintenance Drug List, the drug/product may be dispensed up to a 90 days' supply. |

### 4.3.2 Cost Ceiling

Effective October 1, 2023, Louisiana Medicaid Managed Care Program will implement a cost ceiling of $5,000.00 on pharmacy claims.

Claims submitted for drugs/products that exceed the $5,000.00 cost ceiling limitation will deny with *NCPDP EC 78 – Cost Exceeds Maximum.* Please refer to the specific reject response or contact the PSC at 1-800-424-1664 for assistance and potential override.

Exceptions to this limit are noted in *Section 16.0 Appendix C*.

## 4.4 Refills

For non-controlled products and behavioral health products (including controlled behavioral health products), the system will automatically check for an increase in dose, and when an increase in dosage is detected, the system will not deny the current claim for early refill.

For controlled products (except for Opioids) the call center may assist in overriding this reject if one of the following circumstances exists:

- A change in dosage/therapy/frequency has occurred.
- Two strengths of the same drug are used to make a strength of the prescribed medication that is not currently manufactured.
- A Beneficiary has an active prescription (a prescription in which the days' supply has not expired) for a controlled product prescribed by the same provider

**Note:** The limitations below are applied to whichever is exceeded first.

| Drug Schedule | Refill Limitations | Date to Rx Written Limitations | Comments |
|---|---|---|---|
| DEA Schedule 0 | Original + 11 Refills<br><br>**85%** of the previously dispensed days' supply must be exhausted before able to refill. | 365 days from original Date Rx Written | • Claims exceeding the refill limitation will deny with *NCPDP EC# 76 – Plan Limitations Exceeded.*<br>• Claims exceeding the Date to Rx Written limitation will deny with *NCPDP EC# M4 – Prescription/Service Reference Number/Time Limit Exceeded.* |
| DEA Schedule 2 | No refills allowed | 90 days from original Date Rx Written | • Claims billed as a refill for a Schedule 2 product will deny with *NCPDP EC 73 – Refills Not Covered* and *NCPDP EC 76 – Plan Limitations Exceeded.*<br>• Claims exceeding the Date to Rx Written limitation will deny with *NCPDP EC M4 – Prescription/Service Reference Number/Time Limit Exceeded.* |
| DEA Schedule 3, 4, and 5 | Original + 5 refills<br><br>**90%** of the previously dispensed days' supply must be exhausted before able to refill. | 180 days from original Date Rx Written | • Claims exceeding the refill limitation will deny with *NCPDP EC# 76 – Plan Limitations Exceeded.*<br>• Claims exceeding the Date to Rx Written limitation will deny with *NCPDP EC# M4 – Prescription/Service Reference Number/Time Limit Exceeded.* |

## 4.5 NCPDP Partial Fills

Partial fill functionality is not allowed in the Louisiana Medicaid Managed Care program. Claims submitted as partial fills will deny with *NCPDP Error Code RK- Partial Fill Transaction Not Supported.* See *Section 4.6* below for Incremental Fills of Schedule II Medications.

## 4.6 Incremental Fills of Schedule II Medications

Incremental fills are the dispensing of incremental quantities of the total amount ordered specifically for Schedule II medications, as allowed under federal and state regulations. A single prescription for CII drug may be filled in multiple increments on separate claims only if **ALL** the following conditions are met:

- All incremental claims are processed by the same pharmacy.
- Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed.
- Any quantity remaining on the prescription after 30 days from the date prescribed for non-LTC Beneficiaries, cannot be filled.
- Any quantity remaining on the prescription after 60 days from the date prescribed for LTC Beneficiaries, cannot be filled.
- Reimbursement for incremental fills of CII drugs will not be processed differently and will use established reimbursement policy.
- The $0.10 prescription provider fee will also apply to each incremental fill.

## 4.7 Controlled Product Limitations

### 4.7.1 Morphine Milligram Equivalent (MME)

MMA will utilize current Centers for Disease Control and Prevention (CDC) guidelines to establish a Maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk.

The cumulative MME for all active opioid prescriptions for a beneficiary will be limited to a maximum of 90 MME per day.

Opioid claims with a total MME greater than or equal to (≥) 50 MME per day will not reject but will return the supplemental message *"Advise Naloxone PRN usage. Total daily MME ≥ 50 exceeded, future claims may deny if cumulative MME is ≥ 90."*

Opioid claims that exceed the 90 MME limit will deny with *NCPDP EC 76 – Plan Limitations Exceeded* with the additional message *"90 MME per day exceeded."*

**Note**: Buprenorphine products will not be subject to the MME limitation.

### 4.7.2 Opioid Limitations

Claims for opioid products, have the following edits:

| Opioid Naïve | Opioid Non-Naïve<br>(Paid claim for an opioid within the last 90 days) |
|---|---|
| 7-day quantity limit for oral, non-liquid, short-acting opioids | 30-day quantity limit for oral, non-liquid, short-acting opioids |
| 180mls, or a 7-day supply (whichever is less) for oral liquid opioids. | 30-day quantity limit for long-acting opioids.* |

- *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 past 90 days.
  - Pharmacy claims for a long-acting opioid will deny with *NCPDP EC 75 – Prior Authorization Required* if there is no prior use present in the beneficiary's claim history.
- Diagnosis code requirement to bypass QLs and MME edits for all Schedule II narcotics.
  - Claims submitted for an opioid drug/product will bypass quantity limitations, MME, and prior use edits when a diagnosis for burns/corrosions, or Sickle-Cell crisis is entered on the claim.
  - Claims submitted for an opioid drug/product will bypass quantity limitations, MME, prior use, and concurrent use when a diagnosis for cancer, or palliative care is entered on the incoming claim.
  - For a complete listing of applicable diagnosis codes for the above, please refer to *Section 17.0 – Appendix D*.
- Maximum of 90 MME per day.
- Claims submitted which exceed the quantity limitations will deny with *NCPDP EC 76 – Plan Limitations Exceeded.*

**Note**: If the incoming claim is for a benzodiazepine and there is an active opioid claim in the beneficiary's history, when a seizure diagnosis is entered on the incoming claim, the concurrent use edit will be bypassed. However, if the **incoming** claim is for an opioid, and there is an active benzodiazepine claim in the beneficiary's history, and a seizure diagnosis is entered on the incoming claim, the opioid claim will deny.

**Note**: The above list is not all-inclusive of edits applied for opioid products. Refer to the *Louisiana Medicaid Single PDL* for additional edits that may apply.

### 4.7.3 Sedative/Hypnotic Limitations

Pharmacy claims for all sedative/hypnotic agents (except dexmedetomidine, tasimelteon and zolpidem tartrate oral spray) have limitations depending on previous use of sedative/hypnotics.

- ***Naïve use*** is defined as having no paid claims for a sedative/hypnotic in the previous 60 days.
- ***Chronic use*** is defined as having a paid claim for a sedative/hypnotic in the previous 60 days.

Beneficiaries will have the following limitations for sedative/hypnotic products:

- A 7 days' supply per rolling 30 days for naïve use
- A 15 days' supply per rolling 30 days for chronic use

A diagnosis of palliative care (ICD-10: Z51.5) will bypass the above quantity limitations for oral sedative/hypnotics. All other edits (PA, diagnosis when applicable, etc.) will apply.

## 4.8 Dispense as Written Requirements

MMA will accept the Dispense as Written (DAW) Codes in the table below. These codes are to allow appropriate reimbursement for brand name products. All edits apply.

| DAW Code | DAW Description | Comments |
|---|---|---|
| DAW 0 | No Product Selection Indicated | |
| DAW 1 | Substitution Not Allowed by Prescriber | To be used when the prescriber indicates the brand product is medically necessary. |
| DAW 5 | Substitution Allowed – Brand Drug Dispensed as Generic | To be used by 340B providers when the brand is less expensive than the generic. |
| DAW 8 | Substitution Allowed-Generic Drug Not Available in Marketplace | To be used when a generic equivalent is not available on the market. |
| DAW 9 | Substitution Allowed by Prescriber but Plan Requests Brand | To be used when the brand product is preferred over the generic equivalent. |

Claims submitted for DAW Codes 2, 3, 4, 6, or 7 will deny for *NCPDP EC 22 – M/I Dispense as Written (DAW)/Product Selection Code* with additional message *"Generic substitution required."*

Claims submitted for generic products, where the brand is preferred will deny with *NCPDP EC 606– Brand Drug/Specific Labeler Code Required* with the additional message *"Brand product preferred."*

## 4.9 Electronic Prescribing

Electronic prescriptions are computer-generated prescriptions created by the prescriber and sent directly to the beneficiary's pharmacy of choice. E-Prescribing applications that are certified by SureScripts© (the industry leader in e-Prescribing), allow new prescription orders and refill authorizations from the prescriber to be sent directly to the computers of the selected pharmacies.

E-Prescribing is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions.

Prescribers are encouraged to utilize Electronic Prescribing (e-Prescribing) whenever possible. Prescribers using e-Prescribing will have a client's claims history, eligibility, drug coverage data, as well PA needs available.

## 4.10 Pharmacy and Prescriber Lock-In

Beneficiaries who have Lock-In restrictions may have a primary care physician and up to three (3) specialists, as well as a regular pharmacy provider and one (1) specialty pharmacy provider.

Claims submitted for a Beneficiary with a prescriber Lock-In status, using a prescriber that is not assigned, will deny with *NCPDP EC 56 – Non-Matched Prescriber ID* and will return the additional message *"The prescriber submitted is not the assigned Lock-In Prescriber for the Beneficiary."*

Claims submitted for a Beneficiary with a pharmacy lock-in status, using a pharmacy that is not assigned will deny with *NCPDP EC 50 – Non-Matched Pharmacy Number* and will return the additional message *"The pharmacy submitted is not the assigned Lock-In Pharmacy for the Beneficiary."*

# 5.0 Drug Information and Edits

## 5.1 Covered and Non-Covered Drugs

LDH utilizes a Medicaid single PDL. The PDL indicates the preferred and non-preferred status of covered drugs. The PDL is available on the LDH website: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

The PDL is a list of over 100 therapeutic classes reviewed by the Pharmaceutical & Therapeutics (P&T) committee. With the exception of excluded drug classes listed in the provider manual, medications that are not included in this PDL are almost always covered without the requirement of prior authorization. Examples: hydrochlorothiazide, amoxicillin suspension and digoxin.

Drugs excluded from coverage will deny with *NCPDP EC 70 – Product/Service Not Covered.*

- Covered medications are subject to any applicable POS edits, some of which include PA, quantity, age limits, etc.
  - Pharmacy providers submitting claims for select medications, with limitations or restrictions in place, may in certain situations enter applicable codes at POS for override, see *Appendix E – Point-of-Sale Edits and Overrides* for additional information.
- Covered medications must be manufactured by a company engaged in the Federal Medicaid Rebate Drug Program.
- All written (non-electronic) outpatient prescriptions must be written on a tamper-resistant prescription pad.

The following products are excluded from coverage:

| Description | Comments |
|---|---|
| Anorexics | Except:<br>• Orlistat |
| Nonprescription Drugs | Except:<br>• Over-the-Counter (OTC) antihistamines and antihistamine/decongestant combinations,<br>• Polyethylene Glycol 3350<br>• A and B recommendations for OTC medication by the U.S. Preventive Services Task Force (see *Section 5.2.1 – Preventive Care OTC Products*.) |
| Cosmetic Drugs | Except:<br>• When the state has determined the use to be medically necessary |
| Erectile Dysfunction Drugs | Except:<br>• When used for the treatment of conditions, or indications approved by the FDA, other than erectile dysfunction |
| Cough and Cold Preparations | Except:<br>• Prescription antihistamine and antihistamine/decongestant combination products |
| Fertility Drugs | Except:<br>• Vaginal progesterone when used for high-risk pregnancy to prevent premature births |
| Drug Efficacy Study Implementation (DESI) drugs | |
| Prescription Vitamins and Mineral Products | Except:<br>• Prenatal vitamins<br>• Fluoride Preparations<br>• Vitamin A Injection<br>• Vitamin B Injection<br>• Vitamin D (prescription only)<br>• Vitamin K (prescription only)<br>• Vitamin B12 Injection<br>• Folic Acid (prescription only)<br>• Niacin (prescription only)<br>• Vitamin B6 Injection<br>• Vitamin B1 Injection<br>• Multivitamin (prescription only)<br>• Magnesium Injection<br>• Calcium Injection |

| Description | Comments |
|---|---|
| | • Urinary PH modifiers (Phosphorous, specifically K-Phos Neutral and Phospha Neutral) |
| Durable Medical Equipment/Supplies | Except:<br>• State covered diabetic supplies<br>• Products included in this document |

## 5.2 Over-the-Counter Products

### 5.2.1 Preventive Care OTC Products

The following Over-the-Counter (OTC) medications for preventive care will be covered when a claim is submitted within the specified limitations and when:

- The prescriber issues the Beneficiary a prescription for the preventive care OTC agent; and
- The Beneficiary meets the criteria to obtain the preventive care OTC agent.

| OTC Drug | Medicaid Beneficiary | Preventive Care |
|---|---|---|
| Aspirin 81mg | • Women greater than 12 years of age<br>• Men greater than 44 years of age | • Cardiovascular disease<br>• Colorectal Cancer<br>• 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 |

### 5.2.2 Non-Preventive Care OTC Products

The following OTC medications and supplies for non-preventive care will be covered when:

- The prescriber issues the Beneficiary a prescription for the non-preventive care OTC agent; and
- The product is a covered benefit.

| Non-Preventive OTC Drugs | | | |
|---|---|---|---|
| Insulin | Contraceptives, Topical | Urinary pH modifiers | OTC Vitamin D Preparations |
| OTC Vitamin E Preparations | OTC Niacin Preparations | OTC Calcium Replacement Agents | OTC Magnesium Replacement Agents |

| Non-Preventive OTC Drugs | | | |
|---|---|---|---|
| OTC Phosphate Replacement Agents | OTC Iron Replacement Agents | Normal Saline | Urine Glucose Test Strips |
| Disposable Needles and Syringes used to administer insulin | Test strips for determining blood glucose levels | Family Planning items | Lancets |
| Other non-legend items and supplies that have Pharmacy Program approval | Antihistamine and Antihistamine/Decongestant Combination Products | Polyethylene Glycol 3350 | |

Claims submitted for OTC drugs/products that do not fall within the above categories will deny with *NCPDP EC 70 – Product/Service Not Covered* with the additional message "*OTC product not covered.*"

## 5.3 Diabetic Supplies

Beginning October 1, 2023, blood glucose meters, continuous glucose monitoring (CGM) devices, transmitters and sensors, insulin pumps, insulin pens, diabetic testing strips, ketone test strips, lancets, pen needles, syringes, and control solutions will be billable as a pharmacy benefit for non-Medicare Beneficiaries.

**Note:** COB edits will apply. Diabetic supplies are a Part B-covered benefit. These items are not considered Part D drugs and therefore are not a Part D benefit. After billing Medicare Part B for these items, Medicaid can be billed as the secondary payer using standard COB billing practices.

## 5.4 Vaccines

Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy (LABP) may administer vaccines. Pharmacists with the authorization to administer vaccines may be issued individual Medicaid provider numbers and should acquire an NPI.

Medicaid reimburses pharmacy providers when an authorized pharmacist administers the following vaccines:

- Flu vaccines to Beneficiaries ages 3 years and older
  - Beginning January 1, 2025, pharmacist administration of flu vaccines will not be allowed for Beneficiaries less than 7 years old.

- COVID-19 vaccines to Beneficiaries ages 3 years and older
  - Beginning January 1, 2025, pharmacist administration of COVID-19 vaccines will not be allowed for Beneficiaries less than 17 years old.
- All other covered vaccines, when indicated, to Beneficiaries ages 3 years and older
  - Beginning January 1, 2025, pharmacist administration of other Advisory Committee on Immunization Practices (ACIP) recommended vaccines will not be allowed for Beneficiaries less than 17 years old.
  - Vaccine ingredient cost will not be reimbursed for Beneficiary ages 18 years old or younger due to Vaccines for Children program.

When submitting claims for adult vaccines *NCPDP Field ID 411-DB* (Prescriber ID) and *NCPDP Field ID 444-E9* (Provider ID) will need to be completed in the following way:

- Without a prescription by a prescriber
  - Pharmacist NPI in the Prescriber ID field and the pharmacy NPI in the Provider ID field
- With a prescription by a prescriber
  - Prescriber NPI in the Prescriber ID field and pharmacy NPI in the Provider ID field.

Claims for adult (ages ≥ 19 years) vaccines and administration fees are a covered benefit and will be exempt from copays, and any lock-in limitations. All other edits will apply.

### 5.4.1 Vaccine Counseling

Counseling for vaccines will be reimbursed for Beneficiaries less than 21 years old. Reimbursement will be made in an amount up to $19.72 (either $19.72, or the billed amount, whichever is lower) when criteria has been met, with vaccine administration.

Counseling may be reimbursed up to four (4) counseling visits per Beneficiary per year for vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) or CDC with vaccine administration.

When a claim is submitted for vaccine counseling for a Beneficiary less than 21 years old and the pharmacy provider has been reimbursed for four (4) counseling's in a rolling 365 days, the claim will pay (applicable ingredient cost and administration fee) and return an additional message of *"Counseling not reimbursed/Max 4 per 365 days."*

When a claim is submitted for vaccine counseling for a Beneficiary aged 21 years and older, the claim will pay (applicable ingredient cost and administration fee) and return an additional message of *"Counseling not reimbursed for this age."*

The ingredient cost of the vaccine will not be reimbursed for Beneficiaries under the age of 19 years.

An additional message of *"Counseling not reimbursed."* will be returned for Beneficiaries outside of the 3-20 year old age limitations.

When counseling has been provided and results in the administration of the vaccine, the claim must be submitted with all applicable NCPDP fields, as well as the Professional Service Code (NCPDP Field ID: 440-E5) 'PE – Patient Education' in order to be reimbursed for counseling, administration fee and any applicable ingredient cost. If Professional Service Code 'MA – Medication Administration,' reimbursement will be for the administration fee and any applicable ingredient cost.

When Professional Service Code 'PE" is submitted on a vaccine pharmacy claim for a Beneficiary within the applicable age limits, an **additional** amount up to $19.72 (either $19.72, or the billed amount, whichever is lower) will be reimbursed to the pharmacy for counseling, on top of the administration fee and any applicable ingredient cost.

| Reimbursement according to age of Beneficiary for vaccine, administration and/or counseling | | | |
|---|---|---|---|
| **NCPDP Field** | **Ages 3-18**<br>COVID-19: Ages 3-18<br>Influenza: Ages 3-18<br>All other vaccines: Ages 3-18 | **Ages 19-20**<br>All vaccines (COVID, influenza and others) | **Ages 21 and older**<br>All vaccines (COVID, influenza and others) |
| Ingredient Cost Paid (NCPDP Field ID: 506-F6) | Always $0.00<br><br>**No ingredient cost reimbursed in this age group.** | **"MA" or "PE"** in Professional Service Code field<br><br>Up to maximum allowable, unless claim is for COVID-19 or Monkeypox vaccines, then $0.00 | **"MA" or "PE"** in Professional Service Code field<br><br>Up to maximum allowable, unless claim is for COVID-19 or Monkeypox vaccines, then $0.00 |
| Incentive Amount Paid (NCPDP Field ID: 521.FL) | **"MA"** in Professional Service Code field<br>Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day (no counseling reimbursed with 'MA") | **"MA"** in Professional Service Code field<br>Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day (no counseling reimbursed with 'MA")<br><br>**"PE"** in Professional Service Code field | **"MA"** in Professional Service Code field<br>Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day (no counseling reimbursed with 'MA") |

| Reimbursement according to age of Beneficiary for vaccine, administration and/or counseling | | | |
|---|---|---|---|
| **NCPDP Field** | **Ages 3-18**<br>COVID-19: Ages 3-18<br>Influenza: Ages 3-18<br>All other vaccines: Ages 3-18 | **Ages 19-20**<br>All vaccines (COVID, influenza and others) | **Ages 21 and older**<br>All vaccines (COVID, influenza and others) |
| | **"PE"** in Professional Service Code field<br>Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day<br>**AND**<br>$19.72 (counseling) or billed amount, whichever is lower | Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day<br>**AND**<br>$19.72 (counseling) or billed amount, whichever is lower | **"PE"** in Professional Service Code field<br>Vaccines: $15.22 for first vaccines, or $9.13 for second vaccine billed on the same day<br>**No counseling reimbursed with "PE" in this age group** |
| Flat Sales Tax Submitted (NCPDP Field ID: 481-HA) (Provider fee) | $0.10 when MCO is primary payer.<br>$0.00 when MCO is secondary payer (primary paid > $0.00) | $0.10 when MCO is primary payer.<br>$0.00 when MCO is secondary payer (primary paid > $0.00) | $0.10 when MCO is primary payer.<br>$0.00 when MCO is secondary payer (primary paid > $0.00) |

- The vaccine ingredient cost will not be reimbursed for Beneficiaries less than 19 since the vaccines are provided by the Vaccines for Children (VFC) program, or when the vaccine has been provided by the federal government (i.e., COVID or monkeypox vaccines).
- Vaccine pharmacy claims will be reimbursed an administration fee and no dispensing fee.
- Vaccine pharmacy claims submitted without a Professional Service Code of "MA" or "PE" will deny with *NCPDP EC E5 – M/I Professional Service Code*.
- Only credentialed pharmacists who are enrolled with Louisiana Medicaid may be included in claim submission. If the pharmacist is not enrolled on the DOS, or the pharmacist's NPI is missing on invalid, or if a pharmacy's NPI is entered the claim will deny with *NCPDP EC E9 – M/I Provider ID*.
- '05-NPI' must be entered in the Provider ID Qualifier (NCPDP Field ID: 465-EY) field. If a value other than '05-NPI', or no qualifier is entered, the claim will deny with *NCPDP EC EY – M/I Provider ID Qualifier*.
- Claims submitted for a vaccine administration, and/or counseling with an Incentive Amount Submitted (NCPDP Field ID: 438-E3) of $0.00, the claim will deny with *NCPDP EC E3 – M/I Incentive Amount Submitted.*

## COVID-19

The administration of the COVID-19 vaccine, including the initial dose(s), third dose, and booster dose(s) are covered as a pharmacy benefit.

- COB edits will apply.
- Vaccine administration for Beneficiaries ages 6 months, up to 3 years are not covered as a pharmacy benefit due to the PREP act restrictions on pharmacist administration.

Claims submitted for administration other than the primary dose administration must not be filled early. Pfizer or Novavax second dose vaccine administration should be payable at least 17 days from the previous dose. Moderna second dose vaccine administration should be payable at least 24 days from the previous dose. Third dose vaccine administration should be payable at least 28 days after the second dose. Claims submitted too early will deny with *NCPDP EC 76 – Plan Limitations Exceeded*.

Providers will need to submit claims in the following manner utilizing the NCPDP D.0 format:

| NCPDP Field ID: | NCPDP Field Name | Value | Comments |
|---|---|---|---|
| 405-D5 | Days' Supply | 1 | If value other than '1' is submitted in this field, claim will deny with *NCPDP EC 19 – M/I Days Supply* |
| 407-D7 | Product/Service ID | 11 Digit NDC | Vaccine NDC |
| 409-D9 | Ingredient Cost Submitted | $0.00, or $0.01 | No denial, payment for the drug will either be $0.00, or $0.01, regardless of what is submitted on the claim.<br>MCO can pay $0.00, even when $0.01 is billed. |
| 423-DN | Basis of Cost (BOC) Determination | 15 – Free Product or No Associated Cost<br>Or<br>01 - AWP | When using a value of '15', the ingredient cost entered must be $0.00<br>When using a value of '01', the ingredient cost must be $0.01<br>Claims will reject *NCPDP EC DN – M/I Basis of Cost Determination* if an ingredient cost of $0.00 and a BOC <> 15 is submitted, or if a BOC = 15 and ingredient cost is > $0.00. |

| NCPDP Field ID: | NCPDP Field Name | Value | Comments |
|---|---|---|---|
| 411-DB | Prescriber ID | Prescriber/Pharmacist NPI | Prescriptions initiated by the pharmacy should be submitted using the Pharmacist's Type 1 NPI in this field and a Prescription Origin Code (NCPDP Field ID: 419-DJ) of '5-Pharmacy' |
| 438-E3 | Incentive Amount Submitted | >$0.00 | If the value submitted is $0.00, the claim will deny with *NCPDP EC E3 – M/I Incentive Amount Submitted*, otherwise the fixed amount is paid. |
| 442-E7 | Quantity Dispensed | | The quantity dispensed should be submitted with the value that represents the quantity of the drug product administered.<br><br>Any values submitted that do not align with the applicable dosing will deny with *NCPDP EC E7 – M/I Quantity Dispensed* |
| 440-E5 | Professional Service Code | MA | Medication Administration<br><br>Claims submitted without a Professional Service Code 'MA' will deny with *NCPDP EC E5 – M/I Professional Service Code* |
| 420-DK | Submission Clarification Code (SCC) | 2 – Other Override<br>6 – Starter Dose<br>7 – Medically Necessary<br>10 – Meets Plan Limitations | • SCC 2 indicates the initial dose<br>• SCC 6 indicates the second dose<br>• SCC 7 indicates the third dose<br>• SCC 10 indicates the booster dose(s)<br><br>**Note:** Use of SCC codes is needed for multi-dose vaccines. SCCs of 2, 6, 7, or 10 should allow a claim to process. |
| 444-E9 | Provider ID | Pharmacist NPI | The Vaccinating Pharmacist's NPI |
| 465-EY | Provider ID Qualifier | 05 | NPI |
| 558-AW | Flat Sales Tax Paid | $0.10 | **Note:**<br>Flat Sales Tax Paid will be $0.00 when MCO is secondary payer (primary paid > $0.00) |

## 5.4.2 COVID-19 Vaccine Dosages and Covered NDCs

### Pfizer Bivalent COVID-19 Vaccines

Multi-dose series:

- No early refill allowed
- Maximum Days' Supply: 1
- Maximum Quantity: 0.3
- Quantity Limitation: 4 doses within 180 days
- Refill Limitation: 3

**Note:** Comirnaty® (Pfizer's FDA approved vaccine) has a minimum age limitation of 12 years.

| Pfizer Bivalent | | | |
|---|---|---|---|
| **NDC** | **Generic Name** | **Trade Name** | **Strength** |
| **For Beneficiaries ages 12 years or older, only allow the following NDCs:** | | | |
| 59267030401 | COVID-19 VAC, BV (PFIZER)/PF | PFIZER COVID BIVAL(12Y UP)-EUA | 30 mcg/0.3 mL |
| 59267140401 | COVID-19 VAC, BV (PFIZER)/PF | PFIZER COVID BIVAL(12Y UP)-EUA | 30 mcg/0.3 mL |
| **For Beneficiaries ages 5 years or older, only allow the following NDCs:** | | | |
| 59267056501 | COVID-19 VAC, BV (PFIZER)/PF | PFIZER COVID BIVAL(5-11YR)EUA | 10 mcg/0.2 mL |
| **For Beneficiaries ages 3 to 4 years, only allow the following NDCs:** | | | |
| 59267060901 | COVID-19 VAC, BV (PFIZER)/PF | PFIZER COVID BIVAL(6MO-4Y)EUA | 3 mcg/0.2 mL |

**Note:** NDC that ends in 02 is outer packaging and will not be payable.

The table below outlines dosing of the Pfizer Bivalent COVID-19 Vaccine. The table is to be used for dosing only; all other items are informational:

| Bivalent Pfizer-BioNTech mRNA COVID-19 Vaccine: | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **6 months through 4 years** | Unvaccinated: 0 doses | 3 doses of bivalent vaccine:<br>• First dose followed by,<br>• Second dose at least 3-8 weeks after first dose<br>• Third dose at least 8 weeks (2 months) after second dose | 0.2 mL/3 *µg* |
| | 1 dose of bivalent vaccine | 2 doses of bivalent vaccine:<br>• Second dose at least 3-8 weeks after first dose<br>• Third dose at least 8 weeks (2 months) after second dose | |
| | 2 doses of bivalent vaccine | Single dose of bivalent vaccine:<br>• At least 8 weeks (2 months) after second dose of bivalent vaccine | |
| | At least 3 doses of bivalent vaccine | No dose | N/A |
| | **Previously vaccinated with monovalent mRNA COVID-19 Vaccine** | | |
| | 1 dose of monovalent vaccine | 2 doses of bivalent vaccine:<br>• Second dose at least 3-8 weeks after first dose<br>• Third dose at least 8 weeks (2 months) after second dose | 0.2 mL/3 *µg* |
| | 2 doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• Third dose at least 8 weeks (2 months) after second dose of monovalent vaccine | |
| | At least one dose of monovalent vaccine and 1 dose of bivalent vaccine | No dose | N/A |
| | Unvaccinated: 0 doses | Single dose of bivalent vaccine | |

| Bivalent Pfizer-BioNTech mRNA COVID-19 Vaccine:<br>*Monovalent Pfizer-BioNTech vaccine is no longer recommended and should not be used.* | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **5 years and older** | 1 or more doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• At least 8 weeks (2 months) after the previous dose | **5-11 years old**:<br>0.2 mL/10 *µg*<br><br>**12 years and older**:<br>0.3 mL/30 *µg* |
| | At least 1 dose of bivalent vaccine | No dose | N/A |

**Note:** The table below outlines dosing of the Pfizer bivalent COVID-19 vaccine for people who are moderately to severely immunocompromised.

| Bivalent Pfizer-BioNTech mRNA COVID-19 Vaccine: | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **6 months through 4 years** | Unvaccinated: 0 doses | 3 doses of bivalent vaccine<br>• First dose followed by<br>• Second dose at least 3 weeks after first dose<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | 0.2 mL/3 *µg* |
| | 1 dose of bivalent vaccine | 2 doses of bivalent vaccine<br>• Second dose at least 3 weeks after first dose.<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | |
| | 2 doses of bivalent vaccine | Single dose of bivalent vaccine<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | |
| | 3 doses of bivalent vaccine | See footnote‡ (see link for additional info) | |
| | **Previously vaccinated with monovalent mRNA COVID-19 vaccine** | | |
| | 1 dose of monovalent vaccine | 2 doses of bivalent vaccine<br>• Second dose at least 3 weeks after first dose.<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | |
| | 2 doses of monovalent vaccine | Single dose of bivalent vaccine<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | |
| | 3 doses of monovalent vaccine | Single dose of bivalent vaccine<br>• Third dose at least 8 weeks (2 months) after second dose.‡ | |

<table>
<tr><th colspan="4">Bivalent Pfizer-BioNTech mRNA COVID-19 Vaccine:<br>Monovalent Pfizer-BioNTech vaccine is no longer recommended and should not be used.</th></tr>
<tr><th>Age</th><th>Vaccination History</th><th>Bivalent Vaccine Schedule</th><th>Administer</th></tr>
<tr><td></td><td>At least 1 dose of monovalent vaccine and 1 dose of bivalent vaccine</td><td>See footnote‡ (see link for additional info)</td><td></td></tr>
<tr><td rowspan="8">5 years† and older</td><td>Unvaccinated: 0 doses</td><td>3 doses of bivalent vaccine<br>• First dose followed by<br>• Second dose at least 3 weeks after first dose<br>• Third dose at least 4 weeks after second dose‡</td><td rowspan="8">5 through 11 years: 0.2 mL/10 µg<br>12 years and older: 0.3 mL/30 µg</td></tr>
<tr><td>1 dose of bivalent vaccine</td><td>2 doses of bivalent vaccine<br>• Second dose at least 3 weeks after first dose.<br>• Third dose at least 4 weeks after second dose‡</td></tr>
<tr><td>2 doses of bivalent vaccine</td><td>Single dose of bivalent vaccine<br>• Third dose at least 4 weeks after second dose of bivalent vaccine.‡</td></tr>
<tr><td>3 doses of bivalent vaccine</td><td>See footnote‡ (see link for additional info)</td></tr>
<tr><td colspan="2">Previously vaccinated with monovalent mRNA COVID-19 vaccine</td></tr>
<tr><td>1 dose of monovalent vaccine</td><td>2 doses of bivalent vaccine<br>• Second dose at least 3 weeks after first dose.<br>• Third dose at least 4 weeks after second dose‡</td></tr>
<tr><td>2 doses of monovalent vaccine</td><td>Single dose of bivalent vaccine<br>• Third dose at least 4 weeks after the previous dose of monovalent vaccine.‡</td></tr>
<tr><td>3 doses of monovalent vaccine</td><td>Single dose of bivalent vaccine<br>• Fourth dose at least 8 weeks (2 months) after third dose.‡</td></tr>
</table>

| Bivalent Pfizer-BioNTech mRNA COVID-19 Vaccine:<br>*Monovalent Pfizer-BioNTech vaccine is no longer recommended and should not be used.* | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| | At least 1 dose of monovalent vaccine and 1 dose of bivalent vaccine | See footnote‡ (see link for additional info) | |

### Moderna Bivalent COVID-19 Vaccines

Multi-dose series:

- No early refill allowed
- Maximum Days' Supply: 1
- Maximum Quantity: 0.5
- Quantity Limitation: 4 doses within 180 days
- Refill Limitation: 3

| Moderna Bivalent | | | |
|---|---|---|---|
| **NDC** | **Generic Name** | **Trade Name** | **Strength** |
| **For Beneficiaries ages 6 years or older, only allow the following NDCs :** | | | |
| 80777028205 | COVID-19 VAC, BV (MODERNA)/PF | MODERNA COVID BIVAL (6Y UP) EUA | 50 mcg/0.5 mL |
| **For Beneficiaries ages 3 to 5 years, only allow the following NDCs:** | | | |
| 80777028302 | COVID-19 VAC, BV (MODERNA)/PF | MODERNA COVID BIVAL (6M-5Y) EUA | 10 mcg/0.2 mL |

**Note:** NDC that ends in 99 is outer packaging and will not be payable.

The table below outlines dosing of the Moderna Bivalent COVID-19 Vaccine. The table is to be used for dosing only; all other items are informational:

| Bivalent Moderna mRNA COVID-19 Vaccine: | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **6 months through 5 years** | Unvaccinated: 0 doses | 2 doses of bivalent vaccine:<br>• First bivalent dose followed by:<br>• Second bivalent dose at least 4-8 weeks after the first dose | 0.25 mL/25 *µg* |
| | 1 dose of bivalent vaccine | Single dose of bivalent vaccine:<br>• At least 4-8 weeks after first bivalent dose | |
| | At least 2 doses of bivalent vaccine | No dose | N/A |
| | **Previously vaccinated with monovalent mRNA COVID-19 Vaccine** | | |
| | 1 dose of monovalent vaccine | Single dose bivalent vaccine:<br>• At least 4-8 weeks after dose of monovalent | 0.25mL/25 µg |
| | 2 doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• At least 8 weeks (2 months) after second dose of monovalent | 0.2mL/10 µg |
| | At least 1 dose of monovalent vaccine and 1 dose of bivalent vaccine | No dose | N/A |
| **6 years and older** | Unvaccinated: 0 doses | Single dose of bivalent vaccine | **6-11 years old**:<br>0.25 mL/25 *µg*<br><br>**12 years and older**:<br>0.50 mL/50 *µg* |
| | 1 or more doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• At least 8 weeks (2 months) after the previous dose of monovalent vaccine | |
| | At least 1 dose of bivalent vaccine | No dose | N/A |

**Note:** The table below outlines dosing of the Moderna bivalent COVID-19 vaccine for people who are moderately to severely immunocompromised.

| Bivalent Moderna mRNA COVID-19 Vaccine: | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **6 months and older†** | Unvaccinated: 0 doses | 3 doses of bivalent vaccine:<br>• First dose followed by<br>• Second dose at least 4 weeks after first dose.<br>• Third dose at least 4 weeks after second dose.‡ | **6 months through 11 years**: 0.25 mL/25 *µg*<br>**12 years and older**: 0.50 mL/50 *µg* |
| | 1 dose of bivalent vaccine only | 2 doses of bivalent vaccine:<br>• Second dose at least 4 weeks after first dose<br>• Third dose at least 4 weeks after second dose.‡ | |
| | 2 doses of bivalent vaccine | Single dose of bivalent vaccine:<br>• Third dose at least 4 weeks after second dose. ‡ | |
| | 3 doses of bivalent vaccine | See footnote‡ (see link for additional info) | **6 months through 4 years:** 0.2mL/10 *µg*<br>**5 through 11 years:** 0.25 mL/25 *µg*<br>12 years and older: 0.50 mL/50 *µg* |
| | **Previously vaccinated with monovalent mRNA COVID-19 vaccine** | | |
| | 1 dose of monovalent vaccine | 2 doses of bivalent vaccine:<br>• Second dose at least 4 weeks after first dose.<br>• Third dose at least 4 weeks after second dose.‡ | **6 months through 11 years**: 0.25 mL/25 *µg*<br>**12 years and older**: 0.50 mL/50 *µg* |
| | 2 doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• Third dose at least 4 weeks after second dose of monovalent vaccine.‡ | |
| | 3 doses of monovalent vaccine | Single dose of bivalent vaccine:<br>• Fourth dose at least 8 weeks after third dose.‡ | **6 months through 4 years**: 0.2mL/10 *µg* |

| Bivalent Moderna mRNA COVID-19 Vaccine:<br>*Monovalent Moderna vaccine is no longer recommended and should not be used.* | | | |
|---|---|---|---|
| | 3 doses of monovalent vaccine and 1 dose of bivalent vaccine | See footnote‡ (see link for additional info) | **5 through 11 years**: 0.25 mL/25 *µg*<br>**12 years and older**: 0.50 mL/50 *µg* |

### Novavax COVID-19 Vaccines

Multi-dose series:

- No early refill allowed
- Maximum Days' Supply: 1
- Maximum Quantity: 0.5
- Quantity Limitation: 3 doses within 180 days
- Refill Limitation: 2
- Minimum Age: 12

| Novavax, Adjuvanted<br>Primary Series: For Beneficiaries ages 12 years or older<br>First Booster Dose, for Beneficiaries ages 18 and older<br>Only allow the following NDCs: | | | |
|---|---|---|---|
| **NDC** | **Generic Name** | **Trade Name** | **Strength** |
| 80631010001 | COVID19 VAC (NOVAVAX)/ADJ/PF | NOVAVAX COVID-19 VACC ADJ (EUA) | 5 mcg/0.5 mL |
| 80631010201 | COVID19 VAC (NOVAVAX)/ADJ/PF | NOVAVAX COVID-19 VACC ADJ (EUA) | 5 mcg/0.5 mL |

**Note:** NDC that ends in 10 is outer packaging and will not be payable.

The table below outlines dosing of the Novavax, Adjuvanted COVID-19 Vaccine. The table is to be used for dosing only, all other items are informational:

| Novavax (Monovalent Vaccine) – Protein Sub-Unit | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Bivalent Vaccine Schedule** | **Administer** |
| **12 years and older** | 1 or more doses of monovalent Novavax vaccine | Single dose of bivalent mRNA vaccine at least 8 weeks (2 months) after second dose of Novavax vaccine | **Moderna Bivalent Vaccine:** 0.50mL/50 *µg* **OR** **Pfizer-BioNTech Bivalent Vaccine:** 0.3mL/30 *µg* |
| | At least 1 dose of bivalent vaccine | No Dose | N/A |

**Note:** The table below outlines dosing of the Novavax Monovalent COVID-19 Vaccine for People Who are Moderately to Severely Immunocompromised.

| Novavax (Monovalent vaccine) Type: Protein Sub Unit | | | |
|---|---|---|---|
| **Age** | **Vaccination History** | **Vaccine Schedule** | **Administer** |
| **12 years and older** | 1 or more doses of monovalent Novavax vaccine | 1 single dose of bivalent mRNA vaccine at least 8 weeks (2 months) after Dose 2† | **Moderna:** 0.50 mL/50 ug **OR** **Pfizer-BioNTech:** 0.3 mL/30 ug |

### 5.4.3 Oral Treatments for COVID-19

The Louisiana Medicaid Managed Care Program currently covers Paxlovid and molnupiravir under the FDA Emergency Use Authorization (EUA). Co-pays do not apply to claims submitted for COVID-19 oral therapy.

**Quantity Limitations:**

- Paxlovid: 30 tablets per 5 days
- Molnupiravir: 40 tablets per 5 days

Claims submitted exceeding the above will deny with *NCPDP EC 76 – Plan Limitations Exceeded.*

**Minimum Age Limitations:**

- Paxlovid: 12 years and older
- Molnupiravir: 18 years and older

Claims submitted for Beneficiaries less than the age limit will deny with *NCPDP EC 60 – Product/Service Not Covered for Patient Age*.

**NCPDP Field Requirements:**

| NCPDP Field ID: | NCPDP Field Name | Value | Comments |
|---|---|---|---|
| 423-DN | Basis of Cost (BOC) Determination | 15 – Free Product or No Associated Cost<br>Or<br>01 - AWP | When using a value of '15', the ingredient cost entered must be $0.00<br>When using a value of '01', the ingredient cost must be $0.01<br>Claims will reject *NCPDP EC DN – M/I Basis of Cost Determination* if an ingredient cost of $0.00 and a BOC other than15 is submitted, or if a BOC = 15 and ingredient cost is > $0.00, or if a BOC = 01 and the ingredient cost is $0.00. |

## At-Home OTC COVID-19 Tests

Only OTC At-Home COVID tests that are FDA authorized will be covered.

- Beneficiaries will be exempt from co-pays for covered OTC At-Home COVID tests.
- COB edits will apply.
- 8 tests per rolling 30 days per beneficiary.

Providers will need to submit claims in the following manner utilizing the NCPDP D.0 format:

| NCPDP Field ID: | NCPDP Field Name | Value | Comments |
|---|---|---|---|
| 423-DN | Basis of Cost (BOC) Determination | 15 – Free Product or No Associated Cost<br>Or<br>01 - AWP | If tests are free to the pharmacy:<br>• When claim is submitted with a value of '15', the ingredient cost entered must be $0.00<br>• When claim is submitted with a value of '01', the ingredient cost must be $0.01<br>Claims will reject *NCPDP EC DN – M/I Basis of Cost Determination* if an ingredient cost of $0.00 and a BOC <> 15 is submitted, or if a BOC = 15 and ingredient cost is > $0.00. |
| 411-DB | Prescriber ID | Prescriber/Pharmacist NPI | A pharmacy or pharmacist NPI will be allowed to be entered as the Prescribing provider when a SCC (NCPDP Field ID: 420-DK) of '42 – Prescriber ID' is entered on the incoming claim. |
| 558-AW | Flat Sales Tax Paid (provider fee) | $0.10 | **Note:** Flat Sales Tax Paid will be $0.00 when MCO is secondary payer (primary paid > $0.00) |

## 5.5 Age Restrictions

The PDL may contain products with age restrictions.

When the product has either a minimum or a maximum age requirement and the Beneficiary age does not meet that requirement, the claim will reject with *NCPDP Reject Code 60 – Product/Service Not Covered for Patient Age* with supplemental message *"Age requirement not met."*

Specific drugs/products that have age restrictions may be overridden at POS using applicable Reason for Service, Professional Service and Result of Service Codes.

## 5.6 Long-Term Care Claims

Long-Term Care (LTC) Beneficiaries can be identified by providers submitting a 03 - Nursing Facility on the incoming claim in the Patient Residence Code, *NCPDP Field ID: 384-4X* field or applicable Recipient Type Case.

- OTC medications, diabetic supplies and glucometers are considered a part of the per diem for LTC Beneficiaries. Claims submitted for these products will deny with *NCPDP EC 70 – Product/Service Not Covered* with message "*Drug not covered, included in long-term care per diem rate."* when billed at POS for LTC Beneficiaries.
- Nebulizer medications for Beneficiaries without Medicare, who reside in a LTC facility will be reimbursed at POS.
- If a claim is submitted for a LTC Beneficiary with Medicare coverage, the claim will be denied.
- For a non-maintenance drug, a maximum of 1 month's supply is allowed. Claims submitted for a days' supply of 32 and greater will deny for *NCPDP EC 76 – Plan Limitations Exceeded*.
- For a maintenance drug, a one month's supply, and up to a 90 days' supply is allowed. Claims submitted for a days' supply of 91 and greater will deny for *NCPDP EC 76 – Plan Limitations Exceeded*.
- LTC Beneficiaries are exempt from co-payments.
- All PA, PDL, COB and ProDUR edits will apply to LTC claims.

## 5.7 Hospice Claims

Hospice Beneficiaries can be identified by providers submitting an 11 - Hospice on the incoming claim in the Patient Residence Code, *NCPDP Field ID: 384-4X* field.

Pharmacy providers should only bill for out-patient pharmacy claims for drug products that are unrelated to the terminal illness covered by hospice.

## 5.8 Continuity of Care

Providers should contact the CSC for an override for claims submitted for newly enrolled Beneficiaries who are currently receiving a prescription drug that is not on the PDL.

### 5.8.1 Discharge from Hospital

Claims for behavioral health drugs/products (including, but not limited to, naloxone, buprenorphine containing products, and long-acting injectable antipsychotics), may be dispensed to Beneficiaries who have been discharged from a hospital for a 30 days' supply, for up to one (1) refill, or a 60 days' supply if claim submitted is for a maintenance medication.

If a claim denies for a drug or products prescribed at discharge from a hospital, providers should use Submission Clarification Code '57 – Discharge'. This SCC code will be limited to two (2) per Beneficiary, per rolling 60 days.

# 6.0 Prior Authorizations

## 6.1 Prior Authorizations

The MMA Clinical Call Center will receive PA requests for products that require PA or have clinical edits for all Medicaid Managed Care Plans. PA requests are made by the prescribing physician or the prescribing physician's agent (must be a documented agent). Requests may be initiated by telephone, fax, mail, or WebPA.

Pharmacies do have the ability to initiate a PA acting as a representative for the prescriber. Any pharmacy-initiated request submitted via WebPA will be routed to the prescriber to complete submission and verify all clinical information provided. Pharmacies will not receive PA determination letters and/or notifications. These notifications will be sent to the prescriber.

### 6.1.1 Fair Hearings and Appeals

A Beneficiary's managed care plan will handle all appeals and fair hearing requests. MMA will notify requesters of their appeal rights and procedures. This information will be attached to the *Notice of Decision* facsimile or letter for the denied PA.

### 6.1.2 Grievances

Grievances can be filed at any time by the Beneficiary or an authorized representative acting on behalf of the Beneficiary. These grievances can be submitted via phone, fax, mail or via the Contact Us feature on the Louisiana Medicaid MCO web portal. MMA will handle grievances for:

- Services provided by MMA
- MMA's pharmacy network
- Services provided by any MMA third party vendor

For grievances regarding the medical benefit or services provided by the MCO, MMA will provide callers with the MCO's contact information to contact the MCO directly.

## 6.2 Emergency Supply Overrides

Medications that require a PA, may be eligible for an emergency supply when the pharmacist cannot reach the prescriber and deems the situation an emergency.

- Claims submitted for an emergency fill will be overridden by entering a *Level of Service NCPDP Field ID: 418-DI* '03 – Emergency'.
- Claims indicating emergency situations should be dispensed in at least a 72-hour (3-day) supply, up to a 14-day supply, or full unbreakable package.
- Emergency fills will be limited to, 2 fills per rolling 30 days, per drug strength. Once this limit is exceeded, claims will deny with *NCPDP 76 –Plan Limitations Exceeded* and the pharmacy must call the Call Center for any further consideration.
- Beneficiaries are exempt from paying co-payments for emergency situations.
- A dispensing fee will be reimbursed for each emergency fill.

**Note:** There may be instances where the Level of Service: 3 – Emergency may override edits other than a Prior Authorization requirement (see *Appendix E – Point-of-Sale Edits and Overrides*).

### 6.2.1 Emergency Lock-in Overrides

Circumstances may arise where it is necessary for a pharmacy to grant services for a Lock-In Beneficiary when the provider is not the chosen Lock-In provider.

- Claims that deny for Lock-In can be overridden by entering a *Level of Service NCPDP Field ID: 418-DI* '3 – Emergency'.
- Lock-In emergency overrides will be limited to 1 override per drug strength, per 30 days.

## 6.3 Prospective Drug Utilization Review (ProDUR)

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of MMA assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the MMA ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Pharmacists use their education and professional judgments in all aspects of dispensing.

### 6.3.1 Drug Utilization Review Edits

ProDUR edits involving narcotic analgesics, sedative hypnotics, benzodiazepines, or skeletal muscle relaxants require a telephone call to the PSC to obtain an override.

The following ProDUR edits will deny for the plan:

- Early Refill (ER)
- Drug to Drug (DD)
- Therapeutic Duplication (TD)
- Ingredient Duplication (ID)
- Maximum Daily Dosing (HD)
- Excessive Duration (MX)
- Drug to Pregnancy (PG)
- Drug to Geriatric Precautions (PA)
- Drug to Pediatric Precautions (PA)

### 6.3.2 ProDUR Overrides

The following are the NCPDP interactive **Professional Service**, **Result of Service**, **Reason for Service**, and **Submission Clarification** codes. These codes may be used to override ProDUR denials at the POS. Override codes must be entered each time an error occurs.

**Problem/Conflict Type**: The following override codes may be used by providers for any situation in which a provider-level override is allowed for ProDUR denials.

Claims submitted with service codes that are not applicable to the Reason for Service codes outlined in the below table will continue to reject *NCPDP EC 88 – DUR Reject Error*.

**Note**: Vacation supply, as well as lost, stolen, or damaged medications are also acceptable reasons for an ER override at POS. Providers submitting a claim for a vacation supply should enter the applicable Professional and Reason for Service Codes for early refill and enter a Submission Clarification Code (SCC) '03- Vacation Supply.' Providers submitting a claim for lost, stolen, or damaged medications should enter the applicable Professional and Reason for Service Codes for early refill and enter a SCC '04 – Lost Prescription.'

| Reason For Service Code(s) NCPDP field 439-E4 | Provider Override Allowed? | Applicable Professional Service Code(s)/Description NCPDP field 440-E5 | Applicable Result of Service Code(s)/Description NCPDP field 441-E6 |
|---|---|---|---|
| • PA – Drug to Age<br>• DD – Drug to Drug Interaction<br>• EX – Excessive Quantity<br>• HD – High Dose<br>• NN – Unnecessary Drug<br>• TD – Therapeutic Duplication | Yes | • M0 – Prescriber Consulted | • 1G – Filled, Prescriber Approved |
| • ID – Ingredient Duplication<br>• ER – Early Refill | Yes | • M0 – Prescriber Consulted<br>• P0 – Patient Consulted<br>• R0 – Pharmacist Consulted, Other | • 1A – Filled As Is, False Positive<br>• 1B – Filled Prescription As Is<br>• 1C – Filled, With Different Dose<br>• 1D – Filled, Different Direction<br>• 1E – Filled, With Different Drug<br>• 1F – Filled, Different Quantity |

| Reason For Service Code(s) NCPDP field 439-E4 | Provider Override Allowed? | Applicable Professional Service Code(s)/Description NCPDP field 440-E5 | Applicable Result of Service Code(s)/Description NCPDP field 441-E6 |
|---|---|---|---|
| | | | • 1G – Filled, Prescriber Approved |
| • MX – Excessive Duration | Yes | • M0 – Prescriber Consulted | • 1A – Filled As Is, False Positive<br>• 1B – Filled Prescription As Is<br>• 1C – Filled, With Different Dose<br>• 1D – Filled, Different Direction<br>• 1E – Filled, With Different Drug<br>• 1F – Filled, Different Quantity<br>• 1G – Filled, Prescriber Approved<br>• 2A – Prescription Not Filled<br>• 2B – Not Dispensed, Directions Clarified |

All ProDUR alert messages appear at the end of the claim's adjudication transmission. Alerts appear in the following format:

| Alerts | |
|---|---|
| **Format** | **Field Definitions** |
| Reason for Service | Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD). |
| Severity Index Code | One character. Code indicates how critical a given conflict is. |
| Other Pharmacy Indicator | One character. Indicates whether the dispensing provider also dispensed the first drug in question.<br>• 1 = Your Pharmacy<br>• 3 = Other Pharmacy |
| Previous Date of Fill | Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format. |
| Quantity of Previous Fill | Five characters. Indicates quantity of conflicting drug previously dispensed. |

| Alerts | |
|---|---|
| **Format** | **Field Definitions** |
| Database Indicator | One character. Indicates source of ProDUR message.<br>• 1 = First Databank<br>• 4 = Processor Developed |
| Other Prescriber | One character. Indicates the prescriber of conflicting prescription.<br>• 0 = No Value<br>• 1 = Same Prescriber<br>• 2 = Other Prescriber |

# 7.0 Coordination of Benefits (COB)

LDH is always the payer of last resort. Providers must bill all other payers first and then bill the Beneficiary's MCO. COB edits will be applied when Third-Party Liability (TPL) exists for the Beneficiary on the DOS of the claim.

TPL refers to:

- An insurance plan or carrier
- A program
- A commercial carrier

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured; and a self-funded plan

The terms *Third-Party Liability* and *other insurance* are used interchangeably to mean any source other than the plan that has a financial obligation for health care coverage.

## 7.1 COB General Instructions

### 7.1.1 COB Process

COB processing requires that the **Other Payer Amount Paid**, **Other Payer ID**, **Other Payer Date**, and **Other Payer Patient Responsibility** be submitted on the claim to the plan. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.

System returns **Other Payer** details in the "COB Response Segment" (items returned are subject to information received on the Beneficiary's COB records):

| | |
|---|---|
| Other Payer Coverage Type | Other Payer ID Qualifier |
| Other Payer ID | Other Payer Processor Control Number (PCN) |
| Other Payer Cardholder ID | Other Payer Group ID |
| Other Payer Person Code | Other Payer Help Desk Phone Number |
| Other Payer Patient Relationship Code | Other Payer Benefit Effective Date |
| Other Payer Benefit Termination Date | |

Reimbursement will be calculated to pay the lesser of the LDH's maximum Medicaid allowed amount or the Other Payer Patient Responsibility as reported by the primary carrier, less than the third-party payment.

The following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes. Where applicable, it has been noted which **Other Coverage Code** (NCPDP Field # 308-C8) should be used based on the error codes received from the primary.

| TPL Codes | | |
|---|---|---|
| **NCPDP Field #308-C8** | **When to Use** | **Submission Requirements/Responses** |
| 0 – Not Specified | OCC 0 is allowed; submit when Beneficiary does not have TPL. | Claim will reject with a 41 error if Beneficiary record has TPL.<br>Claim should be submitted to the primary payer for payment. |
| 1 – No Other Coverage | OCC 1 is allowed; submit when Beneficiary does not have TPL. | When the Beneficiary has TPL on file and the OCC 1 is submitted, the claim will continue to reject for NCPDP 41.<br>Claim should be submitted to primary payer for payment. |
| 2 – Exists Payment Collected | OCC 2 is accepted | Clam will process |
| 3 – Exists Claim Not Covered | OCC 3 is accepted | Claim will process but must be submitted with one of the reject codes listed in the OCC 3-Other Payer Reject Code list. |
| 4 – Exists Payment Not Collected | OCC 4 is accepted | Claim will process |
| 8 – Claim Billing for a Co-pay | OCC 8 is not accepted | Claim will reject |

## 7.2 Medicare Part B Crossover Claims

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

Claims that deny due to Beneficiary having primary insurance through Medicare will deny with *NCPDP EC AE – QMB (Qualifier Medicare Beneficiary) – Bill Medicare* with the additional message *"Bill Medicare Part B."*

Pharmacy providers must always bill Medicare first. Claims will be considered for payment when the claim has been approved by Medicare Part B as follows:

- Full charges for a Medicare Part B-eligible drug are applied when the Medicare Part B annual deductible has NOT been met.
- If Medicare Part B denied payment on the claim and the charge was applied to the Beneficiary's Medicare Part B annual deductible, then **the pharmacy MUST submit:**
  - Specific Medicare Part B Other Payer ID
  - Other Coverage Code = 4
  - Other Payer Amount Paid = $0.00
  - Other Payer Patient Responsibility Amount = Medicare Co-pay Amount
- Co-pay charges for a Medicare Part B eligible drug are applied when the Medicare Part B annual deductible has been met, and **the pharmacy MUST submit:**
  - Specific Medicare Part B Other Payer ID
  - Other Coverage Code = 2
  - Other Payer Amount Paid = Amount Paid by Medicare Part B
  - Other Payer Patient Responsibility Amount = Medicare Part B Co-pay Amount

## 7.3 Medicare Part D COB

LDH does not support wrap-around/secondary coverage for Beneficiaries with Medicare Part D coverage or are eligible for Part D coverage, as identified on the Beneficiary record for Medicare Part D covered products.

Claims will deny with *NCPDP EC 620 – This Product/Service May Be Covered Under Medicare Part D* and return the additional message "*Bill Medicare Part D"* for Beneficiaries who have active Medicare Part D coverage or are eligible for Part D coverage, as identified on the Beneficiary record, and the product is Medicare Part D covered.

Claims submitted for a Medicare Part D excluded drug will continue through the adjudication process for Beneficiaries with Medicare Part D coverage.

## 7.4 Other Insurance COB

Claims submitted for Beneficiaries with third-party coverage other than Medicare Part B or Part D will adjudicate as indicated in the below grid, when using the specified Other Coverage Code(s) (OCC). If the appropriate COB fields are not submitted, the claim will deny for *NCPDP 6G – COB/Other Payments Segment Required for Adjudication.*

- If a TPL is on file and OCC 0 or 1 are used, claims will deny with *NCPDP EC 41 – Submit Bill To Other Processor or Primary Payer.*
- COB claims are allowed to bypass PA, quantity limit and age limit denials when the other insurance carrier has paid at least $0.01 on the claim and the pharmacy submits an *OCC 2 – Other Coverage Exists – Payment Indicated.*
- All edits will apply when the pharmacy bills a primary payer, and the claim pays but the payment collected is $0 (when the pharmacy submits *OCC 4 – Other Coverage Exists – Payment Not Collected).*
- The provider prescription fee of $0.10 does not count as payment from the primary.
- If the TPL and co-pay are greater than LDH allowable amount, MMA will pay at $0.00 and therefore, will not send a negative amount in the Amount Paid field.

| Other Coverage Code (OCC) | Description | Allowed |
|---|---|---|
| 0 | Not Specified | Yes – If no TPL on file |
| 1 | No Other Coverage | Yes – If no other coverage found, claim will pay. |
| 2 | Other Coverage Exists Payment Collected | Yes |
| 3 | Other Coverage Billed – Claim Rejected | Yes |
| 4 | Other Coverage Exists – No Payment Indicated | Yes |
| 8 | Claim Billing for Patient Financial Responsibility | No |

## 7.5 OCC 3 Reject Codes

COB claims will deny for Standard TPL when the pharmacy submits an OCC = 3 (Other Coverage Found Claim Not Covered) indicating the Other Payer denied the claim and the Other Payer Reject Code is not found in the below table. These claims will deny with *NCPDP EC 6E – M/I Other Payer Reject Code* with the supplemental message "*Other Payer Reject Code not allowed."*

| Reject Code | Reject Code Description |
|---|---|
| 63 | Institutionalized Patient Product/Service Not Covered |
| 65 | Patient is Not Covered |
| 67 | Filled Before Coverage Effective |
| 69 | Filled After Coverage Terminated |
| 70 | Product/Service Not Covered |
| 71 | Prescriber ID is Not Covered |
| A5 | Not Covered Under Part D Law |

# 8.0 Compound Claims

All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be submitted on the claim.

At least one item in the compound must be a covered drug. Any component of a compound requiring PA will necessitate an approval prior to receiving payment. For additional information, refer to the *Payer Specification* document on the Plan Portal.

**Important Notes:**

- In order for compound claims to adjudicate and reimburse appropriately, providers should enter the following information in the applicable fields of the **Claim Segment** header:
  - A Compound Code (NCPDP Field ID: 406-D6) value of '2 – Compound' should be entered to identify the claim as a multi-ingredient compound.
  - A value of '00 – Not Specified' in the Product/Service ID Qualifier (NCPDP Field ID: 436-E1) field.
  - A value of '0' in the Product/Service ID (NCPDP Field ID: 407-D7) field.
- The specific NDCs for each ingredient of the compound should be entered in the Compound Product ID (NCPDP Field ID: 489-TE) field.

- A Submission Clarification Code (NCPDP Field ID: 420-DK) value of "8" only allows a claim to continue processing if at least one ingredient is covered. Non-rebateable ingredients will process with the submission clarification code, but only rebateable ingredients are eligible for reimbursement.
- The Compound Type (NCPDP Field # 996-G1) is required to be submitted on all compound claims. If this field is not submitted, the claim will reject.
- Compound claims must contain at least two active ingredients. For example, an antibiotic suspension plus flavoring or an injectable antibiotic plus a fluid will not be covered as a compound. Single ingredient claims will deny with *NCPDP EC 7Z – Compound Requires Two or More Ingredients* with supplemental message "*Compounds must contain at least two active ingredients. Compounds with container NDC must also include at least one active compounded ingredient.*"
- The Department will accept up to 25 ingredients. Compound claims with more than 25 ingredients will not be accepted and will deny with *NCPDP 9K – Cmpd Ing Component Cnt Exceeds Num Ing Supported.*
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- If total cost is not equal to the sum of the ingredients' cost, the claim will deny.
- Multiple instances of an NDC within a compound will not be allowed. These claims will deny with *NCPDP 21 – M/I Product/Service ID* with supplemental message *"Duplicate compound ingredients are not allowed"*.
- Compounds will be limited to a $750.00 total ingredient cost. Claims submitted that exceed $750.00 will reject with *NCPDP EC 78 – Cost Exceeds Maximum* with the additional message *"Ingredient cost exceeded. Prior Authorization required."*
- Duplicate edits are applied regardless of the compound status of the claim.

## 8.1 Fields Required for Submitting Multi-Ingredient Compounds

On the **Claim** Segment:

- Enter **Compound Code** (NCPDP Field # 406-D6) of "2."
- Enter **Product/Service ID** (NCPDP Field # 407-D7) as "0" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter **Product/Service ID Qualifier** (NCPDP Field # 436-E1) as "00" to identify the product as a multi-ingredient compound.
- Enter **Quantity Dispensed** (NCPDP Field # 442-E7) of entire product.
- Enter **Gross Amount Due** (NCPDP Field # 430-DU) for entire product.
- **Submission Clarification Code** (NCPDP Field # 420-DK) = Value "8" will only be permitted for POS (not valid for paper claims) and should be used only for compounds.

On the **Compound** Segment:

- **Compound Dosage Form Description Code** (NCPDP Field # 450-EF)
- **Compound Dispensing Unit Form Indicator** (NCPCP Field # 451-EG)
- **Compound Route of Administration** (NCPCP Field # 452-EH)
- **Compound Ingredient Component Count** (NCPCP Field # 447-EC) (Maximum of 25)

For **each line item**:

- **Compound Product ID Qualifier** (NCPCP Field # 488-RE) of "00"
- **Compound Product ID** (NCPDP Field # 489-TE)
- **Compound Ingredient Quantity** (NCPDP Field # 448-ED)
- **Compound Ingredient Cost** (NCPDP Field # 449-EE)

# 9.0 340B Drug Discount Program

Section 340B of the Public Health Services Act (PHSA) 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.

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 Beneficiaries.

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 at: https://340bopais.hrsa.gov/medicaidexclusionfiles.

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.
- "Carved-Out" means that all drug claims billed to Medicaid are dispensed from regular stock not purchased through the 340B program.
- Each covered entity attests to its status to HRSA and only those that carve all Medicaid Beneficiaries into their 340B programs are excluded from each state's drug rebate program.

Duplicate discounts are prohibited in the 340B Drug Pricing Program.

To identify 340B claims and receive applicable reimbursement, providers must submit both a SCC (NCPDP Field ID: 420-DK) of '20 – 340B', and a Basis of Cost Determination (NCPDP Field ID: 423-DN) of '08 – 340B/Disproportionate Share Pricing/Public Health Service'.

Claims submitted using a provider who is not "carved-in" to the 340B program and a SCC of '20-340B' or Basis of Cost (BOC) Determination of '08 – 340B/Disproportionate Share Pricing/Public Health Service' will deny with *NCPDP EC 6Z – Provider Not Eligible to Perform Service/Dispense Product* with the additional message *"340B claims not allowed for non 340B pharmacies. Remove SCC 20 and/or BOC 08 and resubmit claim."*

Claims submitted using a provider who is "carved-in" to the 340B program without a SCC 20 will reject with *NCPDP 34 – M/I Submission Clarification Code* with additional message of *"340B pharmacy must submit SCC 20 for 340B claims."*

Claims submitted using a provider who is "carved-in" to the 340B program without a BOC 08 will reject *NCPDP EC DN – M/I Basis of Cost Determination* with the additional message of *"340B pharmacy must submit BOC 08 for 340B claims."*

**Note**: Claims submitted for Hepatitis Direct Acting Anti-Viral agents will deny when submitted as a 340B claim.

# 10.0 Provider Reimbursement

## 10.1 Provider Reimbursement Rates

For all drugs and supplies (other than vaccinations), the following reimbursement logic is always used.

### Local Pharmacy Reimbursement:

Local Pharmacy means any Louisiana domiciled pharmacy which meets the definition in Louisiana RS 46:460.36. Professional Dispensing Fee, or the Usual and Customary Charge.

Claims shall be reimbursed at the lesser of:

- The National Average Drug Acquisition Cost (NADAC), if available, or the Wholesale Acquisition Cost (WAC) plus the Professional Dispensing Fee; or
- The Federal Upper Limit (FUL), if available, plus the Professional Dispensing Fee; or
- Gross Amount Due (NCPDP field 430-DU)
- Usual and Customary (NCPDP field 425-DQ)

### 10.1.1 Local Pharmacy Professional Dispense Fee

Local Pharmacies will be reimbursed a professional dispensing fee established by LDH and approved by CMS and as published at https://www.ldh.la.gov/.

### 10.1.2 Non-Local Provider Reimbursement Rate

Non-Local Provider Reimbursement rates including retail drug reimbursement, specialty drug reimbursement and dispense fees, are established by the specific fee schedules agreed to within the *Magellan Pharmacy Solutions LA Medicaid MCO Addendum*. Please refer to your signed *Pharmacy Agreement.*

*Magellan Rx Management Provider Manual* or contact the Magellan Pharmacy Networks Department at: RxNetworksDept@MagellanHealth.com for a copy of most recent pharmacy contract.

### 10.1.3 Local Specialty Drug Reimbursement

Specialty Drug Reimbursement for Local Pharmacy shall be reimbursed at the greater of:

- The NADAC, if available, or the WAC plus the Professional Dispensing Fee; or
- The FUL, if available, plus the Professional Fee; or
- The Usual and Customary Charge; or
- The Specialty drug reimbursement rates including dispense fees, established by the specific fee schedules agreed to within the *Magellan Pharmacy Solutions LA Medicaid MCO Addendum*, may be renegotiated or added to from time to time.

### 10.1.4 Vaccines

Refer to Vaccines for reimbursement information.

## 10.2 Maximum Allowable Cost

MMA Maximum Allowable Cost (MAC) program lists pricing for drugs that are reimbursed at an upper limit per unit price, based on current market sources. All products are reviewed on a regular basis and will be adjusted as needed based on market conditions. MMA MAC lists are updated at a minimum every seven (7) days or in accordance with applicable law. If the availability of a drug becomes limited, the MAC will be suspended, or the drug may be permanently removed from MAC lists at MMA's sole discretion. The drug may be added back when MMA market sources confirm adequate supply and distribution.

### 10.2.1 MAC Reimbursement Inquiry and Review Process

Pharmacies can appeal MMA MAC pricing by sending an appeal to email or fax below.

- Email at MACAppeals@primetherapeutics.com
- Fax at 877-823-6373. If a fax is sent, an email address is required so a response may be provided.
- Phone Monday through Friday 8:00 AM – 4:00 PM CT at 888-277-5510 Option 1
- Mail to: Attn: MAC Appeal-2900 Ames Crossing Road-Eagan, MN 55121
- Forms for submission can be located at https://magellanrx.com/provider/macappeals

The following information needs to be provided to initiate the appeal process:

- A copy of the original invoice that contains the purchase price of the drug being appealed.
- Pharmacy NPI or NCPDP, member ID, Rx #, and date of fill.
- Generic drug name, and NDC #
- Brief explanation as to the nature of the appeal.
- The sources currently used to determine MAC pricing are Cardinal, Amerisource, and Anda wholesale price lists, and NADAC published by CMS. MRx reserves the right to change any pricing source at any time.
- Once a MAC pricing appeal is submitted, the MAC Pricing Specialist will investigate the claim and proceed based on the following situations:
- ALL submitted and verified MAC related appeals will receive an email confirmation that the appeal has been entered into the database and will be reviewed for a MAC pricing change within 7 business days.
- Within 7 days, the Pharmacy provider and LDH will receive written notification of the outcome of the MAC appeal.

- LDH has the authority to overturn the MAC appeal decision and written notification will be provided.
- Appeals submitted for drug NDC's that are not on the MMA Therapeutics MAC list or a claim that has been entered as usual and customary and/or submitted will be returned as a non-MAC related issue and appeal will be closed.
- The appeal will remain on file for continual review for up to 90 days.

# 11.0 Pharmacy Relations

All Providers interested in participating in the Magellan Rx Pharmacy network must meet credentialing requirements and submit the following:

- Participating Provider Agreement
- Louisiana Specific Addendum

To enroll, please visit the following:

- https://magellanrx.com/provider/landinghttps://magellanrx.com/provider/landing
- Phone: 800-441-6001 opt 5
- Hours: Monday–Friday 8:00 a.m.–5:00 p.m. EST

# 12.0 Credentialing and Quality Management

All Network Pharmacy Providers must comply with credentialing and quality management initiatives required by PBM. Network Pharmacy Provider agrees to provide PBM with documentation and other information which may be needed in connection with such initiatives. PBM may request copies of all documents required for the credentialing of a Network Pharmacy Provider at any time. Appropriate documents must be provided within 14 days of receipt of notification.

## 12.1 Independent Pharmacy

The following documents are requested and validated during the initial credentialing process:

- Provider Credentialing Pharmacy Credentialing Application Form
- Disclosure Form
- Provider State license, including state license number. Must not expire in the next 30 days.
- Full Unrestricted Provider/Pharmacist Drug Enforcement Administration (DEA) license schedules 2-5 including registrant number. Must not expire in the next 30 days.

- Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.
- Pharmacist In Charge (PIC) license with no restrictions, limitations, or sanctions within the most recent three-years.
- Provider Federal Employee ID Number (EIN)
- Provider State Medicaid number

Recurring credentialing as required in the Plan contracts, or at a minimum every three years, is conducted and the following documents are requested from the Provider and validated:

- Disclosure Form
- Independent Pharmacy Recredentialing Form
- Provider State license, including state license number. Must not expire in the next 30 days.
- Full Unrestricted Provider/Pharmacist DEA license schedules 2-5 including registrant number. Must not expire in the next 30 days.
- Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.
- PIC license with no restrictions, limitations, or sanctions within the most recent three-years
- Provider Federal Employee ID Number (EIN)
- Provider State Medicaid number

## 12.2 Pharmacy Services Administration Organization (PSAO)

For participants in the Magellan Rx network, recertification is conducted annually, and the following documents are requested from the PSAO within 14 days of receipt of the notification.

- Attestation of Compliance Form completed and signed.
- PSAO Store Affiliation Spreadsheet
  - Each pharmacy's state license number should be listed.
  - Each pharmacy's state license number should be active.
  - Each pharmacy's Full Unrestricted Provider/Pharmacist DEA license schedules 2-5 including registrant number should be listed.
  - Each pharmacy's DEA license number should be active.

- Insurance Certificate of Liability Attestation that attests that the organization ensures that all PSAO participating pharmacies have liability insurance – $1,000,000 per occurrence and $3,000,000 in aggregate and copies of said insurance will be provided upon request, when necessary. Must not expire in the next 30 days.

### 12.2.1 Pharmacy Chains

For participants in Magellan Rx network, recertification is conducted annually, and the following documents are requested from the Chain within 14 days of receipt of the notification.

- Attestation of Compliance Form completed and signed.
- Chain Store Affiliation Spreadsheet
  - Each pharmacy's state license number should be listed.
  - Each pharmacy's state should be active.
  - Each pharmacy's Full Unrestricted Provider/Pharmacist DEA license schedules 2-5 including registrant number should be listed.
  - Each pharmacy's DEA license number should be active.
- Must submit Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.

In addition, during initial Provider recruitment and recredentialing, the provider's information will be searched through federal level data, state level data, and data available from all publishing jurisdictions in the United States for all publish disciplinary and licensing boards for all published professions within those jurisdictions. All excluded or sanctioned providers will be reviewed to determine whether any new providers for Medicaid or Medicare networks managed by Magellan are on the reviewed lists. The list will be provided by:

- The OIG (https://oig.hhs.gov/exclusions/exclusions_list.asp);
- General Services Administration List of Parties Excluded from Federal Procurement Programs;
- State Medicaid Exclusions;
- DEA;
- Client Exclusions (if provided); and
- Numerous regulatory, licensing, and registration agencies.

### Reporting Suspected FWA and Overpayments

MMA expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse, or overpayments. To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from MMA, you are obligated to report the overpayment and the reason for overpayment in writing and to return the overpayment to MMA within sixty (60) calendar days of the date on which the overpayment was identified.

Reports of suspected FWA may be made to MMA via one of the following methods:

- MMA PI FWA Hotline: 1-800-349-2919
- Special Investigations Unit email: FraudTipHotline@primetherapeutics.com
- Facsimiles sent to the SIU (877-290-1555)
- Physical address via USPS, FedEx, or other delivery service:

Prime Therapeutics

Attn: Pharmacy Audit & SIU
2900 Ames Crossing Rd
Eagan, MN 55121

- Anonymous Compliance Hotline: Phone: 800.474.8651
- Anonymous Email: reports@lighthouse-services.com

## 12.3 Pharmacy Audits and Investigations

### 12.3.1 Audit Purpose and Policy

MMA's Special Investigations Unit (SIU) provides oversight to the pharmacy compliance audit program, which consists of desktop and onsite audits.

### 12.3.2 Audit vs. Investigations

An audit is an objective and systematic assessment of how well a provider/program is performing as well as meeting expectations and applicable regulations. This is a routine process and can happen at any time. An investigation is usually undertaken in response to reports of misconduct. It is a process of detailed examination to achieve certain objectives. During an investigation, SIU may also interview the pharmacy, staff, or Beneficiary, conduct background checks, and conduct other analyses. When applicable, SIU may report findings to the applicable regulatory agency or client.

### 12.3.3 Desk Audits

A desk audit is conducted by an auditor via email, fax, or mail rather than in person. During each desk audit, we audit a larger number of claims and refills by reviewing the prescription records, labels, signature logs, and any other relevant documentation.

### 12.3.4 Onsite Audits

An instore compliance audit is conducted by an auditor in person at a pharmacy. During each onsite audit, we audit prescriptions and associated refills, conduct a compliance review that includes, but is not limited to, validation of proper licenses, review of regulatory practice requirements and general compliance training. We also review a sample of the signatures in the pharmacy's patient signature log, and validate licenses for out-of-state pharmacy permits, if applicable.

### 12.3.5 Access to Pharmacy Records

Please note that all claims submitted to MMA are subject to audit or investigation regardless of the final claim status. This includes claims that are paid, reversed, denied, and rejected. Pharmacies are expected to maintain and make available to MMA all appropriate documentation and records that support a claim or an element of a claim. This includes transaction logs and records, receipts of payment, and other records.

Documentation should not be altered or created in preparation for an audit or investigation. If a pharmacy is missing documentation, the pharmacy should contact the auditor or MMA SIU and provide an explanation for the missing documentation.

Denying access to records or failure to respond to any audit/investigation request will be treated as a failure to comply with an audit/investigation. If a pharmacy fails to comply with an audit/investigation, MMA may recover any overpayments associated, implement disciplinary action, or terminate the pharmacy with cause from the national network, with LDH approval where applicable.

Pharmacies must allow MMA adequate access to records related to Prescription Drug Services provided under the Agreement. This includes:

- Wholesaler invoices and pedigrees
- Prescription orders
- Signature log/delivery log
- Licensing
- Proof of insurance
- Dispensing history

- Proof of copay collection, if applicable
- Business agreements or contracts with Prescribing Providers
- Bill of sale documentation regarding Pharmacy purchase, when applicable
- Past and current employee lists
- Standard operating procedures

MMA reviews these records to compare the submitted claim information to the original source documentation, such as the prescription order and other relevant documentation, to confirm the accuracy and legitimacy of the claim submitted to MMA.

MMA may request invoice and purchase documentation from wholesalers, manufacturers, and distributors to ensure that the pharmacy had sufficient quantity of certain drugs to substantiate the claims submitted. Said documentation must be provided directly to the auditor by the wholesaler, manufacturer, or distributor—not the pharmacy. If shortages of supply are identified or where documentation is not supplied, all claims associated with the shortages identified are subject to overpayment recovery.

Pharmacies must not photograph or record (either audio or video) interactions with MMA personnel, including telephone discussions, onsite compliance audits, security camera footage or other interactions without MMA's prior written consent. Such activity may result in termination of the Pharmacy Participation Agreement, with LDH approval.

### 12.3.6 Audit Process

All compliance audits will be conducted in accordance with applicable contractual and regulatory requirements. Compliance audits will include the following steps:

Advance notice will be provided to pharmacies (for on-site audits) unless suspected fraud has been identified. When suspected fraud has been identified, no advance notice is required. MMA, and our vendors, will work with pharmacies to make reasonable accommodations when scheduling on-site compliance audits and to ensure minimal disruption to pharmacy operations during the audit process.

A list of documentation required for the review will be provided (along with the required timeframe and submission method for desk audits).

We will review the records to ensure their accuracy and compliance with regulatory and contractual requirements. When on-site we may also interview staff, review policies and procedures and other relevant documentation and will observe staff interactions with customers. Our audit staff comply with all applicable privacy regulations.

Once records have been reviewed, a preliminary report of the findings is provided. It will include a detailed list of the discrepancies found, a reference to the contractual or regulatory requirement(s) in question, and guidelines for any opportunity to contest the

initial findings. Some findings may not allow for submission of additional documentation due to their nature (e.g., wrong patient or prescriber selected).

The compliance audit will be closed, and a final report issued once the additional documentation has been reviewed or the time to submit additional documentation has closed. Any changes to the preliminary results based upon the review of additional documentation will be reflected in the final report.

### 12.3.7 Expenses

Pharmacies may not charge MMA for personnel time involved in responding to MMA's oversight activities. Each pharmacy is responsible for its own expenses, including production of any records it provides to MMA.

## 12.4 Prescription Requirements

"Prescription hard copies" are written prescriptions, refill authorizations, institutional orders, verbal or telephoned orders, facsimile (fax) orders, prescription transfers and electronic prescriptions that the Pharmacy relies on at the time of dispensing. To qualify as an electronic prescription, the electronic prescription must be noted prior to dispensing and must clearly record, in a manner that cannot be altered, the system-assigned user and date and time stamp to take the place of hard copy documentation.

The Pharmacy must retain all documentation related to a prescription claim in accordance with the Pharmacy Participation Agreement and applicable state and federal laws.

A prescription is considered valid when the original prescription order contains the following information at the time of dispensing:

- Full name, address and date of birth of the Covered Person
- Date of Issuance
- Full name, NPI, and telephone number of the Prescribing Provider and, if the prescription is for a Controlled Substance, the Prescribing Provider's DEA number. If the Prescribing Provider did not include their NPI/DEA number(s) on the prescription hard copy, then the Pharmacy is responsible for acquiring the Prescribing Provider ID and/or the Prescribing Provider's DEA number either from the Pharmacy's claims system or by contacting the Prescribing Provider
- The Pharmacy must document correct Prescribing Provider ID on the prescription hard copy or on a prescription label, affixed to the back of the prescription hard copy
- Name of medication and strength prescribed
- Quantity authorized by the Prescribing Provider

- Specific dosage change — The medication dispensed to the Covered Person must be labeled with the Prescribing Provider's direction for use. The Pharmacy must obtain specific directions for use to accurately dispense the prescription. Directions must be more specific than "Use as Directed." The direction "As Directed" is not allowed. Directions may be obtained through direct communication with the Prescribing Provider and must be documented on the prescription hard copy. The medication dispensed to the Covered Person must be labeled with the specific directions for use obtained from the Prescribing Provider. For drugs that are administered on a sliding scale, such as insulin, the Pharmacy must obtain and document the dosage range or maximum per day prior to dispensing.
- Substitution instructions with appropriate documentation — When medically necessary, the Prescribing Provider may write "brand necessary" or "brand medically necessary" on the prescription (including electronic prescriptions) or, the certification must be written in the prescriber's handwriting on a signed and dated attachment (which may be faxed) to the prescription.
- Refill — If there are no refills indicated by the Prescribing Provider, the Pharmacy should assume that no refills are authorized. If refills are added to a prescription, the Pharmacy must retain written documentation of the authorization and assign a new prescription number.
- Prescription number —The prescription hard copy must be labeled with the corresponding prescription number. If the prescription is for a drug under a federally regulated program, including, but not limited to, iPLEDGE or S.T.E.P.S. Data 2000, the Pharmacy must document the authorization number obtained from the program on the prescription hard copy before dispensing.
- Documentation of the date the prescription was received and the name of the caller for verbal or telephoned prescription orders, changes to prescription order, or clarification to any order.

Prescription hard copies missing one or more of the required elements may be considered invalid.

### 12.4.1 Prescription Label Requirements

The prescription label must contain the following elements, in addition to other elements required by state and federal guidelines:

- Full name of Covered Person
- Full name of Prescribing Provider
- Full name and strength of medication dispensed
- Quantity of medication dispensed

- Specific directions for use
- Prescription number
- Number of refills authorized
- Date medication was dispensed

### 12.4.2 Compound Prescription Requirements

In addition to the above information a compound worksheet with detailed NDC, quantity and expiration dates of components is required for each compound claim.

### 12.4.3 Signature Logs

Pharmacies are expected to comply with all state and federal regulatory requirements related to signature logs. Unless otherwise specified by state or federal law, MMA will accept the following signature log documentation. All signature log documentation must tie back to the prescription-in-question as well as the specific date of service in cases of multiple refills. If you have questions about acceptable formats, please contact us at pharmacyaudit@primetherapeutics.com

- **Manual Signature Logs**: typed or handwritten logs maintained to track in-pharmacy patient pick up displaying the Beneficiary's actual physical signature and pick-up date.
- **Delivery Manifests**: a list of drugs that may contain multiple Beneficiaries to documentation shipped to a location with a signature line at the bottom and displaying the Beneficiary's actual physical signature (not to be confused with "delivery confirmations").
- **Delivery Confirmations:** these are third-party delivery confirmations from UPS, FedEx, USPS, or other delivery companies that can be linked back to the prescription-in-question.
- **Point of Sale**: electronic signature for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy.

### 12.4.4 Usual & Customary Pricing

Just as with all claim elements, pharmacies are expected to enter accurate Usual and Customary (U&C) pricing for all claims submitted. U&C charged by the pharmacy to the general public at the time of dispensing should be the same price as a cash paying customer for the same drug. U&C does not include prices associated with discount from manufacturers or coupons from manufacturers. However, loyalty programs affiliated with a pharmacy for cash such as a $4.00 prescription are subject to usual and customary charges.

If the pharmacy alters the U&C price in order to increase claim payment without a true change of the cash price charged to the general public is considered a violation of the provider agreement. The pharmacy must be able to communicate the U&C price to MMA and supply proof of a cash prescription upon request. This could include, but not be limited to, redacted transaction receipts or records. Failure to provide sufficient documentation may result in pharmacy provider education, overpayment recovery, and/or termination from the network, with LDH approval.

### 12.4.5 Test Claims

Pharmacies must not submit test claims of prescriptions that were intended to be reversed; are false or nonexistent; contain "dummy" or false NPI or Beneficiary cardholder ID numbers; or were never requested by the Beneficiary or prescriber.

### 12.4.6 Review of Claim Submission

MMA will, at a minimum, verify the following claim elements when evaluating a prescription:

- **Covered Person** — The prescription must contain the full name of the Covered Person and the correct Covered Person Identification Card number.
- **Date of issuance** — The date of issuance must be on the prescription.
- **Drug name and strength** — The NDC on the claim must correspond with the specific drug and strength prescribed and dispensed. Reasonable efforts must be made to select the most cost-effective form of a prescribed drug or generic equivalent, except when the brand is preferred on the LDH Single PDL. The Pharmacy must submit the originally prescribed product to determine if the drug is covered by Medicaid.
- **NDC** — The NDC on the claim must correspond to the NDC used to dispense the prescription. Price — The accuracy of the calculating and submitting price is based on the NDC and quantity used to dispense the product.
- **Product Selection Code (PSC)** — PSC submissions will be verified. If the generic is not available to the market, the Pharmacy must document on the original hard copy and submit the claim with a DAW-8.
- **Quantity** — The Pharmacy must dispense the quantity as written and supported by the dosing directions unless the quantity written exceeds the Covered Person's Benefit Plan, the quantity written is for greater than the amount needed for the time frame needed based on use instructions (e.g., writing for twenty [20] doses per month when directions are to infuse three [3] times weekly) or the quantity written is intended to be dispensed only if certain situations occur (e.g., hemophilia bleed dose replacement upon submission of infusion records). The Pharmacy must comply with POS messaging,

including, but not limited to, messaging regarding the Covered Person's Benefit Plan limit and must document the reason for dispensing a lesser quantity on the original prescription. If the POS messaging on the claim requires a PA, the Pharmacy must follow POS messaging and must not reduce the quantity. To prompt accurate POS messaging, the Pharmacy must accurately represent the days' supply based on the quantity dispensed and directions for use on the prescription order.

- **Days' supply** — The Pharmacy must submit the correct days' supply, based on directions for use. The Pharmacy must submit the number of consecutive days the prescription drug will last. Overstating the days' supply may impact future refills, while understating the days' supply may exceed the Covered Person's Benefit Plan. The most common days' supply errors occur when dispensing inhalers, insulin and medications with intermittent dosing. The Pharmacy must submit the correct days' supply based on the quantity dispensed and the directions for use on the prescription order. Pharmacists are expected to exercise professional judgement when entering days' supply for all claims submitted. If needed, the pharmacy should call the MMA helpdesk for override assistance.
- **Refill instructions** — Refill history must be reviewed to confirm that the prescription was not refilled in excess of the prescription order. If additional refills are authorized, the Pharmacy must obtain the appropriate prescription order based on the drug class.
- **Auto-ship refills** — Pharmacies must obtain patient consent prior to enrolling a prescription in an auto-ship refill program.
- **Claim edits** — If the Pharmacy receives specific messaging when a claim is submitted, the Pharmacy must ensure that documentation is maintained to support the use of dynamic PA, DUR overrides and the use of Submission Clarification Codes.
- **Prescribing Provider ID number** — The Pharmacy must enter the correct and valid Prescribing Provider's ID number on the claim submission.

MMA relies on the original documentation provided in the audit or an investigation. Documentation that conflicts with or is inconsistent with the documentation provided in response to an audit or investigation will not be accepted during the appeal process.

### 12.4.7 Insulin and Diabetic Supplies

MMA SIU does not promote the breaking of insulin packages. Pharmacists should fill these prescriptions as written by the prescriber whenever possible and submit the correct days' supply. If a plan's limit is exceeded, call the MMA helpdesk to request an override. Pharmacies should be mindful of potential refill too soon issues as a result of entering an incorrect days' supply.

**Insulin Days' Supply Billing Guide for standard concentration insulin (100u/mL)**

| QTY DISPENSED** | PRESCRIBED UNITS PER DAY | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 40 | 60 | 80 | 100 | 120 | 140 | 160 | 200 |
| 10 mL | 25 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 20 mL | 50 | 33<br>30/<br>31* | N/A | N/A | N/A | N/A | N/A | N/A |
| 30 mL | 75 | 50 | 37<br>30/<br>31/<br>34* | 30 | N/A | N/A | N/A | N/A |
| 40 mL | 100<br>90* | 66 | 50 | 40 | 33<br>30/<br>31* | 28 | 25 | N/A |
| 50 mL | N/A | 83 | 62 | 50 | 41 | 35<br>30/<br>31/<br>34* | 31<br>30* | 25 |
| 60 mL | N/A | 100<br>90* | 75 | 60 | 50 | 42 | 37<br>30/<br>31/<br>34* | 30 |
| 90 mL | N/A | N/A | 112 | 90 | 75 | 64 | 56 | 45 |

*Insulin vial products must be dispensed in a manner that most closely aligns with the prescribed dose and maximum benefit to minimize waste.

** QTY Dispensed may be achieved by dispensing multiple 10mL vials

### 12.4.8 Return to Stock

Pharmacies should ensure that all prescriptions that were billed but not picked up by the Beneficiary are returned to stock and the claim reversed within fourteen (14) business days of the claim submission. Failure to return prescription to stock may result in overpayment recovery.

### 12.4.9 Off-Label Use of Drugs for Not Medically Accepted Indications

Paid claims associated with drugs that are billed and dispensed for intended uses that are not generally regarded as Medically Accepted Indications (MAIs), including for dosage strengths and routes of administration that are not consistent with manufacturer prescribing information, are subject to overpayment recovery, with LDH approval. When reviewing claims, clinical auditors/investigators may request documentation to support appropriate dispensing of medications based on standard industry practice including but not limited to documentation of scientific evidence that meets the expectation will demonstrate efficacy and safety for the requested use.

### 12.4.10 Override and Submission Clarification Codes

Just as with all claim elements, pharmacies are expected to enter accurate override and submission clarification codes for all claims submitted. Pharmacies are expected to maintain and make available for audit if requested all relevant documentation and records to support the use of any override or submission clarification codes. Failure to provide sufficient documentation may result in overpayment recovery.

### 12.4.11 Use of Pharmacy-Created Pre-Printed Prescription Forms

Pharmacies should never use pre-printed prescription forms generated in advance by the pharmacy to solicit a prescriber's authorization of a new medication for a Beneficiary without being expressly requested to do so by the Beneficiary or Prescriber. Claims associated with such prescription requests are subject to overpayment recovery. Refill requests and prescriber-originated pre-printed prescription forms are not impacted by this section.

### 12.4.12 Telemarketing and Soliciting Practices

Pharmacies shall not engage in deceptive marketing practices, such as cold call telemarketing, online or in-person soliciting, or recruitment practices to obtain Beneficiary information for the purposes of billing claims without the Beneficiary's explicit knowledge of each individual claim submitted. If the pharmacist or staff knows or suspects that a true patient-doctor relationship does not exist between the Beneficiary and the prescriber, the pharmacy must confirm whether the patient-doctor relationship exists before dispensing. Pharmacies found to be engaged in deceptive or unethical marketing and billing practices will be subject to termination with cause from the network, with LDH approval, and/or overpayment recovery.

### 12.4.13 Disclosure of Ownership

Pharmacies are expected to comply with all state and federal laws related to ownership and potential conflicts of interest, including the Stark Law where applicable. As part of the credentialing process, pharmacies may be required to complete a Disclosure of Ownership form. The pharmacy must report to the Network Department any changes or new ownerships that occur outside of the credentialing cycle. Failure to disclose changes or additions to ownership can result in termination with cause from the Network, with LDH approval.

### 12.4.14 Non-resident Permits

Pharmacies must ensure that they maintain the proper licensure for each state it operates, including in states where medications are mailed or delivered to the Beneficiary. Failure to maintain proper non-resident permits can result in termination with cause from the Network, with LDH approval.

### 12.4.15 Professional Judgement

Pharmacists are expected to exercise professional judgement when dispensing and comply with all state and federal regulations. For example, where quantities appear to exceed MAIs, pharmacists should consult with the authorizing prescriber.

### 12.4.16 Inappropriate Billing Practices / Violations

The following is a partial list of inappropriate billing practices / violations which could be perpetrated by a Network Pharmacy Provider resulting in claims being partially or fully recovered. In addition, legal or other action may be taken against the pharmacy, including immediate termination of the Provider Agreement, with LDH approval:

- Billing multiple payers for the same prescriptions, except as required for coordination of benefits transactions
- Incorrect billing to secondary payers to receive increased reimbursement
- Missing, invalid, illegible, or wrong prescriptions including (but not limited to) prescription missing patient name, doctor name/signature, directions for use, date written, strength, quantity, DEA number (CII-CV drugs), and other required elements
- Billing for a legend or OTC drug without a prescription except where required by law
- Incorrect day supply
- Billing for a quantity of a drug that is different than the quantity dispensed
- Wrong drug, prescriber, Beneficiary, or pack size

- Exceeds/overfilled quantity including but not limited to billing for a quantity of a legend drug that exceeds the total prescribed quantity
- Billing for a greater vial size than what is necessary to supply the ordered dose
- Billing for drugs that are cyclic as continuous days' supply (e.g., 28-day cycle billed as 21 days)
- Billing for drugs as days of administration rather than number of consecutive days the prescription drug will last (e.g., 28-day injection billed as 1 day). Note: this may be subject to plan supply limitations and provider may need to call for override
- Inappropriate use of product selection codes (also known as dispense as written [DAW] codes), Submission Clarification Codes (SCCs) and dynamic PAs
- Claims phishing to identify a drug that is covered (e.g., a Pharmacy submits a claim for one drug, receives a reject or reverses the claim, and resubmits for a new drug within a short period of time)
- Overriding DUR rejects without properly resolving and documenting the resolution
- Misrepresenting or falsifying information to obtain a paid claim, including but not limited to submitting incorrect information on claims that may lead to inappropriate bypass of benefit exclusions, DUR messages, other Benefit Plan edits, or other POS edits or messaging
- Prescription splitting to bypass POS messaging requiring a PA
- Documenting a payment from the primary payor when only the provider fee ($0.10) is paid, bypassing POS and PA edits
- Billing for brand-name drugs when generic drugs are dispensed
- Undocumented substitution
- Submitting claims with an NDC other than the NDC from the package from which the product was dispensed
- Billing an incorrect dosage form (e.g., billing for a tablet when a powder is used to dispense the prescription)
- Billing for non-covered prescriptions as covered items
- Billing for prescriptions that are never picked up (including not reversing claims that are processed when prescriptions are filled but never picked up)
- Billing for numerous prescriptions without providing prescriptions to Covered Persons
- Refill too soon or unauthorized refill
- Missing or incomplete/invalid signature log
- Drug diversion
- Invalid prescription transfer
- Failed to respond to audit

- Beneficiary denied receiving prescription or prescriber denied authorizing prescription
- Patient safety (dosage)
- Billing for a higher priced drug when a lower priced drug was prescribed or dispensed
- Billing multiple loading doses instead of the appropriate subsequent maintenance doses
- For general LTC dispensing, billing more than once per month for Federal Legend Drugs for Covered Persons in an LTC facility where Short-Cycle Dispensing is not allowed
- Billing compound products in a manner inconsistent with MMA's credentialing criteria or the compound billing requirements described in the Compound Drugs Billing Guidelines of this Manual
- Applying an expiration date on the prescription order that is earlier than the date the product expires according to the manufacturer
- Misrepresenting or failing to report an accurate U&C
- Billing the Covered Person for any associated audit and/or investigation recovery
- Misrepresenting the origin code
- Billing an NDC or drug that was never purchased by the Pharmacy
- Billing for drugs associated with wholesaler invoices that the respective wholesaler denies providing to the Pharmacy because the drugs were not purchased from the wholesaler
- Billing for drugs from a wholesaler that cannot provide drug ancestry or pedigree documentation supporting the legitimate purchase record of the drug
- Submitting a claim for a non-FDA approved drug (such as compound kits and patches)
- Billing for weight-based drugs without weight dosing calculations
- Failing to implement documentation or process changes communicated in a previous audit
- Billing high-cost products when lower-cost equivalent products are available, except when brand is preferred over the generic
- Billing for drugs that the Covered Person did not authorize or receive
- Billing for drugs that the Prescribing Provider did not order
- Billing for Pharmacy pre-selected services and/or products
- Billing for services and/or products that are not clinically appropriate
- Billing for drugs utilizing another Pharmacy's credentials
- Billing in a manner to bypass Network contract status
- Billing for drugs when the Covered Person and the Prescribing Provider did not have a valid Patient-Prescribing Provider relationship

- Billing for a therapeutic interchangeable medication without contacting the Prescribing Provider before the claim is submitted to confirm the interchange
- Billing for prescriptions during posted business hours when the Pharmacy is not physically open.
- Mail order Pharmacies running overnight batch billing is not considered to be an immediate unacceptable billing practice, but may be reviewed for potential audit
- Other state/federal laws not followed or miscellaneous discrepancies

## 12.5 Appeals of Audit Results

### 12.5.1 Audit Appeal Process

Pharmacies have sixty (60) calendar days from the date the final audit report is issued by MMA (or MMA's vendor) to submit an appeal or submit a request for a one-time thirty (30) calendar day extension.

Appeals must be submitted in writing and include the Pharmacy's name, the claims/prescriptions appealed, any additional documentation not provided at the time of audit and an explanation of the appeal. Audit findings, including associated recoveries, will be deemed finalized if an appeal is not received from the Pharmacy within the sixty (60) calendar days from the date of notification of the audit findings or ninety (90) calendar days if an extension was requested.

Documentation provided by the Pharmacy as part of its audit appeal may result in additional findings. Appeal results are considered final. For a copy of *MMA's Pharmacy Audit Guidelines and Appeal Form*, visit Prime's website at https://www.primetherapeutics.com/resources/audit-guidelines/.

Documentation that conflicts with the initial documentation submitted will not be accepted during the appeal process.

Prescribing Provider or Covered Person attestations received to support the manner in which a claim is submitted must be received directly from the Prescribing Provider or Beneficiary.

Appeals received after the due date of sixty (60) calendar days (or ninety (90) calendar days with extension) will not be considered.

### 12.5.2 Pharmacy Provider Education

MMA may disseminate Louisiana Medicaid approved policy to pharmacy providers when discrepancies are found. Pharmacies subject to re-education are monitored to determine whether the identified issues have been remediated. If issues are not resolved to the

satisfaction of MMA, MMA may take additional remedial action, as permitted by the Agreement with LDH Pharmacy approval.

### 12.5.3 Pharmacy Investigations

MMA may conduct an investigation of any Pharmacy when MMA suspects or identifies potential FWA activity. During an investigation, MMA may request access to the Pharmacy's facilities, personnel and any supporting documentation to support claims submitted to MMA during the period under investigation. Pharmacies may not receive notification in advance of an onsite investigation. Timing of communications and reports to the Pharmacy may vary. MMA will issue applicable reporting to the Pharmacy throughout the investigative process. MMA reserves the right to terminate all Pharmacies under the same ownership or control based on the results of an investigation, with LDH approval. Pharmacies must comply with investigations that MMA conducts.

### 12.5.4 Remediation Action

Pharmacy audits and investigations may identify a Pharmacy's failure to comply with MMA's terms and conditions. As noted in the *Introduction to MMA Therapeutics*, failure to comply with MMA's contractual terms and conditions, including, but not limited to, those described in this Manual, as revised, may result in pharmacy provider re-education, payment suspension, full or partial financial recoupment, termination from participation in any network, termination of the Agreement, or other remediation actions, as determined by MMA, with LDH approval. A Pharmacy may be immediately terminated from any network or the Agreement upon MMA's receipt of any evidence of a Pharmacy engaging in FWA, with LDH approval.

### 12.5.5 Termination Appeals

Pharmacies have thirty (30) days from the date of notification of termination or an extended time as required by law to submit a termination appeal. Appeals must be submitted in writing and include the Pharmacy's name and an explanation of the appeal. Terminations will be deemed finalized if an appeal is not received from the Pharmacy within the applicable appeal period or an extended time frame as required by law. Pharmacy termination appeals must be submitted in writing to the Pharmacy Network Contracting department by **Fax at 877.823.6373** or by **email to: Termination@PrimeTherapeutics.com**.

# 13.0 Definitions, Abbreviations, and Acronyms

| Term | Definition |
|---|---|
| AAC | Actual Acquisition Cost |
| AWP | Average Wholesale Pricing |
| BOC | Basis of Cost |
| CAP | Corrective Action Plan |
| CDC | Centers for Disease Control and Prevention |
| CMS | Center for Medicare & Medicaid Services |
| COB | Coordination of Benefits |
| CSC | Clinical Support Center |
| CT | Central Time |
| DAW | Dispense as Written |
| DEA | Drug Enforcement Administration |
| DESI | Drug Efficacy Study Implementation |
| EIN | Employee ID Number |
| FDA | Food & Drug Administration |
| FUL | Federal Upper Limit |
| FWA | Fraud, Waste, and Abuse |
| GSN | Generic Sequence Number |
| HIC3 | Hierarchical Ingredient Code 3 |
| HRSA | Health Resources and Services Administration |
| ICD-10 | International Statistical Classification of Disease – 10th Revision |
| IRS | Identical, Related, and Similar |
| LABP | Louisiana Board of Pharmacy |
| LaCHIP | Louisiana Children's Health Insurance Program |
| LDH | Louisiana Department of Health |
| LEIE | List of Excluded Individuals and Entities |
| LTC | Long-Term Care |
| LTE | Less than Effective |
| MAC | Maximum Allowable Cost |
| MAIs | Medically Accepted Indications |
| MCOs | Managed Care Organizations |
| MMA | Magellan Medicaid Administration, LLC |
| MME | Morphine Milligram Equivalent |
| NADAC | National Average Drug Acquisition Cost |
| NCPDP | National Council for Prescription Drug Programs |

| Term | Definition |
|---|---|
| NDC | National Drug Code |
| NPI | National Provider Identifier |
| OCC | Other Coverage Code |
| OIG | Office of Inspector General |
| OPA | Office of Pharmacy Affairs |
| OTC | Over the Counter |
| PAD | Physician Administered Drugs |
| PAs | Prior Authorizations |
| PBM | Pharmacy Benefits Manager |
| PDL | Preferred Drug List |
| PHI | Protected Health Information |
| PHSA | Public Health Services Act |
| POS | Point-of-Sale |
| ProDUR | Prospective Drug Utilization Review |
| PSAO | Pharmacy Services Administration Organization |
| PSC | Pharmacy Support Center |
| QMBs | Qualified Medicare Beneficiaries |
| RetroDUR | Retrospective Drug Utilization Review |
| SCCs | Submission Clarification Codes |
| SCHIP | State Children's Health Insurance Program |
| SIU | Special Investigations Unit |
| TPL | Third-Party Liability |
| TPN | Total Parenteral Nutrition |
| UAC | User Administration Console |
| U&C | Usual and Customary |
| UCF | Universal Claim Form |
| UOM | Unit of Measure |
| VFC | Vaccines for Children |
| WAC | Wholesale Acquisition Cost |

# 14.0 Appendix A – Directory

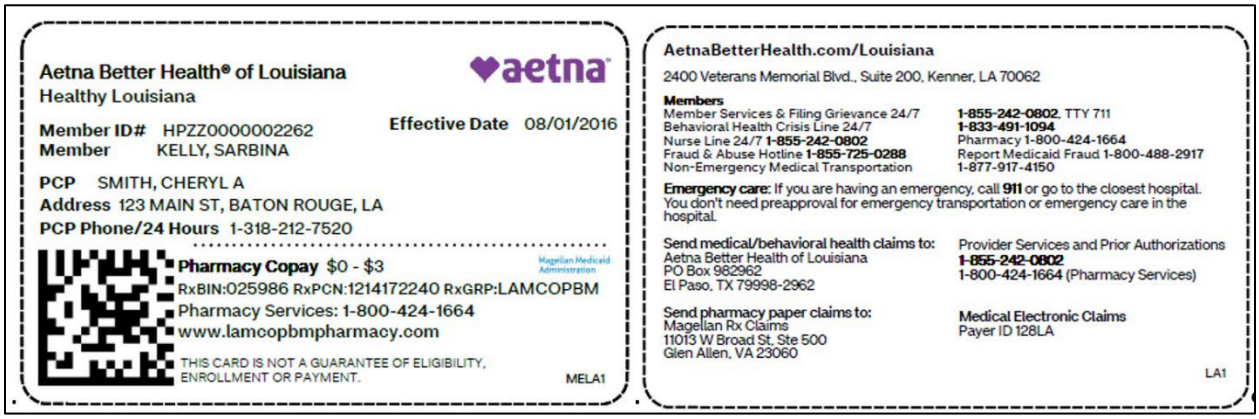
| Provider Services | Phone Number/Email/Web Address | Availability/Comments |
|---|---|---|
| MMA Pharmacy Call Center (will connect callers to both the PSC & CSC) | Phone: 1-800-424-1664<br>Fax: 1-800-424-7402 | Monday–Friday<br>7:00 AM to 7:00PM CT<br>After-hour support is available 24 hours a day, 7 days a week |
| MMA LA MCO Web Portal | 1-800-424-1664<br>https://www.lamcopbmpharmacy.com | Monday–Friday<br>7:00 AM to 7:00PM CT<br>After-hour support is available 24 hours a day, 7 days a week |
| MMA Provider Network Portal | 1-800-441-6001 opt 5<br>https://magellanrx.com/provider/landing | Monday–Friday<br>8:00 AM to 5:00 PM CT |
| Check Write and Remittance Advice (RA) to pharmacies | providerrelations@primetherepeutics.com | Monday-Friday<br>8:00 AM.-5:00 PM CT |
| Magellan Paper Claims | Magellan Rx Claims,<br>Attn: LA MCO Paper Claims Department<br>11013 W. Broad St., Suite 500,<br>Glen Allen, VA 23060 | Only a UCF will be accepted. |
| MMA PI FWA Hotline | Phone: 1-800-349-2919<br>Fax: 1-877-290-1555<br>FraudTipHotline@primetherapeutics.com<br>Prime Therapeutics, LLC<br>Attn: Pharmacy Audit & SIU<br>2900 Ames Crossing Rd<br>Eagan, MN 55121 | Monday-Friday<br>9:00 AM to 5:00 PM CT<br>Voicemail is available on weekends, evenings, and corporate holidays. |
| Anonymous Compliance | Phone: 800.474.8651<br>Email: reports@lighthouse-services.com | 24-hour hotline |
| Louisiana Department of Health Provider Enrollment. | 1-833-641-2140<br>https://ldh.la.gov/page/4125 | Monday–Friday<br>8:00 AM to 5:00 PM CT |
| Aetna Better Health of Louisiana, MCO | 1-855-242-0802 | 8:00 AM -5:00 PM CT |
| AmeriHealth Caritas Louisiana, Inc, MCO | 1-888-922-0007 | Monday – Friday<br>7:30 AM – 4:00 PM CT |

| Provider Services | Phone Number/Email/Web Address | Availability/Comments |
|---|---|---|
| Healthy Blue, MCO | 1-844-227-8350 | Monday – Friday<br>7:00 AM – 7:00 PM CT |
| Humana Healthy Horizons in Louisiana, MCO | 1-800-448-3810<br>LAProviderRelations@humana.com | Monday – Friday<br>7:00 AM – 7:00 PM CT |
| Louisiana Healthcare Connections, MCO | 1-866-595-8133 | Monday – Friday<br>7:00 AM – 7:00 PM CT |
| UnitedHealthcare Community Plan, MCO | 1-877-842-3210<br>providertechsupport@uhc.com | Monday – Friday<br>7:00 AM – 7:00 PM CT |

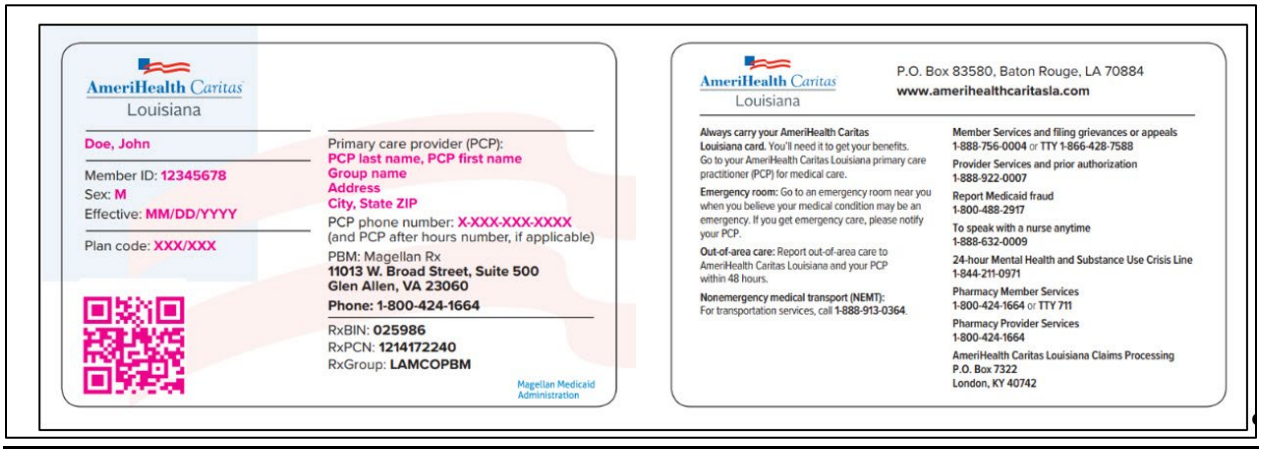
# 15.0 Appendix B – Beneficiary ID Card Examples

As mentioned in *Section 3.1 Beneficiary Identification Card,* below are examples of ID cards for each of the six (6) MCO health plans.

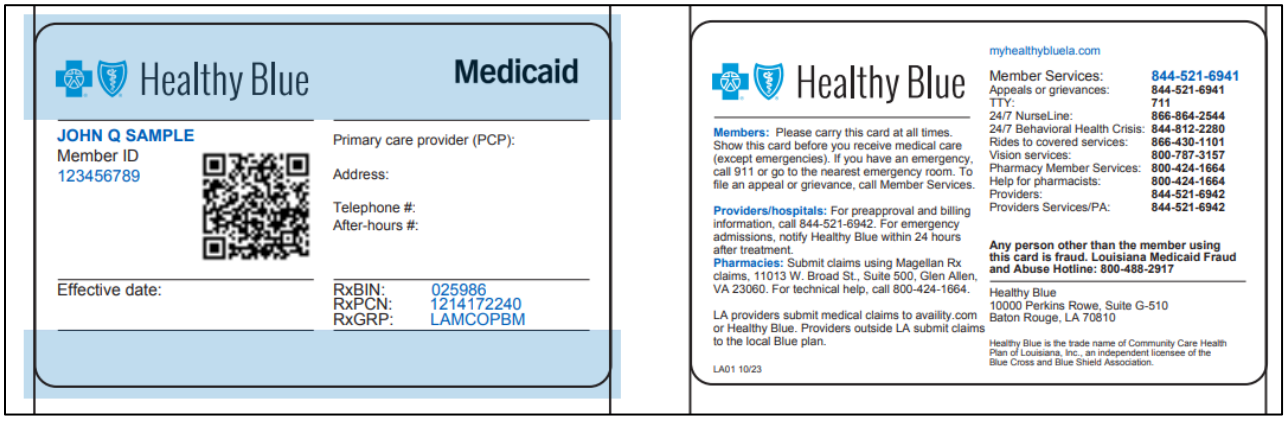
### Aetna Better Health of Louisiana



## AmeriHealth Caritas Louisiana, Inc

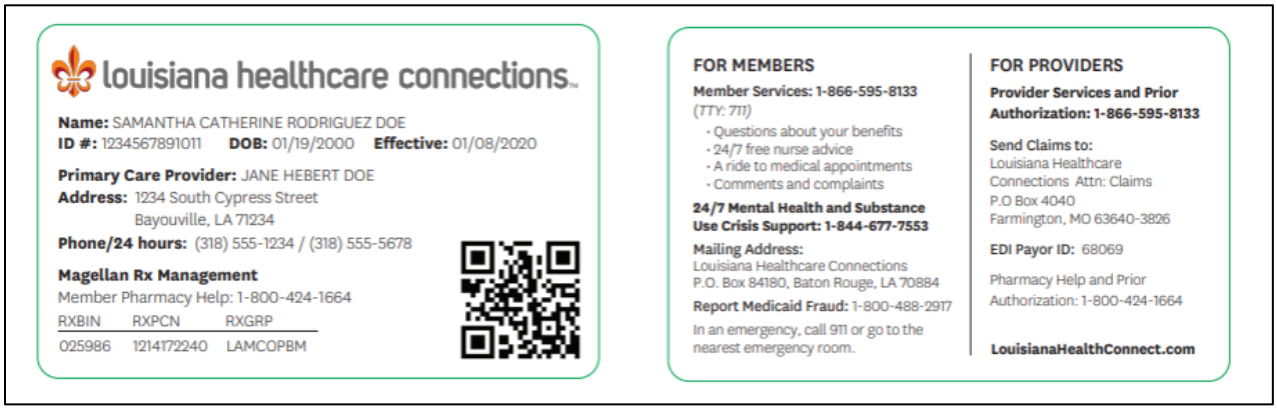



## Healthy Blue

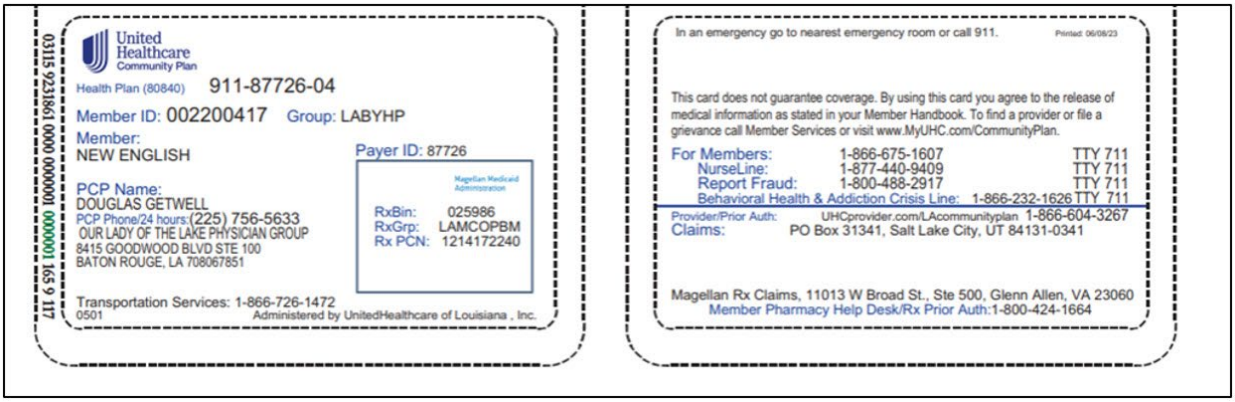



## Humana Healthy Horizons in Louisiana

## Louisiana Healthcare Connections




## UnitedHealthcare Community Plan



# 16.0 Appendix C – Cost Ceiling Exceptions

As mentioned in *Section 4.3.2 – Cost Ceiling*, all drugs will be subject to a cost ceiling, **except** for the products in the table below.

| Cost Ceiling | | |
|---|---|---|
| **Drug Code** | **Description** | **Comments** |
| **All drugs will be subject to a cost ceiling, *except* for the products mentioned below. The products below do not have limitations based on cost.** | | |
| **HIC3**:<br>M0C, M0E, M0P, M0M, M0K, M0F, M0F, M0I | Bleeding Disorder (Antihemophilic factors, ITP, etc.) | |
| **HIC3**:<br>W7K | Immune Globulins | |
| **TC**:<br>30 | Antineoplastic Agents | |
| **HIC3**:<br>N1B, N1C, N1E, N1F, N1G | Colony Stimulating Factors | |
| **TC**:<br>48 | Anticonvulsant Agents | |
| **TC**:<br>07 | Antipsychotics and Antidepressants | The following HICLs will not be included in the exception and therefore the cost ceiling will apply:<br>**HICL**:<br>000113 – Clonidine HCL<br>000120 – Guanfacine HCL<br>010865 – Modafinil<br>024703 – Atomoxetine HCL<br>034868 – Armodafinil<br>045666 – Solriamfetol HCL |
| **TC**:<br>11 | | |
| **HICL**:<br>040927 | Hetlioz | |
| **HIC3**:<br>Z2E, S2J, Z28, M0L, Z2U, S2Q, L1A, H0E, V4D, C7J | Immunosuppressive Agents | |

| Cost Ceiling | | |
|---|---|---|
| **Drug Code** | **Description** | **Comments** |
| **All drugs will be subject to a cost ceiling, *except* for the products mentioned below. The products below do not have limitations based on cost.** | | |
| **HIC3**:<br>C7I, W5A, W5I, W5L, W5O, W5T, W5Z, W0I, W5J, W5M, W5P, W5U, W5G, W0E, W5C, W5K, W5N, W5Q, W5X, W0B, W5G, W5Y, W0D, W0E, W0G, W0H, W0J, W0K, W0N, W5O<br><br>**HICL**:<br>044568, 044791, 045679 | Antiviral Agents (including Hepatitis and HIV Agents) | |
| **HIC3**:<br>B0B, B0F<br><br>**HICL**:<br>036792, 041620, 016926<br><br>**GSN**:<br>064682, 067462<br><br>**NDC**:<br>51167033101 | Cystic Fibrosis Agents (Kalydeco, Orkambi, etc.) | |
| **HIC3**:<br>N1H | Sickle Cell Medications | |
| **HIC3**:<br>L1A | Systemic Antipsoriatic Agents | |
| **HIC3**:<br>D7F | Bile Agents | |
| **HIC3**:<br>B0D | Respiratory Agents | |
| **HIC3**:<br>P1A, P1M, P1P | Systemic Hormonal Agents | |
| **HIC3**:<br>B1B | Pulmonary Hypertension Agents | |
| **GSN**:<br>082394 | Hemostatics | |

| Cost Ceiling | | |
|---|---|---|
| **Drug Code** | **Description** | **Comments** |
| **All drugs will be subject to a cost ceiling, *except* for the products mentioned below. The products below do not have limitations based on cost.** | | |
| GSN:<br>063599, 074870 | Growth Hormones | |
| GSN:<br>050813 | Xyrem | |
| GSN:<br>065483 | Ventavis | |
| GSN:<br>067588 | Veletri | |
| GSN:<br>051970 | Zavesca | |

# 17.0 Appendix D – Opioid Quantity and MME Limit Exceptions

As referenced in *4.8.2 Opioid Limitations* listed in the below table are diagnosis codes that are exempt from opioid quantity limits and the 90 MME per day limit.

| 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 of 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 |
| 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 |

| ICD-10-CM Diagnosis Code | Description |
|---|---|
| T25.7* | Corrosion of third degree of ankle and foot |
| D57.0* | Hb-SS disease with crisis |
| D57.21* | Sickle-cell/Hb-C disease with crisis |
| D57.41* | Sickle-cell thalassemia, unspecified, with crisis |
| D57.81* | Other sickle-cell disorders with crisis |
| 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.

# 18.0 Appendix E – Point-of-Sale Edits and Overrides

The following table provides a brief description of POS edit abbreviations and information related to instances where claims submitted for specific products, in certain situations may have POS overrides available, when a pharmacy provider enters the applicable code(s).

Providers should also reference the *Louisiana Medicaid Single PDL* and the *ICD-10-CM Diagnosis Code Policy Chart* for drug specific criteria and diagnosis requirements.

In situations where an override is not available, a Prior Authorization may be submitted.

| POS Edit Abbreviation | POS Override(s) |
|---|---|
| AL – Age Limit | Pharmacy claims for select medications may have age limitations in place, and may in some instances be allowed to be overridden via an applicable Level Of Service code or applicable DUR code(s) being entered at POS. |
| BY – Diagnosis Codes Bypass Some Requirements | In some instances, a valid diagnosis code entered on a pharmacy claim for specific drugs may result in bypassing certain edits, such as, quantity limitations, concurrent use edits, etc. |
| CU – Concurrent Use with Other Medication is Restricted | Pharmacy claims for select medications may have concurrent use edits in place. These edits, may in some instances, be overridden via applicable DUR codes being entered at POS. |
| DD – Drug-Drug Interaction | Pharmacy claims may reject for drug-drug interactions depending on the drug submitted and the beneficiary's clinical history. In some instances, a drug-drug interaction may be overridden at POS by applicable DUR codes being entered. |
| DS – Maximum Days' Supply Allowed | Pharmacy claims for select medications may have days' supply limitations in place. These limitations, may in some instances be allowed to be overridden at POS via an applicable Level of Service code, applicable DUR code(s), or applicable diagnosis code being entered. |
| DT – Duration of Therapy Limit | Pharmacy claims for select medications may have a limitation on the maximum duration of therapy. These limitations, may in some instances be allowed to be overridden at POS via applicable DUR code(s) being entered. |

| POS Edit Abbreviation | POS Override(s) |
|---|---|
| DX – Diagnosis Code Requirement | Pharmacy claims for select medications may have a diagnosis code requirement. This requirement may in some instances be allowed to be overridden at POS via an applicable level of service code. |
| ER – Early Refill | Pharmacy claims will deny for early refill if the beneficiary has requested the medication prior to 85% (for non-controlled medications), or 90% (for controlled medications) of the medication being utilized. In some instances, this edit may be allowed to be overridden at POS via applicable DUR code(s) being entered. |
| MD – Maximum Dose Limit | Pharmacy claims for select medications may have a maximum dose limitation. These limitations, may in some instances be allowed to be overridden at POS via applicable Level of Service, or applicable DUR code(s) being entered. |
| PU – Prior Use of Other Medication is Required | Pharmacy claims for select medications may have a prior use of other medication requirement. This requirement, may in some instances be overridden at POS via applicable Level of Service, or applicable DUR code(s) being entered. |
| QL – Quantity Limit | Pharmacy claims for select medications may have quantity limitations. These limitations, may in some instances be allowed to be overridden at POS via an applicable Level of Service code, applicable DUR code(s), or applicable diagnosis code being entered. |
| TD – Therapeutic Duplication | Pharmacy claims may reject for therapeutic duplication depending on the drug submitted and the beneficiary's clinical history. In some instances, a therapeutic duplication may be overridden at POS by applicable Level of Service, or applicable DUR code(s) being entered. |

| POS Edit Abbreviation | POS Override(s) |
|---|---|
| YQ – Yearly Quantity Limit | Pharmacy claims for select medications may have a yearly quantity limitation. These limitations, may in some instances be allowed to be overridden at POS by applicable diagnosis code(s) being entered. |