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PROGRAM DESCRIPTION

PHARMACY PRACTICE REQUIREMENTS

The DHHS requires that providers of pharmacy services to South Carolina Medicaid beneficiaries adhere to all state and federal requirements regarding the practice of pharmacy. Additionally, South Carolina Medicaid-enrolled pharmacies located outside of the state of South Carolina must adhere to all federal and state requirements specific to the state in which the pharmacy is located.

PHARMACY

"Pharmacy" means a location for which a pharmacy permit is required from its respective Board of Pharmacy and in which prescription drugs and devices are maintained, compounded, and dispensed for patients by a pharmacist. This definition includes a location where a pharmacist provides pharmacy-related services. All such pharmacies are eligible to apply for participation in the South Carolina Medicaid program. (See Section l regarding enrollment procedures.) South Carolina Board of Pharmacy-permitted non-dispensing drug outlets are INELIGIBLE for Medicaid participation.

Out-of-state pharmacies *must* be enrolled with the South Carolina Medicaid program in order to be reimbursed for any prescriptions dispensed to South Carolina Medicaid beneficiaries. Non-resident pharmacies (*i.e.*, pharmacies located outside of South Carolina) whose primary business is filling mail-order prescriptions must have a special permit issued by the South Carolina Board of Pharmacy in order to engage in the sale, distribution, or dispensing of legend drugs or devices in South Carolina. This special non-resident South Carolina permit is required in order to be eligible for Medicaid participation.

Providers desiring to enroll in the South Carolina Medicaid program must have a licensed pharmacist on the premises and may not subcontract pharmaceutical services that are to be billed to the Medicaid program.

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PROGRAM DESCRIPTION

PHARMACIST

A "pharmacist" is an individual health care provider licensed by the State to engage in the practice of pharmacy.

A pharmacist is a learned professional authorized to provide patient care services within the scope of their knowledge and skills.

"Practice of Pharmacy" means:

- The interpretation, evaluation, and dispensing of prescription drug orders in the patient's best interest;
- Participation in drug and device selection, drug administration, prospective drug reviews, and drug or drug-related research;
- Provision of patient counseling and the provision of those acts or services necessary to provide pharmacy care and drug therapy management; and responsibility for compounding and labeling of drugs and devices (except labeling by a manufacturer, re-packager, or distributor of non-prescription drugs and commercially packaged legend drugs and devices);

Proper and safe storage of drugs and devices and maintenance of proper records for them; or the offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, education, management, and control of pharmacy.

SCOPE OF COVERAGE

The basic objective of the Medicaid Pharmacy Services program is to provide needed pharmaceuticals for the purpose of saving lives in an emergency or a short-term illness, for sustaining life in chronic or long-term illness, or for limiting the need for hospitalization. This manual outlines additional requirements and restrictions set forth by the DHHS in its standards for providing services to Medicaid beneficiaries.

Pharmacy services include the dispensing of most *generic* legend (*i.e.*, products that require a prescription in order to be dispensed) and most *generic* non-legend pharmaceuticals to eligible beneficiaries. (See the *Medicaid Coverage of Generic Products* in this section.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

SCOPE OF COVERAGE (CONT'D.)

Only **rebated** pharmaceuticals that are Food and Drug Administration (FDA) approved may be considered for reimbursement.

(See the *Omnibus Budget Reconciliation Act of l990-Rebate Requirements* in this section.) For each pharmaceutical dispensed, a valid prescription authorized by a licensed practitioner (physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file.

The SC Medicaid pharmacy benefit will not cover drug samples, pharmaceuticals obtained through Patient Assistance Programs (PAP), or any other free pharmaceuticals. Additionally, Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

NON-FORMULARY PROGRAM

The DHHS maintains an "open," or non-formulary, pharmacy services program. With certain specified exceptions, most rebated *generic* legend and *generic* non-legend pharmaceuticals are routinely covered by the Medicaid program (see *Medicaid Coverage of Generic Products* in this section for further clarification). However, some drugs require clinical prior authorization (see *Prior Authorization* in this section) in order to be considered for reimbursement by Medicaid. The National Drug Code (NDC) number listed on the product's stock container or packaging is used for identification and claims filing.

PHARMACY POINT-OF-SALE (POS) SYSTEM

The South Carolina Medicaid program has contracted with Magellan Medicaid Administration, Inc. to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies on-line, "real time" access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review (ProDUR). Although not mandatory, providers are strongly encouraged to utilize POS transmission in order to avoid potentially costly rejections of submitted claims. Magellan Medicaid Administration only accepts claims from participating pharmacies which have valid provider contracts and who are enrolled with the South Carolina

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

PHARMACY POINT-OF-SALE (POS) SYSTEM (CONT'D.)

Medicaid Pharmacy Services Program. For more information on POS claims submission and to request billing specifications, pharmacy providers should contact Magellan Medicaid Administration's Provider Relations Department at 804-965-7619. (Additional claims submission options and requirements are discussed in detail in the Magellan Medicaid Administration Pharmacy Provider Manual; that manual may be accessed at http://southcarolina.fhsc.com.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 – REBATE REQUIREMENTS

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that pharmaceutical manufacturers have a rebate agreement in effect with the Centers for Medicare and Medicaid Services (CMS) in order for their pharmaceuticals to be reimbursed by the Medicaid program.

The pharmaceuticals of those manufacturers who have NOT entered into such an agreement are non-covered by the Medicaid program. However, *devices or supplies* such as insulin syringes and over-the-counter (OTC) family planning products remain as covered items since this limitation in coverage applies only to *medications* dispensed to Medicaid beneficiaries.

South Carolina Medicaid requires the submission of a product's 11-digit National Drug Code (NDC) number. The first five digits of the NDC number comprise the labeler code; it is this labeler code that identifies the manufacturer of the product. The Medicaid pharmacy claims processing system uses this labeler code to determine if the pharmaceutical is rebated and therefore, potentially, Medicaid-covered. It should be noted that manufacturers that utilize several different labeler codes may *not* have rebate agreements in effect with CMS for *all* of their labeler codes. Therefore, the labeler code is the controlling factor rather than the manufacturer's name.

Manufacturer rebate payments to the State are based on prescription claims payment data identified by NDC number. To assure that the appropriate manufacturer is invoiced for the rebate monies due the State, pharmacy providers are required to submit accurate NDC numbers when filing Medicaid claims to Magellan Medicaid Administration, Inc., the POS contractor for South Carolina Medicaid.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 – REBATE REQUIREMENTS (CONT'D.)

The NDC number being submitted to Medicaid for reimbursement must be the actual NDC number on the package or container from which the medication was dispensed.

Submitting inaccurate NDC numbers may result in: DHHS' billing the wrong manufacturer for the rebate, disputes in the amount of rebate due, and postpayment review of the records of the pharmacy provider.

Additionally, failure to correctly reflect the actual NDC number dispensed may negatively impact revenues generated for the State and potentially result in a greater expenditure of state funds. Therefore, it is imperative that pharmacists take care to correctly identify the specific NDC number of the pharmaceutical dispensed. Appropriate updates to computer software programs will facilitate the use of accurate NDC numbers.

GENERAL EXCLUSIONS

The following is a listing of products *excluded* from South Carolina Medicaid coverage. These items are considered non-covered, regardless of circumstance.

1. Weight control products (except for lipase inhibitors)
2. Investigational pharmaceuticals or products
3. Immunizing agents (except for influenza, pneumococcal, and hepatitis-B vaccines). See Magellan Medicaid Administration Pharmacy Provider Manual for additional information regarding specific coverage guidelines, particularly as related to hepatitis-B vaccine
4. Pharmaceuticals determined by the Federal Drug Administration (FDA) to be less than effective and identical, related, or similar drugs (frequently referred to as "DESI" drugs)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

GENERAL EXCLUSIONS (CONT'D.)

5. Except for omalizumab (*e.g.*, Xolair®), leuprolide acetate (*e.g.*, Lupron®, Eligard®, and Viadur®), palivizumab (*e.g.*, Synagis®), and Rh_o(D) immune globulin (*e.g.*, RhoGAM®), Risperdal Consta, Invega-Sustenna, Depo Provera and Abilify Maintena injectable pharmaceuticals *administered by the practitioner in the office, in an outpatient clinic or infusion center, or in a mental health center* are not covered.

   Note: Medicaid reimbursement for Cerezyme® (imiglucerase) or Respigam® is limited solely to physician providers, hospital providers, and infusion centers through their respective Medicaid program area (*e.g.*, Physicians Services, Hospital Services, etc.)

   RhoGAM®, Synagis®, Lupron®, Eligard®, Viadur®, Xolair®, and Depo Provera may be billed via point-of-sale by the pharmacy services provider if administered in a physician's office or clinic. Due to safety and product stability issues, the pharmacy provider must deliver these pharmaceuticals *directly* to the physician's office or clinic. Additionally, Risperdal Consta®, Invega-Sustenna and Abilify Maintena may be billed via point-of-sale by the Pharmacy Services provider if administered in a South Carolina Department of Mental Health outpatient clinic. (See *Claims Submission for Certain Physician-Injectable Products* elsewhere in this section for additional information.)

6. Products used as flushes to maintain patency of indwelling peripheral or central venipuncture devices. These products are not covered under Pharmacy Services, but are covered through the DHHS Department of Durable Medical Equipment (DME).

7. Fertility products

8. Pharmaceuticals that are not rebated

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

GENERAL EXCLUSIONS (CONT'D.)

9. Nutritional supplements (Enteral nutrition therapy administered through a feeding tube and Total Parenteral Nutritional [TPN] therapy may be covered through the DHHS Department of Durable Medical Equipment; however, neither program reimburses for oral nutritional supplements.)
10. Oral hydration therapies for adults
11. Pharmaceuticals used for cosmetic purposes or hair growth
12. Anti-hemophilia factor

    Note: *Fee-for-service* reimbursement for anti-hemophilia factor is limited to the South Carolina Department of Health and Environmental Control's CSHCN (formerly CRS) Pharmacy; that state agency administers the SC Hemophilia program. For *beneficiaries enrolled in a Medicaid MCO*, the MCO is responsible for the provision and reimbursement of anti-hemophilia factor.
13. Cough/Cold medications
14. Devices and supplies (*e.g.*, diabetic supplies such as lancets, infusion supplies, etc.). These items may be billed through the DHHS Department of DME. However, certain glucometers, test strips and spacers for metered dose inhalers may also be billed through the Pharmacy POS system by an enrolled DME provider.
15. Erectile dysfunction (ED) products prescribed to treat impotence

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION

Pharmaceuticals requiring prior authorization (PA) are outlined below. South Carolina Medicaid's PA program, administered by Magellan Medicaid Administration, is comprised of a clinical PA process as well as a non-clinical PA process. Regarding *clinical* PA requests, the *prescriber* or the prescriber's designated office personnel must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181 toll-free) in order to furnish necessary patient-specific medical information. (Although faxed requests from prescribers are permissible [see *Request for Prior Authorization* form in this section], *telephoned PA requests may be processed more expeditiously* since all needed information can be supplied at the time of the telephone call.) Magellan Medicaid Administration employs a clinical staff of pharmacists and pharmacy technicians whose primary responsibilities include responding to prescribers' prior authorization requests. Based on established criteria, Magellan Medicaid Administration makes the determination regarding coverage of the product prescribed for the beneficiary. The Magellan Medicaid Administration Clinical Call Center telephone number is reserved for use by health care professionals and should not be furnished directly to beneficiaries. Magellan Medicaid Administration's *beneficiary call center* telephone number for questions regarding Pharmacy Services-related issues is 800-834-2680; providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only*.

Upon verification that usage is appropriate and in compliance with Medicaid policies, *non-clinical PAs generally may be processed at the point of sale by the pharmacist* by utilizing specific claims filing instructions contained in the Magellan Medicaid Administration Pharmacy Provider Manual. (If additional assistance is needed regarding non-clinical PAs, the provider may contact Magellan Medicaid Administration's Technical Call Center, toll-free, at 866-254-1669.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

It should be noted that for certain categories of drugs, the need for prior authorization is based on the age and/or gender of the beneficiary or on the quantity to be dispensed.

[Maximum quantity limitations have been established for certain drugs; these established maximum quantities are based upon a 31-days' supply of medication and have been determined using the drug manufacturers' current dosing recommendations. Effective February 1, 2007, DHHS implemented a Dose Optimization program, an enhancement to the current Quantity Limits program. Listings of drugs subject to quantity limitations may be found at http://southcarolina.fhsc.com. See *Quantity of Medication* elsewhere in this section for detailed information.] Furthermore, only *rebated* pharmaceuticals may be considered for possible reimbursement through the PA process.

Note: With few specified exceptions, Medicaid does not routinely cover brand name products for which there are therapeutically equivalent generic products available. See *Medicaid Coverage of Generic Products* elsewhere in this section for further information.

The drugs (or categories of drugs) outlined below require prior authorization. Those products requiring *clinical* prior authorization by the prescriber are designated as such.

1. **Non-preferred drugs:** A Preferred Drug List (PDL) has been implemented by South Carolina Medicaid. Therapeutic classes included in the PDL may also be subject to PA requirements outlined elsewhere in this section. A listing of drugs included in the PDL may be found at http://southcarolina.fhsc.com.

   Prescribers are strongly encouraged to write prescriptions for "preferred" products. However, if a prescriber deems that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the prior authorization request.

   A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

2. The following **home or self-administered** injectable products (see *Important Note* which follows):

   - Certain specified immunizing agents (*i.e.*, influenza, pneumococcal, and hepatitis-B vaccines; coverage guidelines are outlined in the Magellan Medicaid Administration Pharmacy Provider Manual; also, see *Special Coverage Groups/Issues* information elsewhere in this section).

   - Growth hormone products such as Serostim®, Nutropin®, Norditropin®, Humatrope®, and Genotropin® (the prescriber should contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 or complete the *South Carolina Medicaid Growth Hormone Prior Authorization Request* form found elsewhere in this section).

   Certain (rebated) injectable products, which are packaged and usually prescribed for home administration, are *routinely covered* by Medicaid. Therefore, those specified home-administered pharmaceuticals are not subject to prior authorization nor do they require any special billing procedures. Routinely covered injectable products are: insulin; diabetic and epinephrine emergency kits; Imitrex®; and Betaseron®, Avonex®, and Copaxone®.

   Important Note:

   Unless otherwise specified, injectables administered in a physician's office, emergency room, infusion center, or other clinical setting shall not be billed by pharmacy providers to the Medicaid Pharmacy Services program since such products are NOT reimbursable by Pharmacy Services.

   In order for an injectable product to be considered for reimbursement by Pharmacy Services, the drug must be rebated and administered in the patient's home (to include long-term care facility settings, boarding homes, etc.). Pharmacy providers may bill for only those injectable products for which the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

pharmacist has verified that the injectable will be self- or home-administered.

Therefore, the submission of a Medicaid pharmacy claim for an injectable product signifies that the pharmacist has verified the Medicaid beneficiary's self- or home-administration of that product. Postpayment-payment reviews will be performed to ensure adherence to this billing policy.

Staff in the facility, infusion center, or office where the injectable drug is to be administered should contact their respective Medicaid program area (*i.e.*, Physicians Services, Hospital Services, etc.) to obtain Medicaid coverage, billing, and reimbursement information. See also *General Exclusions* portion of this section regarding non-covered injectable medications.

Exceptions: RhoGAM®, Synagis®, Lupron®, Eligard®, Viadur®, Xolair®, and Depo Provera may be billed via the point-of-sale system by the pharmacy services provider if administered in a physician's office or clinic. (It should be noted, however, that Xolair® requires prior authorization. The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request approval.) Due to safety and product stability issues, the pharmacy provider must deliver these pharmaceuticals *directly* to the physician's office or clinic. Additionally, Risperdal Consta®, Invega-Sustenna, and Abilify Maintena may be billed via point of sale by the Pharmacy Services provider if administered in a South Carolina Department of Mental Health outpatient clinic. Abilify Maintena requires a PA. (For additional information regarding these exceptions, see the *Special Groups/Issues* portion of this section.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

3. **Medicare Part B-covered pharmaceuticals** (including their respective generics) for *dually eligible* beneficiaries. These products include:

   - Immunosuppressants (*e.g.*, CellCept®, Imuran®, Neoral®, Prograf®, Sandimmune®, Sangcya®, Simulect®, Zenapax®, Gengraf®, Rapamune®, Orthoclone OKT3®, and Atgam®)
   - Chemotherapy agents (oral)
   - Anti-emetics (oral)
   - Inhalation drugs
   - Interferon Beta-1A (Avonex®)

   Providers must have a supplier billing number in order to bill *Medicare Part B* for immunosuppressant drugs. The Medicare supplier billing number may be obtained by calling the National Supplier Clearinghouse at 866-238-9652 (toll-free). For those non-ESRD transplant patients whose surgeries were sponsored by Medicare, coverage of immunosuppressants is a lifetime *Medicare Part B* benefit. Those beneficiaries who have received a kidney transplant and had Medicare entitlement solely due to ESRD, and have not become entitled to Medicare due to age or disability, are NOT eligible for lifetime Medicare Part B coverage of immunosuppressants. However, Medicare Part B does sponsor coverage of these drugs for ESRD patients for a 36-month period following the date of discharge from the hospital stay during which the Medicare-covered transplant surgery was performed. Medicare Part B should continue to be billed for reimbursement of immunosuppressants until the provider receives a denial of coverage. Once Medicare Part B denial of coverage for immuno-suppressive drug therapy is confirmed (or if Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated), the pharmacist should then submit the claim to the beneficiary's Part D prescription drug plan (PDP).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

Regarding oral chemotherapy agents for dually eligible beneficiaries, if the oral chemotherapy drug being prescribed is used to treat cancer, then the provider should bill *Medicare Part B* for reimbursement. If such a drug is NOT being used to treat cancer but rather some other medical condition, the provider should bill *Medicare Part D* for reimbursement.

Medicare Part B is the primary payer if the oral anti-emetic replaces an intravenous anti-emetic and the initial oral anti-emetic dose is administered within two hours of chemotherapy administration.

If Medicare Part B reimburses any portion of the Pharmacy Services provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist may request prior authorization (PA) to bill Medicaid secondarily using Magellan Medicaid Administration's point-of-sale system. Pharmacists may request prior authorization by contacting the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free). If the amount paid was applied toward the annual deductible, a copy of the Medicare Part B explanation of benefits (EOB) must be faxed to the Magellan Medicaid Administration Clinical Call Center at 888-603-7696 (toll-free). Pharmacists are encouraged to indicate the beneficiary's 10-digit Medicaid identification number on Medicare EOBs furnished to Magellan Medicaid Administration. While subsequent fills for that specific drug therapy will continue to require PA, faxing additional copies of the Medicare EOB will not be necessary each time the prescription is refilled.

Providers should go to: http://www.palmettogba.com for complete Medicare Part B policy and billing codes pertaining to covered outpatient pharmaceuticals (including inhalation drugs).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

To facilitate claims submission, it may be necessary for the pharmacist to contact the prescriber for additional diagnostic or patient-specific information in order to determine which payer (Part B or Part D) should be billed as primary. (See Section 3 of this manual for billing instructions.)

4. **Sildenafil when prescribed for the treatment of pulmonary arterial hypertension (PAH).** The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to communicate patient-specific clinical information. If coverage is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy and dosage.

5. **Amphetamines** for patients over the age of 21 to treat: Adult Attention Deficit Disorder (AADD) or narcolepsy.

   Note: Pharmaceuticals used as anorexiants are excluded from coverage. Amphetamines for FDA-approved indications for patients from birth to the date of their 21st birthday are routinely covered and do not require prior authorization.

6. **Lactulose** solution used: 1) as an adjunct to protein restriction and supportive therapy for the prevention and treatment of portal-systemic encephalopathy (PSE) including hepatic pre-coma and coma or 2) in the treatment of chronic constipation *if trials with conventional laxative therapies have been unsuccessful*.

   Note: Lactulose solution is non-covered if prescribed for the initial treatment of chronic constipation in lieu of trials with conventional laxative therapies.

7. **Tretinoin** used for patients over the age of 21 to treat: 1) acne vulgaris, 2) forms of skin cancer or 3) the following dermatologic conditions: lamellar ichthyosis, mollusca contagiosa, verrucae plantaris, verrucae planae juvenilis, ichthyosis vulgaris bullous congenital ichthyosiform and pityriasis rubra pilaris.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

Note: Pharmaceuticals used for cosmetic purposes are excluded from coverage; therefore, tretinoin is non-covered when prescribed for photoaged skin or skin conditions related to the normal aging process (*e.g.*, wrinkles, liver spots). Tretinoin used for FDA-approved indications for patients from birth to the date of their 21st birthday is routinely covered and does not require prior authorization.

8. **Lipase inhibitors (*e.g.*, Xenical®)** when prescribed for morbid obesity or hypercholesterolemia; in addition to meeting the conditions specified below, the patient must be at least 18 years of age

   (The prescriber must contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request approval).

   Xenical® (orlistat) for diagnosis of morbid obesity:

   - Patient must have a diagnosis of obesity in the presence of other risk factors (*e.g.*, hypertension, diabetes, dyslipidemia).
   - Patient must have an initial body mass index (BMI) $\geq$ 30 kg/m^2.
   - Patient must be on a reduced fat and calorie diet with nutritional counseling regarding adherence to dietary guidelines.

   Xenical® (orlistat) for diagnosis of hyper-cholesterolemia:

   - Patient must have a diagnosis of hypercholesterolemia with treatment failures.
   - Patient must have experienced an adverse reaction as a direct result of EACH of the FDA-approved drug classes for treating hypercholesterolemia.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION (CONT'D.)

9. **Panretin® (alitretinoin)**

   The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to request approval; if approved, coverage may be granted for a period of four months. (There is a limit of one tube of Panretin® gel on the initial prescription.)

10. **Targretin® (bexarotene)**

    The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to request approval; if approved, coverage may be granted for a period of four months.

    (On the initial prescription, there is a limit of one tube of Targretin® gel OR a one month's supply of oral medication.)

11. **Certain anti-ulcer products** [*i.e.*, proton pump inhibitors (PPIs) that are not included on the PDL.]

    The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to communicate patient-specific clinical information. If coverage of the requested product is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy and dosage.

12. **Certain anti-arthritis products** (*i.e.*, cyclooxygenase-2 [COX-2] inhibitors)

    The anti-arthritis prior authorization program includes:

    - COX-2 inhibitors, all strengths and dosages.

    Note: Prior authorization is not required for COX-2 inhibitor prescriptions/refills for patients 60 years of age and greater.

    The prescriber must contact Magellan Medicaid Administration's Clinical Call Center (866-247-1181) to communicate patient-specific clinical information. If coverage of the requested product is approved, subsequent PA requests will be necessary at certain intervals for that specified therapy; generally, prior authorization approval for anti-arthritis drugs is in effect for up to one year.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Other Prior Authorization Protocols

Regarding pharmaceuticals dispensed to Medicaid beneficiaries enrolled in a hospice program, only those drugs **not** related to the terminal illness may be billed as fee-for-service to the Medicaid program; such drugs must be prior authorized *by the hospice provider* (rather than by Magellan Medicaid Administration) before delivery. Pharmacists must contact the hospice provider to verify that the services being rendered are for a condition not related to the patient's terminal illness.

(Detailed billing instructions may be found in the Magellan Medicaid Administration Pharmacy Provider Manual. See also *Special Coverage Groups/Issues* elsewhere in this section for additional information regarding Medicaid hospice services.)

Regarding dual eligibles enrolled in a Medicare-approved hospice program, Medicare Part A pays for drugs prescribed for symptom control or pain relief. However, Medicare Part A is not permitted to pay for prescriptions intended to treat the beneficiary's terminal illness. The beneficiary's Medicare Part D prescription drug plan covers drugs unrelated to the terminal illness.

Other Prior Authorization Protocols (Cont'd.)

It is important to note that patients may not be billed for any products for which Medicaid reimbursement may be requested through Magellan Medicaid Administration's prior authorization process. Patients may be billed only in those instances where the request for prior authorization has been denied due to clinical criteria not having been met.

Since non-clinical PAs generally may be processed successfully by the pharmacist at the point of sale, it is the pharmacist's responsibility to submit such claims in a timely and accurate fashion. To facilitate the claims submission process (*e.g.*, to verify place of administration for injectable products), the pharmacist may have to contact the prescriber in order to obtain patient-specific diagnostic or related information.

Prescribers may request prior authorization from Magellan Medicaid Administration via telephone, fax (888-603-7696, toll-free), or mail; requests for prior authorization will be responded to within 24 hours of receipt. (For expediency, telephonic requests are preferred.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Other Prior Authorization Protocols (Cont'd.)

The DHHS requires that PA be requested (and subsequent approval entered into Magellan Medicaid Administration's system) prior to the dispensing of the medication; thus, retroactive PAs may be considered only in cases of retroactive Medicaid eligibility determination.

It should be noted that Magellan Medicaid Administration's prior authorization process does not require a "PA number" to be entered on a POS (or paper) claim; the only requirement is that the PA record is activated in Magellan Medicaid Administration's system prior to claim submission. Clinical prior authorization timelines may vary, depending upon category of drug requested and patient-specific diagnostic information.

If the request for prior authorization is denied, Magellan Medicaid Administration's Clinical Call Center staff will notify the originator of the request verbally at the time of telephonic contact or by fax if the request was made via that method.

For clinical prior authorizations in which a Magellan Medicaid Administration pharmacy technician or pharmacist requests additional information from the prescriber, Magellan Medicaid Administration will deny the PA request if the prescriber does not respond to a request for information within three working days. Denial letters are not issued in such instances.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST

PRESCRIBER:

NAME: _____ (FIRST) (LAST)

National Provider ID #_____

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____ (FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ___/___/___ **SEX:** ☐ M ☐ F

REQUEST DATE: ___/___/___

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____)_____

PRIOR AUTHORIZATION REQUESTED FOR: (Please check appropriate prior authorization type)

☐ **Orlistat** (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	☐ **Quantity Limits** ☐ **PDE5 Inhibitor for Pulmonary Arterial Hypertension** **Other:** _____	**NOTE:** **"Brand Medically Necessary"** PA requests require a *South Carolina MedWatch form.* **"Growth Hormone"** PA requests require a *Growth Hormone request form.*

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates): _____

_____

MEDICAL JUSTIFICATION FOR PRODUCT USE: _____

_____

PRESCRIBER'S SIGNATURE AND SPECIALTY: _____

MAGELLAN MEDICAID ADMINISTRATION USE ONLY: ☐ **APPROVED** ☐ **DENIED**

DATE: _____/_____/_____

MAP RPh/TECH: _____

NDC: _____

COMMENTS: _____

_____

_____

SUBMIT REQUESTS TO: **MAGELLAN MEDICAID ADMINISTRATION**
FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

Revised: May 2010 General PA Form

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST – PROTON PUMP INHIBITORS

PRESCRIBER:

NAME: _____ (FIRST) (LAST)

National Provider ID #_____

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____ (FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ___/___/___ **SEX:** ☐ M ☐ F

REQUEST DATE: ___/___/___

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____)_____

Patient's Diagnosis: _____

Have any recent GI procedures been performed? (Check and complete ALL that apply.)

Procedure:	Date of Procedure:	Findings:
☐ Upper GI Series	____/____/____	_____
☐ Barium Swallow	____/____/____	_____
☐ Endoscopy	____/____/____	_____

Has the Patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past 2 years? ☐ Yes ☐ No
If Yes, Medication Name: _____ **Strength:** _____ **Frequency**_____ **Date of trial:** ____/____/____

Is the Patient H.Pylori positive? ☐ Yes ☐ No **Date:** ____/____/____

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

SUBMIT REQUESTS TO: **MAGELLAN MEDICAID ADMINISTRATION**
FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

October 2010 Proton Pump Inhibitors - PA Form

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – ADULT TREATMENT

PRESCRIBER:

NAME: _____
(FIRST) (LAST)

Prescriber Specialty: _____

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____
(FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ___/___/___ **SEX:** ☐ M ☐ F

REQUEST DATE: ___/___/___

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ **ICD-9 CODE:** _____

Initiation of Therapy: ☐ Yes ☐ No **Continuation of Therapy:** ☐ Yes ☐ No

Provocative Stimulation Test and Findings : _____

Is patient receiving full supplementation of deficient pituitary hormones? ☐ Yes ☐ No
If yes, please list _____

Does the patient have reduced bone mineral density (BMD) using the WHO criteria? ☐ Yes ☐ No
If yes, please provide T-Score: _____

Does the patient have a high risk lipid profile? ☐ Yes ☐ No
If yes, please provide total cholesterol or LDL level: _____

Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone? ☐ Yes ☐ No
If yes, please list: _____

For renewal, is the patient showing improvement? ☐ Yes ☐ No
*** Increase in BMD per DEXA scan:** ☐ Yes ☐ No
*** Reduction in lipid panel:** ☐ Yes ☐ No
Document percent reduction: _____

Prescriber's Signature: _____ **Date:** ___/___/___

SUBMIT REQUESTS TO: **MAGELLAN MEDICAID ADMINISTRATION**
FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

Revised: May 2010 Growth Hormone – Adult

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – PEDIATRIC TREATMENT

PRESCRIBER:

NAME: _____
(FIRST) (LAST)

Prescriber Specialty: _____
(*Note: Requesting prescriber must be a nephrologist or pediatric endocrinologist*)

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____
(FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ___/___/___ **SEX:** ☐ M ☐ F

REQUEST DATE: ___/___/___

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ **ICD-9 CODE:** _____

Birth Weight: _____ **Gestational Age at Birth:** _____

Last Recorded Height: _____ **Date of Measurement:** _____

Last Recorded Weight: _____ **Date of Measurement:** _____

Biological Mother's Height: _____ **Biological Father's Height:** _____

Therapy: ☐ Initiation ☐ Continuation

Bone Age Studies Results: _____

Epiphyses: ☐ Open ☐ Closed

Has Patient been evaluated by ☐ Endocrinologist ☐ Pediatric Nephrologist

Current Growth Velocity: _____

PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST.

Prescriber's Signature: _____ **Date:** ___/___/___

SUBMIT REQUESTS TO: MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

Revised: May 2010 Growth Hormone – Pediatric

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MEDICAID COVERAGE OF TOBACCO CESSATION PRODUCTS

DHHS reimburses for certain pharmaceuticals used to facilitate the discontinuation of tobacco products. A prescription written for a tobacco cessation product specified below is covered within program limitations (*e.g.,* monthly prescription limit) for all Medicaid beneficiaries. Prior authorization is not required (except where indicated) for reimbursement of the tobacco cessation products listed below, however, there are quantity limitations for these pharmaceuticals as well as a coverage-period limit.

Medicaid coverage of tobacco cessation pharmaceuticals includes prescriptions authorized for any of the following *rebated* drugs:

- Bupropion sustained release products
- Chantix® (varenicline) tablets
- Nicotine Replacement Therapy (NRT) pharmaceutical products: legend and over-the-counter patches and gum. *(NRT lozenges, inhalers and sprays are noncovered unless approved through the prior authorization process*.)

Reimbursement for tobacco cessation products is available for one twelve-week course of treatment consisting of 90 days (three consecutive months) per beneficiary per calendar year. Pregnant beneficiaries are entitled to two twelve-week courses of treatment consisting of 90 days (three consecutive months) per calendar year. Medicaid-covered maximum quantity limitations for tobacco cessation products are:

- Bupropion extended release 150 mg – 180 tablets per 90-day period
- Chantix® (varenicline) tablets – 180 tablets per 90-day period
- Nicotine patches – 90 patches per 90-day period
- Nicotine gum – 1,512 pieces per 90-day period

To request prior authorization for NRT lozenges, nasal inhalers, or sprays, prescribers should contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181. Documentation verifying the patient's inability to use the patches or gum and the medical necessity of the NRT lozenges, nasal inhaler, or spray will be required.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

LONG-TERM CARE BENEFICIARIES

Regarding *non-dually eligible* long-term care patients (including swing bed patients), with certain specified exceptions, the Medicaid program sponsors payment for up to four prescriptions per month for beneficiaries over the age of 21. However, pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid beneficiaries if certain prescription limit override criteria are met; see *Prescription Limit* elsewhere in this section for further details. (Children from birth to the date of their 21st birthday are allowed unlimited prescriptions per month.)

Providers are advised that, with the exception of insulin, *all* OTC products must be furnished by the nursing facility, and as such, these items may not be billed separately to the Pharmacy Services program. OTC drugs are reimbursed in the per diem rate for all facilities in accordance with procedures established by DHHS. Therefore, OTC products may not be billed to the patient/responsible party, relative, organization, or any other entity.

Nearly all parenteral therapies furnished to non-dually eligible long-term care patients are routinely covered and do not require prior authorization in order to be billed to Medicaid. Furthermore, except for insulin, parenteral therapies do not count toward the adult beneficiary's monthly prescription limit. In addition to non-insulin parenteral therapies, the following items are exempt from the current monthly limit for adult long-term care patients:

- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals and devices

See *Prescription Limit* elsewhere in this section for additional information regarding routine exceptions to the monthly prescription limit for adult beneficiaries.

Deductions for Non-Covered Medical Expenses

Non-dually eligible individuals in nursing facilities, whose cost of care is sponsored by Medicaid and who have monthly recurring income, are allowed deductions from their monthly income if they incur medical expenses which are not covered by Medicaid or another third party.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Deductions for Non-Covered Medical Expenses (Cont'd.)

Non-covered medical expenses are those expenses which are recognized by State law as medical expenses, but which are not covered by Medicaid or any other third party payer such as Medicare, TRICARE, private insurance, etc. Non-covered medical services include those items/services that exceed Medicaid limits (for patients over the age of 21, drugs dispensed above the four prescriptions per month limit which do not meet the prescription limit override criteria), less than effective, or non-rebated drugs. Non-covered services do not include items/services that are recognized in allowable costs for Medicaid long-term care rate setting purposes.

A deduction will be allowed when the following information is provided to the nursing facility:

- A bill which states the item/service furnished, the date rendered, and the cost
- A statement or prescription from a licensed practitioner that verifies medical necessity

The deduction(s) will be made in the month in which the required documentation is provided to the nursing facility. Deductions will not be allowed for expenses that were incurred prior to entering the nursing facility. Services/items, which were rendered more than three months prior to the month of the request, will not be allowed as deductions except under the following circumstances:

- When eligibility is determined for a retroactive period; or
- When there is a delay in approving an application on an individual who is a resident of a nursing facility; or
- When there is a delay in a determination by a third party payer regarding coverage of an item/service

Deductions will be allowed for prescription drugs that are noted under *General Exclusions* elsewhere in this section, exceed the monthly prescription limit for adult Medicaid patients (and which do not meet specified override criteria), or are not covered by another third party payer. The amount deducted cannot exceed the lesser of $12.00 or the actual cost of the prescription.

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The DHHS Drug Utilization Review program is composed of the: 1) retrospective DUR program, 2) prospective DUR component, 3) DUR Panel's responsibilities and drug history reviews, 4) patient counseling for Medicaid beneficiaries receiving prescriptions, and 5) records requirement of a pharmacy patient record system (see *Records Requirements* elsewhere in Section 2 for detailed information regarding this specific component).

RETROSPECTIVE DUR

The DHHS retrospective DUR program involves monthly reviews of patient drug history profiles by a panel of physicians and pharmacists. These monthly reviews seek to assist prescribers by focusing upon the possibility of adverse drug effects. Many clinical factors influence prescription decisions, including the patient's health status, side effects reported by the patient or detected by the prescriber, and available alternative treatments. Non-clinical factors also impact these reviews. To prescribe appropriately, the practitioner needs all relevant clinical and personal information, including the drugs ordered by other prescribers. Upon notification of a potential drug therapy problem, written notification is sent to the prescriber(s) and dispensing pharmacies. This notification describes the potential drug therapy problem and includes the comprehensive drug history profile.

The DUR Panel conducts a retrospective review of the patient drug history profiles and evaluates the drug history information for: therapeutic appropriateness, over and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect dosage or duration of therapy, and clinical abuse/misuse. Providing practitioners

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

RETROSPECTIVE DUR (CONT'D.)

with specific, focused and *comprehensive drug information* increases their awareness of potential drug therapy problems.

This allows prescribers to make any necessary prescription changes in order to prevent adverse outcomes.

PROSPECTIVE DUR

Prospective DUR means a review of the patient's drug therapy and prescription drug order as part of a drug regimen review before each prescription is filled or dispensed. As an integral part of the POS system, ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The point-of-sale ProDUR system assists the pharmacist in these functions by addressing multiple situations in which potential drug problems may exist. Drug utilization review performed prior to dispensing helps pharmacists ensure that beneficiaries receive appropriate medications. This is accomplished by providing information that may not have been previously available to the dispensing pharmacist.

Because the ProDUR system examines previously paid claims from all participating pharmacies as it reviews a beneficiary's Medicaid-reimbursed prescription history, drugs that interact with or are affected by previously dispensed medications can be detected. The ProDUR system is offered as an informational tool to assist the pharmacist in performing his/her professional duties.

The potential problems that the ProDUR system detects include:

- Overutilization (*i.e.*, early refill)
- Underutilization
- Excessive daily dose
- Insufficient daily dose
- Therapeutic duplication
- Drug to drug interaction
- Drug-age contraindication
- Drug-pregnancy contraindication
- Excessive quantity
- Drug-diagnosis contraindication

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

PROSPECTIVE DUR (CONT'D.)

Non-computerized pharmacy providers (or those providers who choose not to utilize the point-of-sale system for claims submission) must manually screen each prescription for certain therapeutic problems, using standards consistent with OBRA 1990 requirements.

If the Medicaid POS ProDUR system is not utilized, DHHS' prospective DUR

program requires that, in compliance with OBRA 1990 requirements, the pharmacist must perform a drug regimen review which includes, but is not limited to, the following activities:

1. Evaluation of prescription drug orders and pharmacy patient records for:
   - Known allergies
   - Rational therapy – contraindications
   - Reasonable dose and route of administration
   - Incorrect dosage or duration of therapy
   - Reasonable directions for use
   - Therapeutic appropriateness
   - Appropriate use of generic products
2. Evaluation of prescription drug orders and pharmacy patient records for duplication of therapy and therapeutic duplication.
3. Evaluation of prescription drug orders and pharmacy patient records for interactions such as:
   - Drug-drug
   - Drug-food
   - Drug-disease (if available)
   - Adverse drug reactions
   - Clinical abuse/misuse
4. Evaluation of prescription drug orders and pharmacy patient records for proper utilization, including overutilization or underutilization, and optimum therapeutic outcomes.

SECTION 2 POLICIES AND PROCEDURES

DRUG UTILIZATION REVIEW PROGRAM

PROSPECTIVE DUR (CONT'D.)

See the Prospective Drug Utilization Review section in the Magellan Medicaid Administration Pharmacy Provider Manual for additional information.

DUR PANEL

The DUR Panel is a panel composed of physicians and pharmacists. This panel of health care practitioners has responsibilities pertaining to:

1. The retrospective DUR program, including the retrospective review of patient drug history profiles
2. Criteria used in the retrospective DUR process and subsequent application of standards for both the retrospective and prospective DUR programs
3. Decisions regarding interventions with prescribers and pharmacists in response to therapy problems identified through retrospective DUR

PATIENT COUNSELING

Patient counseling is defined as the oral or written communication by the pharmacist to a patient or caregiver providing information on the proper use of drugs and devices.

South Carolina Medicaid requires that, upon receipt of a prescription drug order for a "new" medication and following review of the patient's pharmacy record, the pharmacist shall personally offer counseling to the patient or the patient's agent. Using his or her best professional judgment, the pharmacist's counseling shall include a discussion of those matters that the pharmacist considers appropriate for the patient or patient's agent in that particular situation. The discussion must be in person, whenever practicable, or by telephone or written communication and shall include appropriate elements of patient counseling.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/ DISPENSING LIMITATIONS

ELIGIBILITY

The Medicaid program reimburses for covered medical services for individuals who have a valid 10-digit identification number (as printed on the permanent plastic South Carolina Healthy Connections Card) and whose eligibility for that date of service has been verified. For pharmacy providers, eligibility verification may be accomplished by claims submission through Magellan Medicaid Administration's POS system.

It is important to note that *possession of the plastic Medicaid card does not guarantee Medicaid eligibility*; beneficiaries may become ineligible for Medicaid for a given month only to regain eligibility at a later date. Therefore, it is possible that a beneficiary will present a Medicaid card during a period of ineligibility. To avoid such rejections, pharmacy providers are strongly encouraged to submit claims via Magellan Medicaid Administration's "real time" point-of-sale system. Pharmacists are not obligated to dispense medications if the beneficiary (or his/her caregiver) is unable to present the plastic Medicaid card or other appropriate documentation containing the individual's Medicaid health insurance number. (Refer to Section 1 for further information on Medicaid eligibility and for a detailed description of the South Carolina Healthy Connections Medicaid Insurance Card.)

The POS system also facilitates claims processing by identifying those Medicaid beneficiaries enrolled in certain waiver programs who may be eligible for enhanced benefits; conversely, it also alerts the pharmacy provider that, in some instances, Medicaid coverage may be restricted or limited.

Use of the point-of-sale system provides *immediate* verification that the individual is currently eligible for Medicaid coverage and also determines if benefits are restricted or enhanced.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

ELIGIBILITY (CONT'D.)

Therefore, if non-POS claims are submitted, the provider is at risk for possible non-payment by Medicaid due to beneficiary ineligibility or other factors (including exceeding the monthly prescription limit for an adult beneficiary).

There is no prior authorization mechanism or other method available by which to override the monthly prescription limit if the adult beneficiary's four "slots" have already been utilized for non-essential medications and the rejected prescription is for a pharmaceutical which is also deemed non-essential. Thus, in some instances, providers who submit non-POS claims will be at risk for exceeding the adult beneficiary's monthly prescription limit (see *Prescription Limit* elsewhere for further details). Furthermore, where the Medicaid point-of-sale system is utilized in claims submission, an adult beneficiary may receive services (if necessary) from more than one pharmacy in a given month without compromising his/her monthly prescription limit.

In order to ensure that Magellan Medicaid Administration and DHHS Pharmacy Services staff resources are appropriately utilized, providers should instruct beneficiaries to call the Magellan Medicaid Administration Beneficiary Call Center at 800-834-2680 (toll-free) for inquiries regarding Pharmacy Services-related issues. Other Medicaid inquiries from beneficiaries should be directed to 888-549-0820 (toll-free).

In addition to providing traditional fee-for-service medical care coverage, DHHS has implemented the SC Medicaid Managed Care Program. Providers should refer to the Managed Care Supplement for additional information.

Note: The above requirements are specific to fee-for-service Medicaid. Many beneficiaries are now enrolled in a Medicaid Managed Care program and, as such, are subject to the guidelines as outlined in their specific managed care plan. Providers must verify plan participation prior to rendering services. Providers should refer to the Managed Care Supplement for additional information.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

PRESCRIPTION LIMIT

Medicaid-eligible beneficiaries from *birth to the date of their 21st birthday* are allowed unlimited prescriptions per month.

For patients over the age of 21, unless otherwise specifically allowed, the traditional fee-for-service Medicaid program sponsors reimbursement for a maximum of four prescriptions per beneficiary per month (see monthly prescription limit override criteria outlined below). Current *routine* exceptions to the monthly prescription limit for adult beneficiaries are:

- Insulin syringes used in the administration of home parenteral therapies (not applicable to non-dually eligible long-term care patients; see specific long-term care OTC policy outlined elsewhere in this section)
- Home-administered parenteral therapies (however, *insulin* counts toward the monthly prescription limit, but claims for insulin which reject for exceeding the monthly prescription limit may be overridden if certain criteria are met)
- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals and devices

Monthly Prescription Limit Override Criteria for Adult Beneficiaries

Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid beneficiaries if the prescription limit override criteria are met. A total of three overrides per beneficiary per month is allowed.

Pharmacists should submit the prescription limit override code, a “5” in the Prior Auth Type Code (PATC) field, if all of the following criteria are met. Adult Medicaid beneficiaries are entitled to four prescriptions per month and up to three overrides for prescriptions that meet the following criteria. Pharmacists should submit the prescription limit override code on the claim if:

1. The monthly prescription limit has been met, *and*
2. The adult patient has one of the following conditions, *and*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

Monthly Prescription Limit Override Criteria for Adult Beneficiaries (Cont'd.)

3. The prescription is for an *essential* drug used in the adult patient's treatment plan for one of these conditions:
   - Acute sickle cell disease
   - Behavioral health disorder
   - Cancer
   - Cardiac disease (including hyperlipidemia)
   - Diabetes
   - End stage lung disease
   - End stage renal disease (ESRD)
   - HIV/AIDS
   - Hypertension
   - Life-threatening illness (not otherwise specified)
   - Organ transplant
   - Terminal stage of an illness

It is inappropriate for pharmacy providers to choose to ignore this particular billing process for all of their adult Medicaid patients. Conversely, it is inappropriate for pharmacy providers to generally promote this particular billing mechanism since not all prescriptions can meet the override criteria.

The override of the monthly prescription limit is reserved for only those prescriptions that, in the clinical judgment of the pharmacist, meet the prescription override criteria outlined above.

Use of the monthly prescription limit override code is systematically restricted for those therapeutic classes that normally do not meet the override criteria (*e.g.*, vitamins, laxatives, and so forth). However, it should be noted that this override restriction does not imply that use of the override code is appropriate for *all* prescriptions for medications in the non-restricted therapeutic classes. Pharmacists are expected to make sound decisions regarding use of the prescription limit override on an individual prescription/patient basis. *If a pharmacist is uncertain as to the appropriateness of a prescription limit*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

Monthly Prescription Limit Override Criteria for Adult Beneficiaries (Cont'd.)

override for a particular medication, the pharmacist should contact the prescriber to obtain additional clinical information so that an informed Medicaid coverage decision may be made. Following careful consideration, if the pharmacist deems a prescription in a restricted therapeutic class to meet the stipulated override criteria, he or she may call the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free) to request prior authorization.

- Pharmacists must NOT use the override code for a prescription until after the adult beneficiary's monthly prescription limit has been reached.
- Since children from birth to the date of their 21st birthday are eligible for an unlimited number of Medicaid-covered prescriptions per month, the override mechanism should never be utilized when submitting claims for children.

Pharmacists may reverse pharmacy claims (previously submitted during the given month) that would have met the prescription limit criteria (provided the monthly prescription limit had already been met) in order to submit claims for that month for prescriptions that do not meet the prescription limit override criteria. Subsequently, the reversed claims that meet the override criteria may be resubmitted using the override code. Pharmacies will be audited for appropriate utilization of the prescription limit override code. (See Section 3 for claims submission procedures to be utilized when an allowable override to the monthly prescription limit is necessary.)

Providers are advised that there is no "special authorization" process in effect or other method allowed by which the monthly prescription limit may be overridden when claims for *non-essential* medications are denied for exceeding the limit and *multiple* pharmacy providers are involved. Therefore, providers who submit non-POS claims are at risk for exceeding the monthly prescription limit for adult beneficiaries and are strongly encouraged to consider claims submission via the point-of-sale system. Through use of the POS system, the pharmacy provider has immediate access to the claims adjudication process and receives an on-line, "real time" notification if the monthly prescription limitation is exceeded.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

QUANTITY OF MEDICATION LIMITS / DOSE OPTIMIZATION PROGRAM

Medicaid reimburses for a maximum one-month supply of medication per prescription or refill or for a days' supply commensurate with the smallest package size available. The DHHS defines a one-month supply as a maximum 31-day supply per prescription for non-controlled substances.

Providers should refer to the South Carolina Controlled Substances Regulations promulgated by the South Carolina Department of Health and Environmental Control (DHEC) for maximum quantity limitations on prescriptions for controlled substances.

Furthermore, certain pharmaceuticals are subject to maximum quantity limitations. Those products which have quantity limits may be found at http://southcarolina.fhsc.com. The Quantity Limits listing is updated periodically; therefore, providers may find it beneficial to refer to the Web site for the most current information. The established maximum quantities are based upon a month's supply of medication. Prior authorization will be necessary for any quantity exceeding the established per month limitation. Prescribers should contact the Magellan Medicaid Administration Clinical Call Center at 866-247-1181 (toll-free) to request prior authorization.

Effective with dates of service February 1, 2007, DHHS implemented a Dose Optimization program. The focus of the Dose Optimization program is improved patient compliance with drug therapy regimens, reduced potential for exceeding the maximum recommended dose as determined by the Food and Drug Administration, and decreased adverse drug events.

Dose Optimization is an enhancement to the current Quantity Limits program. Medications that may be indicated for once or twice daily dosing are identified and where clinically applicable, Dose Optimization edits limit the number of times the medication is dosed. This editing process does not interfere with the total daily dosage of the medication prescribed for the patient. Prescribers are asked to consider appropriate Dose Optimization guidelines when higher strengths of the drug are commercially available. For example, prescriptions authorized for two Aricept® 5 mg tablets daily should instead be authorized for the commercially available Aricept® 10 mg tablet with instructions of one tablet daily.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

QUANTITY OF MEDICATION LIMITS / DOSE OPTIMIZATION PROGRAM (CONT'D.)

When clinically appropriate, DHHS encourages pharmacy providers to contact prescribers regarding those prescriptions where changes may be appropriate to conform to daily dosing limitations.

For those patients who require unique dosing regimens, pharmacy providers should ask the prescriber or the prescriber's designated office personnel to contact Magellan Medicaid Administration's Clinical Call Center at 866-247-1181 to request prior authorization. Those products subject to Dose Optimization may be found at http://southcarolina.fhsc.com. The Dose Optimization listing will be updated periodically; therefore, providers may find it beneficial to refer to the Web site for the most current information.

Providers should note that DHHS requires the use of the "metric decimal" quantity on Medicaid pharmacy claims. **A "rounded" or "rounded up" number must NOT be submitted as the billed quantity when the dispensed amount is a fractional quantity.** *If the dispensed quantity is a fractional amount, then the billed quantity must accurately reflect the specific metric decimal quantity that is dispensed*.

Billing incorrect quantities negatively affects quarterly rebate invoice data and results in under- or overpayment to providers. Furthermore, mispaid claims due to inaccurate quantities are subject to postpayment review and when appropriate, recoupment of monies. Pharmacy providers must evaluate their software and billing processes in order to ensure that the prescription quantity that is billed to Medicaid accurately reflects the dispensed quantity. Billing inquiries should be directed to Magellan Medicaid Administration's Technical Call Center at 866-254-1669. (See *Postpayment Reviews* elsewhere in this section for additional information.)

REFILLS

Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices. Refill documentation should be accurate and easily accessible for postpayment review purposes. If a refill authorization is received orally, sufficient documentation must be present on the original prescription. However, in those refill instances where a new and separate prescription is

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

REFILLS (CONT'D.)

necessary (*i.e.*, controlled substance prescription), a new prescription must be issued in accordance with state and federal requirements. **Automatic Refill Programs shall not be utilized for SC Medicaid beneficiaries.** A pharmacy provider shall not automatically generate refills for a SC Medicaid beneficiary.

It is understood that certain circumstances may necessitate an early refill (*e.g.*, change in dosage, stolen or damaged prescriptions, etc.). If the prescription is refilled early (*i.e.*, before 75% of the medication should have been exhausted, according to the prescriber's directions), a ProDUR denial error message ("early refill 866-254-1669") will be returned via the POS system. When there are circumstances that justify an early refill, the pharmacist must request prior authorization by contacting the Magellan Medicaid Administration Technical Call Center at the toll-free number indicated. Requests for "early refill" overrides must meet certain specified criteria; those not meeting the established criteria will be denied.

MEDICAID COVERAGE OF GENERIC PRODUCTS

Medicaid does not cover brand name products for which there are therapeutically equivalent, less costly generics available unless documentation of a treatment failure is furnished.

Furthermore, **the treatment failure must be directly attributed to the patient's use of a generic for the brand name product**.

A South Carolina Medicaid MedWatch form, completed by the prescriber and forwarded to the Magellan Medicaid Administration Clinical Call Center (toll-free fax number: 888-603-7696), serves as the required documentation of a treatment failure with a generic product. (See a copy of the South Carolina Medicaid MedWatch form in this section and a camera-ready copy in the Forms section of this manual.) If the requested brand name product is not approved for Medicaid reimbursement, Magellan Medicaid Administration's Clinical Call Center staff will notify the prescriber. Conversely, if coverage of the product is approved, Medicaid will reimburse the patient's pharmacy, provided all other relevant program requirements are met; such prior authorization approval is in effect for the duration of that specific therapy.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

MEDICAID COVERAGE OF GENERIC PRODUCTS (CONT'D.)

As stated above, Medicaid does not routinely cover brand name products for which there are therapeutically equivalent, less costly generics available EXCEPT for the following brand name products [traditionally categorized as Narrow Therapeutic Index (NTI) drugs]: digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin, and carbamazepine.

Any of these pharmaceuticals, however, may be subject to upper limit of payment policies requiring prescriber certification for the use of the brand name product.

In addition to the South Carolina Medicaid MedWatch form requirement (where indicated), the prescriber's *handwritten* notation on the prescription certifying "brand medically necessary" or "brand necessary" is the required mechanism by which Medicaid will reimburse for the specified brand name drug. Furthermore, in order to avoid recoupment of Medicaid monies, this certification must be present on the prescription *prior* to billing Medicaid for any brand medically necessary product.

For further information, providers should consult the *Upper Limits of Payment for Certain Multiple Source Products* and *Brand Medically Necessary* material found elsewhere in this section.

SUBSTITUTION OF EQUIVALENT DRUG PRODUCTS

With respect to prescriptions reimbursed through the South Carolina Medicaid program, Medicaid beneficiaries for whom the pharmaceuticals are intended are deemed to have consented to substitution of a less costly equivalent generic product that will result in a cost savings to the South Carolina Medicaid program. Therefore, individual patient consent for substitution as stipulated in S.C. Code of Laws 40-43-86 (H) (6) shall not be required.

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS

Maximum reimbursement rates for certain multiple source drugs (both legend and OTC) are set by the CMS or by DHHS and cannot be exceeded. The entire listing of products having either a federal upper limit (FUL) of payment or a South Carolina Maximum Allowable Cost (SCMAC) may be found at http://southcarolina.fhsc.com. The MAC listing at http://southcarolina.fhsc.com includes *all products*, either state or federally mandated, *with a maximum allowable cost (MAC)* and *includes unit dose forms* of those products listed. This on-line MAC listing is

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS (CONT'D.)

continually monitored and updated to reflect any state or federal changes, additions, or deletions.

Generic equivalents of products having an established FUL or SCMAC are subject to the respective upper limit of payment indicated. Thus, *all* products that contain the same active ingredient(s) and strength(s) are subject to the established pricing restriction.

Furthermore, FULs or SCMACs are applicable for sugar-free or alcohol-free products, provided they contain the same active ingredient(s) and strength(s) as those pharmaceuticals indicated on the MAC listing. Additionally, any product with an upper limit of payment restriction that is packaged in a specialized dosage or convenience pack (e.g., Sterapred®) is subject to the established FUL or SCMAC.

However, it should be further noted that in those instances where the WAC + 0.8% for a given NDC is *lower* than the established FUL or SCMAC, the provider's reimbursement will be based upon that specific product's lower WAC + 0.8%. Furthermore, when the provider agrees to dispense and subsequently bill a prescription to the Medicaid program, Medicaid's reimbursement must be accepted as payment in full. Under no circumstances may the patient be billed the difference between the submitted charge and Medicaid's reimbursement.

Providers are reminded that only *rebated products* (whether brand name or generic) may be considered for Medicaid reimbursement. Certain pharmaceuticals subject to upper limits of payment restrictions may have both legend and OTC packaging. Claims for most OTC pharmaceuticals may be transmitted routinely through Magellan Medicaid Administration's POS system. Providers are reminded that a valid prescription must be on file for all items reimbursed through the Pharmacy Services program.

Unless prior authorization has been approved for the brand name drug, reimbursement for products included on the MAC listing will be based upon the lowest per-unit price (whether SCMAC, FUL, or WAC + 0.8%) in effect on the date of service. (As indicated in the *Medicaid Coverage of Generic Products* section, prior authorization of the brand name product is not necessary for certain specified NTI drugs; however, NTI drugs *are subject to the "brand*

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS (CONT'D.)

necessary" or "brand medically necessary" certification requirements described below.)

For those brand name products having an established FUL or SCMAC on the date of service, providers are reminded that in addition to the South Carolina Medicaid MedWatch form requirement (where the prescriber must document the occurrence of a treatment failure that is attributable to the generic product), the prescriber's *handwritten* notation on the prescription certifying "brand medically necessary" or "brand necessary" is required. This certification must be present on the prescription *prior* to billing Medicaid for any brand medically necessary prescription.

If the "brand medically necessary" certification is absent from the face of the prescription, a dual line prescription form does not satisfy the brand medically necessary certification requirement; the prescriber's signature on the "Dispense As Written" signature line does not satisfy the brand medically necessary certification requirement; nor does the prescriber's verbal authorization satisfy the "brand medically necessary" certification requirement. A "blanket" authorization does not satisfy the "brand medically necessary" certification requirement. Therefore, in order to avoid recoupment of Medicaid monies, care should be taken prior to billing to ensure that the appropriate certification is indicated on *each* prescription for those claims transmitted (and reimbursed) as brand medically necessary.

Effective February 17, 2010, the pharmacist must only use the DAW code of '1' to obtain higher Medicaid reimbursement when the prescriber certifies in his/her own handwriting that a specific brand is medically necessary for a particular patient.

If non-POS claims submission methods are utilized (and the provider fails to properly designate the claim as "brand medically necessary" where indicated), requests for manual adjustments of those paid claims will not be honored.

Providers should note the requirement that the NDC submitted to Medicaid for payment **must** be identical to the NDC listed on the package from which the prescription was dispensed. Submission of any other NDC is a violation of Medicaid policy.

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

UPPER LIMITS OF PAYMENT FOR CERTAIN MULTIPLE SOURCE PRODUCTS (CONT'D.)

Regardless of the reason (limitations in computer programming, software, etc.) that any such violations occur, providers should take immediate steps to correct the problem.

Only the specific manufacturer's NDC on the product actually dispensed may be submitted for payment. Similarly, although a provider may be willing to accept reimbursement based upon the SCMAC or FUL, a non-prior authorized brand name NDC should not be submitted *unless it is identical to the NDC indicated on the package from which the prescription was dispensed*.

"Brand medically necessary" claims (including those for NTI drugs) are subject to postpayment review by the DHHS Division of Program Integrity, and all pertinent documentation (*e.g.*, prescriptions or chart orders containing the specified terminology in the prescriber's own handwriting) must be retained in the provider's records. Medicaid payment will be recouped for any claim so designated if the prescriber's certification is not present on the prescription. (See *Brand Medically Necessary* information found elsewhere in this section.)

TELEPHONE ORDERS

Telephone prescriptions are permissible; however, those for "brand medically necessary" pharmaceuticals are required to be signed by the prescriber and must be appropriately certified as "brand medically necessary" prior to being billed to the Medicaid program. To facilitate adherence to this policy, the pharmacist may fax the prescription to the prescriber for signature and "brand medically necessary" certification. Providers are reminded that all state and federal requirements must be adhered to regarding the dispensing of telephone prescriptions.

ELECTRONICALLY TRANSMITTED PRESCRIPTIONS

Electronically transmitted prescription drug orders are reimbursable by Medicaid; however, such prescriptions must meet state and federal requirements.

TAMPER-RESISTANT PRESCRIPTION PADS

Effective April 1, 2008, Medicaid-covered outpatient prescription and OTC (over-the-counter) drugs are reimbursable only if non-electronic prescriptions are issued on a tamper-resistant pad.

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PRESCRIBING/DISPENSING LIMITATIONS

TAMPER-RESISTANT PRESCRIPTION PADS (CONT'D.)

These new federal requirements result from amendments to section 1903(i) of the Social Security Act, as required by Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007.

Electronic prescriptions meeting federal and state requirements are excluded from this requirement.

As of April 1, 2008, to be considered tamper-resistant, a prescription pad must contain, at least one of the following three characteristics:

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

Effective October 1, 2008, a prescription pad must contain all three characteristics to be considered tamper-resistant and Medicaid reimbursable.

This rule does apply to nursing facilities, intermediate care facilities for the intellectually disabled, and other like residential facilities where their prescriptions are separately reimbursed by Medicaid and not included in the facility's rate.

The tamper-resistant pad requirement rule does NOT apply to refills of prescriptions presented at a pharmacy before April 1, 2008. In addition, the requirement does NOT apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. The requirement does NOT apply to managed care entities when the managed care entity pays for the prescription.

To the extent permissible under state and federal law and regulation, this requirement does not restrict emergency fills of non-controlled or controlled substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription(s) within 72

SECTION 2 POLICIES AND PROCEDURES

PRESCRIBING/DISPENSING LIMITATIONS

TAMPER-RESISTANT PRESCRIPTION PADS (CONT'D.)

hours after the date on which the prescription(s) was issued.

Future postpayment audits of pharmacy claims for Medicaid reimbursement, whether conducted by the DHHS Division of Program Integrity or any other agent, will review compliance with the above requirements.

PRESCRIPTION INFORMATION TRANSFER

The one-time transfer of original prescription information for dispensing one refill is permissible between pharmacies in South Carolina, subject to state and federal requirements.

PRESCRIPTION ORIGIN CODE

Effective with dates of service on or after May 5, 2010, the South Carolina Department of Health and Human Services (DHHS) will require that the prescription origin code be submitted on pharmacy claims for new prescriptions. The following values will be accepted in NCPDP field 419-DJ:

1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy

Claims with this field left blank or submitted with a "0" (not specified) will reject.

REDISPENSING OF MEDICATIONS

The policy concerning the re-use of drugs returned from patients is contained in state and federal requirements regarding the practice of pharmacy. Re-use of these items would constitute fraud unless the pharmacist documents these drugs by name, date of service, etc., and makes appropriate refund to the Medicaid program.

Due to federal drug rebate program issues, it is preferable to accomplish such "refunds" by claims reversal via the POS system rather than by check.

Once the original paid claim has been reversed (*i.e.*, voided), the provider should immediately resubmit a "corrected" claim, reflecting the amended quantity dispensed and reduced usual and customary charge. If necessary, providers should consult Magellan Medicaid Administration's Technical Call Center staff [866-254-1669] in order to facilitate the claims reversal/resubmission process.

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

The pharmacy provider should submit the pharmacy's usual and customary charge when billing Medicaid. The amount reimbursed by Medicaid for a drug dispensed **shall not exceed the lowest of:**

A. **The federally mandated upper limit of payment** (FUL) for the drug, if any, less 10% plus the current dispensing fee as established by the DHHS in accordance with federal requirements.

B. **The South Carolina Maximum Allowable Cost (SCMAC)** plus the current dispensing fee as established by the DHHS in accordance with federal requirements.

C. **The Wholesale Acquisition Cost (WAC)** plus 0.8%, plus the current dispensing fee as established by the DHHS in accordance with federal requirements. (**Note:** The Wholesale Acquisition Cost used in calculating the WAC price is furnished weekly to Magellan Medicaid Administration by a contracted pricing source. The NDC number used in billing Medicaid must be the NDC number contained on the package from which the drug was actually dispensed. Non-compliance with this policy may result in the recoupment of Medicaid monies.)

D. **The provider's usual and customary charge** to the general public for the prescription as written for the brand actually dispensed. (If the provider's submitted charge for a medication is less than Medicaid's calculated reimbursement, the system will subtract any applicable copayment from the submitted charge and pay the provider the difference).

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

PAYMENT METHODOLOGY INFORMATION (CONT'D.)

Note: When a pharmacist submits a "partial fill" prescription to Medicaid, the beneficiary's copayment and the pharmacist's dispensing fee will be prorated based on the fractional percentage of the quantity dispensed compared to the quantity prescribed. The pharmacy should only do a partial fill if there is a shortage of the drug and the pharmacy does not have enough in stock to fill the prescription.

COPAYMENT

Effective April 1, 2011, the copayment amount on all applicable prescriptions is $3.40 per prescription. Providers are responsible for collecting applicable copayments and may not refuse service to a beneficiary due to his/her inability to pay copayment at the time the service is rendered. However, an inability to pay at the time of dispensing does not relieve the beneficiary of the responsibility for the copayment amount. The amount of the copayment will be deducted from the Medicaid reimbursement for all claims to which copayment applies. Following is a listing of those beneficiary groups and/or services that are *exempt* from the collection of copayment:

- Beneficiaries from birth to the date of their 19th birthday.
- Beneficiaries residing in long-term care facilities (NFs, ICF-IIDs) [exemption does not apply to beneficiaries residing in adult residential care facilities/boarding homes or retirement homes].
- Beneficiaries receiving the Medicaid hospice benefit.
- Beneficiaries enrolled under the Family Planning pay category.
- Beneficiaries who are pregnant (verified by either the patient or prescriber). Pharmacy providers must enter a "2" in the *Prior Authorization Type Code* field in order to identify the prescription as copayment-exempt. [The previous policy exempting copayment only for those prescriptions annotated as "related to pregnancy" or "pregnancy-related" has been replaced with this policy, which exempts pregnant beneficiaries from any copayment requirements.]

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

COPAYMENT (CONT'D.)

- Beneficiaries who are members of the Health Opportunity Account (HOA) Program.
- Beneficiaries who are members of a Federally Recognized Indian Tribe.

Since the collection of copayment was established to supplement the dispensing fee, compassionate waiver of copayment shall be limited to a case-by-case basis. Non-compliance by a provider may subject his or her reimbursement to adjustment.

Note: When a pharmacist submits a "partial fill" prescription to Medicaid, the beneficiary's copayment and the pharmacist's dispensing fee will be prorated based on the fractional percentage of the quantity dispensed compared to the quantity prescribed.

Regarding coordination of benefits claims, no third party insurer copayments should be collected from beneficiaries if the claim is for a covered Medicaid product. Only the South Carolina Medicaid copayment (if applicable) should be collected from the beneficiary.

Claims for injectable medications covered by the Pharmacy Program that have a route of administration of "intravenous" and require multiple fills of the same drug (same dosage form and strength) will only require one copay per calendar month.

SECTION 2 POLICIES AND PROCEDURES

PAYMENT METHODOLOGY INFORMATION

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SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ ISSUES

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

On January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented Medicare prescription drug coverage, known as Medicare Part D. Under Part D, CMS contracts with Prescription Drug Plans (PDPs) to make available a drug coverage benefit for Medicare eligibles (*i.e.,* individuals who have Medicare Parts A or B).

Although individuals eligible for both Medicare and Medicaid (*i.e.,* dual eligibles) no longer receive the complete drug coverage benefit through Medicaid, dual eligibles continue to be eligible for all other Medicaid services that are currently provided. Furthermore, Medicaid continues to cover certain specified PDP-excluded drug categories for dual eligibles only. For additional information, see the section below entitled *Medicaid and Certain PDP-Excluded Drug Categories*.

Resources for Medicare Part D Beneficiaries

Beneficiaries may apply or obtain Medicare Part D and PDP information by:

1. Telephone: 1-800-MEDICARE (1-800-633-4227)
2. Web site: http://www.medicare.gov/
3. Online application: http://www.socialsecurity.gov/prescriptionhelp/

Auto-Enrollment of Dual Eligibles

To participate in Part D, Medicare eligibles must have enrolled in a PDP that CMS has approved for South Carolina. To ensure that dual eligibles continue to have prescription drug coverage, CMS automatically enrolls (auto-enrolls) dual eligibles into PDPs if they have not self-enrolled. It should be noted that the PDP into which CMS has auto-enrolled a beneficiary may not be the plan that best accommodates the individual's needs (due to formulary restrictions, pharmacy provider network issues, etc.).

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

South Carolina PDPs

There are many different companies that have an assortment of prescription plans available for South Carolina Medicare beneficiaries. Enrollment in a PDP is generally for the calendar year. Medicare beneficiaries may only switch plans during the annual open enrollment period. However, dual eligibles may change plans at any time by calling 1-800-MEDICARE and enrolling in their plan of choice. [Note: Medicare eligibles who are residents of South Carolina must enroll in a PDP that CMS has approved for Part D beneficiaries in South Carolina.]

Medicaid Point-of-Sale (POS) Denial Responses

Pharmacy claims submitted via POS to South Carolina Medicaid for a dual eligible will deny with NCPDP response code 41, "submit bill to other processor or primary payer". Pharmacy providers should do an E1 query through Medicare to determine which Prescription Drug Plan a beneficiary is enrolled in.

Medicare Part B Drugs

Providers should note that Part D is an additional Medicare benefit and does not replace Medicare Part A, B, or C. Medicare Part B coverage remains viable for certain designated drugs under specific conditions (*e.g.*, immunosuppressants following a Medicare-sponsored organ transplant, oral chemotherapy agents, oral anti-emetics, etc.). Therefore, for dually eligible beneficiaries, pharmacists will continue to submit such claims (using their respective *supplier* billing numbers) to Medicare Part B for payment consideration. In some circumstances, however, these drugs may be deemed non-covered by Medicare Part B. An example would be an oral chemotherapy drug such as methotrexate when used to treat rheumatoid arthritis. Useful information regarding those drugs that are covered by Part B (rather than Part D) may be found by clicking on Parts B & D Information at http://www.cms.hhs.gov/pharmacy. Pharmacy Services providers should refer to the Medicare Parts B and D Coverage Issues Table at this Web site link, to be aware of those circumstances when these drugs may be deemed non-covered by Medicare Part B and, therefore, billable to Part D.

If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should then be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP). To

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

Medicare Part B Drugs (Cont'd.)

facilitate claims submission, it may be necessary for the pharmacist to contact the prescriber for additional diagnostic or patient-specific information in order to determine which payer (Part B or Part D) should be billed as primary.

Effective April 1, 2010, if Medicare Part B reimburses for any portion of the pharmacy services provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist should bill Medicaid secondarily using the Magellan Medicaid Administration Services Point of Sale (POS) system.

Note: Effective with dates of service January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D Prescription Drug Plan (PDP) must be billed for any allowable secondary payment.

If the amount paid was applied toward the annual deductible, a copy of the Medicare Part B Explanation of Benefits (EOB) must be faxed to the Magellan Medicaid Administration Services Clinical Call Center at 1-888-603-7696 (toll free). Pharmacists are encouraged to indicate the beneficiary's 10-digit Medicaid identification number on Medicare EOBs furnished to Magellan Medicaid Administration Services. While subsequent fills for that specific drug therapy will continue to require PA, faxing additional copies of the Medicare EOB will not be necessary each time the prescription is refilled.

When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated.

Medicaid and PDP-Non-Covered Drugs

Providers are aware that prescription plans have different formularies, preferred drug lists, and prior authorization (PA) programs; the PDPs have these types of processes and programs in effect. It is important for beneficiaries to know that the PDP must notify the individual 60 days before removing one of his or her prescriptions from PDP coverage. Regarding PDP non-covered drugs, providers should be aware that *South Carolina Medicaid will* ***not*** *be a secondary payer for products such as a PDP's non-formulary drug or non-preferred drug or a PDP's PA-required drug.*

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

Medicaid and Certain PDP-Excluded Drug Categories

There are several drug categories that PDPs are not required by CMS to cover. *If* the PDP has chosen not to cover such items, South Carolina Medicaid will provide coverage of those products ***for dual eligibles only***, subject to Medicaid's existing rules and policies (*i.e.,* product must be rebated; product may require PA under Medicaid rules, etc.). The PDP-excluded drug categories include: barbiturates, benzodiazepines, cough and cold products, vitamins/ minerals, and over-the-counter (OTC) drugs (except for a pharmaceutical such as an OTC proton pump inhibitor or an OTC non-sedating antihistamine since those drugs belong specifically to PDP-covered therapeutic classes).

Only barbiturates, benzodiazepines, vitamins/ minerals, and OTC drugs may be billed to South Carolina Medicaid after the pharmacy provider receives a denial from the *dual eligible's* PDP.

Long-Term Care Facilities

Providers should note that full-benefit dual eligibles residing in long-term care facilities such as nursing homes are not responsible for any cost-sharing (*e.g.,* copayments) under the Part D benefit. These individuals retain their limited personal needs allowances for their personal expenses and do not have to spend the allowance on drug costs. Additionally, providing OTC drugs remains the responsibility of the long-term care facility; therefore, OTC coverage for long-term care residents is not the responsibility of the PDP or the Medicaid outpatient drug program.

Regarding nursing homes and the Part D benefit, PDPs are required to provide convenient access to long-term care pharmacies serving Part D enrollees residing in long-term care facilities. Nursing home staff members are encouraged to use the Web-based Prescription Plan Finder tool at http://www.medicare.gov/ for individual resident inquiries.

CMS's Contingency Plan for Dual Eligibles

If a situation occurs where a dual eligible needs to have prescriptions filled at the pharmacy and this individual is unaware of the PDP into which he or she is enrolled, the pharmacy provider should contact CMS's True Out-of-Pocket (TrOOP) facilitator contractor (NDC Health is the TrOOP facilitator) to determine the PDP and copayment information. (Information about the TrOOP facilitator may be found at http://medifacd.ndchealth.com.)

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

CMS's Contingency Plan for Dual Eligibles (Cont'd.)

If the dual eligible is not enrolled in a PDP, then the pharmacy provider should follow through with CMS's POS-facilitated enrollment process **to ensure that the individual obtains his or her needed prescription medication(s) before leaving the pharmacy**. Pharmacy providers should note that this process is applicable to only **dual eligibles**

CMS has contracted with Humana to serve as the enrollment contractor for non-enrolled dual eligibles. Humana will expedite the validation of dual eligibility and process claims at POS to facilitate enrollment in a Medicare Part D Plan with low income premium subsidy for dual eligibles that were not auto enrolled. This enrollment in Contract X0001 will be done through the Limited Income Newly Eligible Transition program, LINET.

Pharmacy providers may execute an E1 query to determine whether a dual eligible is already enrolled in Contract X0001. Beneficiaries may receive services through Contract X0001 for up to two months until CMS enrolls them into another plan. The pharmacy provider should submit an E1 query each new month to determine when the beneficiary has been enrolled into a permanent Part D plan. Pharmacy providers and dual eligible beneficiaries may contact Humana at 1-800-783-1307 for assistance with LINET.

WAIVER PROGRAMS OPERATED BY DIVISION OF COMMUNITY LONG TERM CARE

The Division of Community Long Term Care (CLTC) operates 3 home and community-based services waiver programs through its statewide network of area offices. These waivers serve the following individuals: 1) the Community Choices waiver serves the elderly and disabled; 2) the HIV/AIDS waiver serves beneficiaries with HIV/AIDS; 3) The VENT waiver serves beneficiaries that are dependent on mechanical ventilation. Those individuals enrolled in the HIV/AIDS or VENT waiver programs are allowed two additional prescriptions per month above the current monthly limit.

(All previously designated exceptions to the monthly limit remain in effect for waiver program participants).

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

SOUTH CAROLINA DEPT. OF DISABILITIES AND SPECIAL NEEDS WAIVER PROGRAMS

The Department of Disabilities and Special Needs (DDSN) operates four home and community-based services waiver programs through its statewide network of local boards. These waivers serve the following individuals: 1) the IR/RD waiver serves individuals with intellectual or related disabilities; 2) the HASCI waiver serves individuals with head and spinal cord injuries; 3) the Pervasive Developmental Disorder waiver serves beneficiaries ages 3-10 who have been diagnosed with a pervasive developmental disorder including Autism or Asperger's Syndrome; and 4) the Community Supports waiver program serves individuals of all ages that have IR/RD or related disabilities.

Adult beneficiaries enrolled in the IR/RD waiver are allowed two additional prescriptions per month above the current monthly limit, and those enrolled in the HASCI waiver are allowed three additional prescriptions per month above the current monthly limit. (Those pharmaceuticals designated as routine exceptions to the monthly limit remain in effect).

The Department of Health and Human Services (DHHS) sponsors the Medically Complex Children's waiver through the Division of Community Options, which serves children under the age of 18 with complex medical problems, and the Psychiatric Residential Treatment Facility (PRTF) waiver is provided through the Division of Behavioral Health, which serves children between the ages of 4 and 18 with a primary diagnosis of a severe emotional disturbance. Children enrolled in the Medically Complex Children's waiver do not receive their prescription coverage under Fee-For-Service (FFS) Medicaid.

FAMILY PLANNING SERVICES

The Family Planning Program is a statewide program whose primary objective is to ensure that all eligible beneficiaries have access to publicly supported outpatient family planning services. Additionally, one course of treatment for certain sexually transmitted infections (STIs) found during the family planning visit will be covered. Potential beneficiaries are between the ages of 10 and 55 who: 1) are at or below 185% of the Federal Poverty Level, 2) have no health insurance, 3) are legal residents of South Carolina, and 4) have not had a sterilization procedure.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

FAMILY PLANNING SERVICES (CONT'D.)

Outpatient contraceptive pharmaceuticals and devices (both legend and over-the-counter), family planning office or clinic examinations, related laboratory services, and counseling services related to family planning and birth control methods are covered under this program.

Additionally, covered services include testing for STIs when performed during the initial or annual physical exam and treatment for certain STIs diagnosed during the initial or annual family planning office or clinic visit. Providers are reminded that Medicaid beneficiaries must present a prescription for *any* pharmaceuticals or devices dispensed to them, including OTC items.

All prescriptions written for STIs, family planning pharmaceuticals, devices, or supplies are exempt from the collection of the $3.40 Medicaid copayment; also, contraceptive items do not count toward an adult participant's monthly prescription limit.

Beneficiaries can receive initial antibiotic treatment for the following STIs: syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis but will only be allowed to receive one course of treatment per year under the program. **The physician must write the ICD-9 diagnosis code on the prescription for the STI treatment in order for the medication to be considered for reimbursement by Medicaid.**

Participants in the Family Planning Program receive the same permanent plastic South Carolina Healthy Connections Medicaid card as others participating in the Medicaid program; thus, pharmacy services providers who do not utilize the Medicaid POS system for claims submission will be at risk for possible claims rejection.

MEDICAID HOSPICE SERVICES

Medicaid hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient as well as the psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified by their attending physician and/or the Medical Director of the hospice company to be terminally ill (*i.e.*, a

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

MEDICAID HOSPICE SERVICES (CONT'D.)

life expectancy of six months or less). Medicaid hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. Among those services covered by the hospice provider are medical appliances and supplies, including drugs and biologicals, used for the relief of pain and symptom control related to the patient's terminal illness. A beneficiary who elects the hospice benefit must waive all rights to other Medicaid services related to treatment of the terminal condition for the duration of the election of hospice care.

Services (including prescriptions) rendered for illnesses or conditions NOT related to the terminal illness of the patient require prior authorization *from the hospice provider* (rather than from Magellan Medicaid Administration) before delivery. It is necessary for the hospice provider to verify that the services being provided are for a condition not related to the terminal illness. Furthermore, hospice providers must maintain a documentation log of each prior authorization action and make this documentation available to the staff of DHHS upon request. Documentation must include the service that is prior approved; the service provision date; the Medicaid provider; the approving hospice authority and the date approval was issued. In situations where a dispute regarding whether a prior authorization was obtained, the documentation log will serve as the primary basis in resolving the disagreement.

It should be noted that even though prior authorization may be granted by the hospice provider, all claims billed to Medicaid remain subject to the coverage guidelines outlined in this manual. Furthermore, providers who do not utilize the Medicaid POS system for claims submission will be at risk for possible claims rejection. Specific billing instructions pertaining to hospice patients may be found in the Magellan Medicaid Administration

Pharmacy Provider Manual. Providers should contact the SCDHHS Provider Service Center at 1-888-289-0709 or submit an online inquiry at http:www.scdhhs.gov/contact-us if further information is needed.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

PALMETTO SENIORCARE CAPITATED BILLING PROGRAM

Palmetto SeniorCare is a PACE (Program of All-Inclusive Care for the Elderly) program that provides an array of services to Medicaid beneficiaries eligible for long term care who reside in Richland and Lexington counties who are age 55 or older. These beneficiaries have voluntarily agreed to receive medical care *only* through PACE. Thus, they waive the right to choose any providers other than those providers who receive prior approval from PACE. Instead, these individuals accept the PACE as sole provider of all direct or indirect medical care.

A capitated payment is made to PACE each month for each enrolled beneficiary. **Once an individual is enrolled in the PACE program, neither Medicaid nor Medicare will pay any other providers for services rendered.** Pharmacy services providers who do not utilize Magellan Medicaid Administration's POS system for claims submission will be at risk for possible claims rejection. Questions regarding the PACE program may be directed to the PSC at 1-888-289-0709 or you may submit an online inquiry at http://www.scdhhs.gov/ contact-us.

CLAIMS SUBMISSION FOR CERTAIN PHYSICIAN-INJECTABLE PRODUCTS

Pharmacy providers may bill South Carolina Medicaid for certain physician-injectable products (in lieu of physicians having to "buy and bill") when the product is administered to a patient in the physician's office or clinic. This billing option is applicable for services provided to non-dually eligible, Medicaid fee-for-service beneficiaries only, and is not applicable for beneficiaries enrolled in a Medicaid managed care organization (MCO).

Physicians' offices/clinics may either "buy and bill" omalizumab, leuprolide acetate, palivizumab (Synagis®), or Rh_o(D) immune globulin, Risperdal Consta, Invega-Sustenna, Depo Provera and Abilify Maintena in compliance with existing Medicaid policies, or use the option of pharmacy billing.

Under this option, pharmacists may submit claims for Medicaid fee-for-service beneficiaries for omalizumab, leuprolide acetate, palivizumab, or Rh_o(D) immune globulin, Risperdal Consta, Invega Sustenna, Depo Provera and Abilify Maintena even though these injectables will be administered in the physician's office.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

CLAIMS SUBMISSION FOR CERTAIN PHYSICIAN-INJECTABLE PRODUCTS (CONT'D.)

As noted previously in this section, physicians must request PA for omalizumab and Abilify Maintena; PA is not required for leuprolide acetate, palivizumab, or Rho(D) immune globulin, Risperdal Consta, Invega Sustenna or Depo Provera.

Due to safety and product stability issues, the pharmacy provider must ensure that the pharmaceutical is delivered *directly* to the physician's office/clinic.

REIMBURSEMENT GUIDELINES FOR INFLUENZA, RABIES, AND PNEUMOCOCCAL VACCINES

Regarding long term care patients, the *Medicare Part B* program covers the administration of influenza and pneumococcal vaccines when furnished in compliance with any applicable State law by a provider of the services having a supplier number. Medicaid will not directly reimburse pharmacy providers for such vaccines where the long term care patient is dually eligible for both Medicare and Medicaid coverage. However, for those long term care patients having *only Medicaid coverage*, DHHS reimburses for the influenza virus and pneumococcal vaccines. Reimbursement is limited to no more than one influenza virus vaccine per beneficiary per flu season (*i.e.*, 270 consecutive days). After the initial pneumococcal vaccine is administered to an adult beneficiary, coverage for any necessary revaccination will be considered on a case-by-case basis. Rabies vaccines are covered for all FFS Medicaid beneficiaries with no restrictions, and are exempt from the monthly prescription limit.

Furthermore, those pharmacists with special certification to administer immunizations may submit claims to the Medicaid Pharmacy Services program for the *in-store administration* of influenza and pneumococcal vaccines. Such claims must be submitted using the NCPDP number or NPI. Reimbursement is limited to beneficiaries 21 years of age and older who have only Medicaid coverage; claims for those patients who are dually eligible for both Medicare and Medicaid must be billed to Medicare Part B.

Note: Effective with dates of service beginning January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D PDP must be billed for any allowable secondary payment.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

REIMBURSEMENT GUIDELINES FOR INFLUENZA, RABIES, AND PNEUMOCOCCAL VACCINES (CONT'D.)

Influenza and pneumococcal vaccines administered in either setting are exempt from the monthly prescription limit. In addition to payment for the vaccines themselves, the SCMAC amounts established for these vaccines include a fee for administration of the drug.

Providers who have Medicare Part B reimbursement questions or who wish to obtain an enrollment application in order to request assignment of a Medicare Part B supplier number should contact the Medicare Part B Customer Service Center at 866-238-9654. It should be noted that a DMERC supplier number cannot be used to transmit vaccine claims that are covered under Part B Medicare.

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL

The Division of Third Party Liability identifies Medicaid beneficiaries having health insurance coverage in order to have that insurance pay for services primary to Medicaid. Providers utilizing the POS system for claims submission should receive immediate confirmation of other third party coverage if a claim rejects for that reason. [Providers who do not use the POS system must contact Magellan Medicaid Administration's Technical Call Center staff to obtain insurance verification and details regarding other third party coverage.] **Since Medicaid is the payer of last resort, the provider MUST request payment from any available third party resource (including Medicare Part B) and may bill Medicaid only after third party payment is made or denied.**

(Note: If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should then be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP). Regarding PDP non-covered drugs, providers should be aware that South Carolina Medicaid will ***not*** *be a secondary payer for products such as a PDP's non-formulary or non-preferred drug or a PDP's PA-required drug.)*

If the provider submits a claim to Medicaid prior to billing the responsible third party payer(s), the claim will reject (NCPDP edit 41) and will not be processed further until the provider either indicates the amount paid by the other third party payer(s) or is able to substantiate payment denial by the other third party carrier(s).

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL (CONT'D.)

If it is determined that the provider is not fully complying with this claims submission policy, recoupment of the Medicaid monies will result.

If the POS system is used to transmit claims to Medicaid and the "submit to primary carrier" error message is returned, additional messaging information regarding the appropriate carrier code (unique five-digit code which identifies the insurance company), the patient's policy number, and the carrier name will be furnished on-line to the provider to facilitate submission of the claim to the designated third party payer(s). [A list of unique five-digit carrier codes may be found at http://southcarolina.fhsc.com.

Furthermore, where necessary, providers may contact Magellan Medicaid Administration's Technical Call Center staff to obtain relevant health insurance information.] It should be noted that a beneficiary may have more than one active other insurance policy. Subsequent carrier code/policy information will be displayed via the POS system until all active insurance coverage is exhausted. *No primary insurer copayments or deductible amounts should be collected from beneficiaries if the claim is for a Medicaid-covered product. Only the South Carolina Medicaid copayment (if applicable) should be collected from the beneficiary*. Billing questions regarding appropriate "other coverage" coding, etc., where other third party insurance is involved may be directed to Magellan Medicaid Administration's Technical Call Center staff at 1-866-254-1669.

When an insurance coverage has lapsed and the patient or provider has sufficient documentation to validate the termination date, such information (annotated to include the beneficiary's 10-digit

Health Insurance Number) should accompany a completed *Health Insurance Information Referral Form*; the application of a "lapse date" to the beneficiary's insurance record will facilitate timely claims processing and payment. Completed documents may be faxed to Medicaid Insurance Verification Services (MIVS) at 803-252-0870. Additionally, the *Health Insurance Information Referral Form* may be used to furnish information to DHHS staff regarding potential private health insurance coverage not yet reflected in the database. (A sample *Health Insurance Information Referral Form* may be found in Section 5.)

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

PHARMACY SERVICES AND THIRD PARTY LIABILITY TPL (CONT'D.)

It should be noted that Kaiser Permanente is an HMO that currently has no enrolled pharmacy providers in South Carolina; therefore, Medicaid beneficiaries having insurance coverage through this particular HMO should not be denied pharmaceutical services since there are no Kaiser Permanente-enrolled pharmacies within the state of South Carolina. (See Section 3 and the Third-Party Liability Supplement found elsewhere in this manual for additional TPL-related information. The Magellan Medicaid Administration Pharmacy Provider Manual also contains detailed claims filing instructions regarding coordination of benefits/third party liability.)

ZIDOVUDINE (AZT) SYRUP FOR NEWBORNS

In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, the DHHS will allow the pharmacy provider to bill Medicaid using the mother's Medicaid Health Insurance Number when dispensing the initial six weeks' supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible *only* in those instances where the newborn has not yet been assigned a Medicaid Health Insurance Number at the time of dispensing. This special billing policy pertains ONLY to the initial dispensing of AZT syrup; **other medications dispensed to newborns may not be billed to Medicaid in such a manner.**

RETROACTIVE MEDICAID ELIGIBILITY REIMBURSEMENT ISSUES

When a patient becomes retroactively eligible for Medicaid coverage, pharmacists may subsequently choose to bill Medicaid for reimbursement.

(This is a *voluntary* practice; in such cases, the provider is not obligated to submit claims to the Medicaid program.) Often, however, these patients have already paid for prescriptions dispensed prior to their retroactive eligibility determination. In these instances, if the provider *chooses* to bill Medicaid in order to make appropriate refunds to the patient, Medicaid's reimbursement is payment in full. The provider may only keep any applicable Medicaid copayment. (See Section l for additional policy regarding retroactive eligibility.)

SECTION 2 POLICIES AND PROCEDURES

SPECIAL GROUPS/ISSUES

MEDICAID COVERAGE OF OTC PHARMACEUTICALS

The South Carolina Department of Health and Human Services reimburses for most *rebated* over-the-counter (OTC) generic pharmaceuticals, including those products formerly designated as "legend."

The majority of nationally marketed over-the-counter products are rebated by their respective manufacturers and may be considered for Medicaid reimbursement within program guidelines (*e.g.*, monthly prescription limit). Most chain pharmacies, however, do not provide federally mandated rebate monies for their "house brand" OTCs; and thus, those specific products are deemed not covered. Additionally, in some instances, prior authorization may be required (*e.g.*, product not on PDL).

For each OTC product dispensed, a valid prescription authorized by a licensed practitioner (*i.e.*, physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file. Covered over-the-counter family planning pharmaceuticals and devices are exempt from the monthly prescription limit in effect for adult beneficiaries. Insulin and insulin syringes are reimbursed through the Pharmacy Services program. Diabetic devices and supplies (*e.g.*, glucometers, test strips, and lancets, etc.) are covered under the South Carolina Medicaid Durable Medical Equipment (DME) program; however, certain preferred glucometers, test strips and spacers for metered dose inhalers may be billed by an enrolled DME provider under the Pharmacy POS system.

COVERAGE POLICY FOR MULTI-INGREDIENT COMPOUNDS

Providers should be aware that multi-ingredient compounds are *non-covered* by South Carolina Medicaid if that specific combination of ingredients is commercially available from a pharmaceutical manufacturer. Therefore, such compounds must not be billed to Medicaid. Additionally, the reconstitution of commercially available products is not considered compounding and as such, may not be billed to Medicaid as a compound. (See Section 3 for instructions regarding claims submission.)

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

TYPES OF RECORDS

Records are defined as, but are not limited to the following: prescription drug orders, chart orders, annotations to identify the specific drug dispensed, drug invoices, annotations to reflect refills issued, retained copies of claims filed (if submitting non-POS claims), pharmacy patient record system per individual patient, and any other documentation required by state and federal laws or requirements. Additionally, specific claims payment and/or denial information pertaining to other third party payers should be retained as part of the provider's records. Such coordination of benefits (COB) documentation serves to substantiate that the provider has made every effort possible to collect monies from all other third party payers prior to submitting a claim to Medicaid. All records pertinent to this section must be readily available.

A pharmacy patient record system must be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The pharmacy patient record system shall provide for the immediate retrieval of information necessary for the dispensing pharmacist to identify previously dispensed drugs at the time a prescription drug order is presented for dispensing.

Pharmacists are advised that a pharmacy patient record system should include the following information:

- Full name of the patient for whom the drug is intended
- Address and telephone number of the patient
- Patient's age or date of birth
- Patient's gender
- List of all prescription drug orders obtained by the patient at the pharmacy during the two years immediately preceding the most recent entry showing the prescription number, name, and strength of the drug, the quantity and date received, the number of refills given, the date of each refill, the identity and quantity of each refill if different from the prescribed quantity, the identity of the dispensing pharmacist and the name of the prescriber

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

TYPES OF RECORDS (CONT'D.)

- Pharmacist's comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug and additional comments such as the refusal of the pharmacist's offer to counsel or the patient's refusal to provide information.

The pharmacist shall make a reasonable effort to obtain information from the patient or the patient's agent regarding any known allergies, drug reactions, idiosyncrasies and chronic conditions or disease states of the patient and the identity of any other drugs, including OTC drugs, or devices currently being used by the patient which may relate to prospective drug utilization review. This information shall be recorded in the patient's record.

An automated system that provides the information detailed in the *Records Requirements* portion of this section and meets the requirements outlined in the South Carolina Pharmacy Practice Act may be utilized. Such an automated system shall have the capability of producing sight-readable information on all original and refill prescription drug orders and the pharmacy patient record system.

ACCURACY OF RECORDS

It is crucial that information be recorded in an accurate manner consistent with Medicaid guidelines and pharmacy law. Records function as proof of services rendered and are used for postpayment review purposes.

RECORDS RETENTION

As stated in Section l, the provider must maintain such records as are necessary to disclose fully the extent of services provided and must make these records available during regular business hours. **The minimum retention period for Medicaid records is five years.**

Additionally, should a change in ownership occur, such records generated by the previous owner should be maintained by the responsible party for three years or longer if an on-going postpayment review is involved. Computer storage of prescription file information is allowed, providing that such storage meets all state and federal requirements.

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

LONG-TERM CARE FACILITY RECORDS

Copies of chart orders must be retained for postpayment review purposes either by the nursing facility or by the pharmacy, as described in the information above. A chart order is defined as a lawful order from a practitioner for a drug or device for patients of a hospital or extended care facility. If requested, it is the pharmacy provider's responsibility to obtain these records for auditing purposes.

SECTION 2 POLICIES AND PROCEDURES

RECORDS REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

Postpayment reviews of documentation, program compliance, and billing procedures are conducted by the Division of Program Integrity. Many of the discrepancies cited could be avoided by adhering to the policies and procedures outlined in the Medicaid Pharmacy Services Provider and Magellan Medicaid Administration Pharmacy Provider Manuals and state and federal requirements regarding the practice of pharmacy. The following topics represent some of the most common discrepancies identified during postpayment reviews:

TAMPER-RESISTANT PRESCRIPTION PADS

Effective October 1, 2007, pharmacies that receive Medicaid reimbursement for written, non-electronic outpatient prescriptions and/or their refills, issued on prescription pads that do not meet the specified criteria for tamper-resistant or those that were not exempt from the criteria, will be required to repay the full Medicaid reimbursement for the prescription(s).

"BRAND MEDICALLY NECESSARY" PRESCRIPTIONS

The use of the "Brand Medically Necessary" claims filing designation (*i.e.*, DAW code of '1') affects reimbursement only for those brand name products with upper limits of payment restrictions (*i.e.*, FUL or SCMAC) established for that date of service. The pharmacist must only use the DAW code of '1' to obtain higher Medicaid reimbursement when the prescriber certifies *in his/her own handwriting* that a specific brand is medically necessary for a particular patient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription blank (*e.g.*, signing on the "Dispense As Written" line) does not satisfy the brand medically necessary requirement, nor does a blanket statement from the prescriber stating that the patient must have a brand name product satisfy this federal requirement.

The *prescriber's* (NOT his or her staff or agent's) handwritten notation on the prescription certifying "brand necessary" or "brand medically necessary" is the only permissible means for obtaining Medicaid reimbursement for the brand name product.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

"BRAND MEDICALLY NECESSARY" PRESCRIPTIONS (CONT'D.)

Therefore, in order to avoid recoupment of Medicaid monies, care should be taken PRIOR to billing (*i.e.*, prescriber must complete the South Carolina Medicaid MedWatch form and certify the prescription as "brand necessary" or "brand medically necessary") to ensure that *appropriate claims filing procedures have been followed*.

Note: Those brand name NTI drugs having an established FUL or SCMAC on the date of service do NOT require prior authorization via approval of the South Carolina Medicaid MedWatch form; however, NTI drugs are subject to the "brand necessary" or "brand medically necessary" certification requirements outlined above. Prescriptions for NTI drugs which are not properly annotated are subject to postpayment review and recoupment of Medicaid monies.

SECTION 2 POLICIES AND PROCEDURES

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID - MEDWATCH

A. Patient Information

1. Patient Name: _____ (First) (Last)
2. SC Medicaid Recipient's ID #: _____
3. Date of Birth (mm/dd/yy): ____/____/____
4. Sex ☐ Male ☐ Female
5. Weight _____ lbs OR _____ kgs
6. Request Date (mm/dd/yy): ____/____/____

B. Adverse Event or Product Problem

1. ☐ Adverse Event ~OR~ (please refer to number 2)
2. Outcomes attributed to adverse event (*check **all** that apply*)
   - ☐ Congenital Anomaly
   - ☐ Death (Date: ____/____/____)
   - ☐ Disability
   - ☐ Hospitalization (initial or prolonged)
   - ☐ Life-threatening
   - ☐ Required intervention to prevent permanent impairment/damage
   - ☐ Other: _____
3. Date of Event (mm/dd/yy): ____/____/____
4. Date of this Report (mm/dd/yy): ____/____/____
5. Describe Event or Problem:
6. Relevant tests / laboratory data, including dates:
7. Other relevant history, including pre-existing medical conditions (e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

C. Suspect Medication(s)

1. Drug Name: _____
2. Strength: _____
3. Therapy Dates (if unknown, give duration) From: ____/____/____ To: ____/____/____ (Or, give best estimate)
4. Diagnosis for Use (indication): _____
5. Event abated after use stopped or dose reduced? ☐ Yes ☐ No ☐ Doesn't Apply
6. Lot # (if known): _____
7. Exp. Date (if known): _____/_____/_____
8. Event reappeared after reintroduction? ☐ Yes ☐ No ☐ Doesn't Apply
9. NDC # (for product problems only): _____
10. Concomitant medical products and therapy dates (exclude treatment of event):

D. Prescribing Physician

Name: _____
SC Medical License # (not DEA #): _____
Telephone #: (_____) _____-_____
FAX #: (_____) _____-_____
Signature of Prescriber: _____

E. Reporter

1. Name, Address and Phone #:
2. Health professional? ☐ Yes ☐ No
3. Occupation:
4. Also reported to:
   - ☐ Distributor
   - ☐ Manufacturer
   - ☐ User Facility

If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: ☐

Pharmacy Fax Number (if known): (_____) _____-_____

SUBMIT REQUESTS TO: MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

Revised: May 2010 MedWatch Form

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

APPROPRIATE UTILIZATION OF MONTHLY PRESCRIPTION LIMIT OVERRIDE PROCESS

Pharmacists may utilize an override code to exceed the monthly prescription limit for *adult* Medicaid beneficiaries if certain prescription limit override criteria are met. However, it is inappropriate for pharmacy providers to generally promote this particular billing process since not all prescriptions can meet the override criteria. Pharmacists should submit the prescription limit override code on the claim if: 1) *the monthly prescription limit has been met*, 2) the patient has one of the following conditions, and 3) the prescription is for an *essential drug* used in the patient's treatment plan for one of these conditions: *acute sickle cell disease, behavioral health disorder, cancer, cardiac disease (including hyperlipidemia), diabetes, end stage lung disease, end stage renal disease (ESRD), HIV/AIDS, hypertension, life-threatening illness (not otherwise specified), organ transplant, or terminal stage of an illness.*

The override of the monthly prescription limit is reserved for only those prescriptions that meet the prescription override criteria. Pharmacists are expected to make sound clinical decisions regarding use of the prescription limit override on an individual prescription/patient basis. If a pharmacist is uncertain as to the appropriateness of a prescription limit override for a particular medication, the pharmacist should contact the prescriber to obtain additional clinical, patient-specific information so that an informed Medicaid coverage decision may be made. In such instances, the prescription should be annotated to reflect the patient's diagnosis as verified verbally by the prescriber. **Pharmacists must NOT use the override code for a given prescription until after the adult beneficiary's monthly prescription limit has been reached. Since children from birth to age 21 are eligible for an unlimited number of Medicaid-covered prescriptions per month, the override mechanism must NOT be utilized when submitting claims for children.**

Pharmacy providers are advised to carefully review their current practices regarding the override process. Pharmacies will be audited to ensure compliance with prescription limit override policies.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

QUANTITY OF MEDICATION

The quantity dispensed must not exceed the total quantity ordered by the prescriber. Additionally, the quantity dispensed and the quantity billed must agree.

Generally, to avoid prescription splitting and unnecessary use of the adult beneficiary's limited number of monthly prescriptions, if a prescription is written for an amount sufficient for a 30-day supply, no less than a 30-day supply may be billed to the Medicaid program. However, due to issues regarding drug stability or patient safety, some exceptions to this policy are deemed reasonable (*e.g.*, clozapine therapy, C-IIs, etc.). If the provider does not have enough stock on hand to fill a prescription as written, he or she may submit a POS claim indicating the partial quantity dispensed. (Detailed information regarding partial fill functionality may be found in the Magellan Medicaid Administration Pharmacy Provider Manual.) If a non-POS method of claims submission is used, billing Medicaid should be deferred until the entire quantity ordered by the prescriber has been dispensed to the beneficiary.

The Medicaid program reimburses for a maximum one-month supply of medication per prescription or refill or for a days' supply commensurate with the smallest package size available. The DHHS defines a one-month supply as a maximum 31-days' supply per prescription for non-controlled substances. Providers should refer to the South Carolina Controlled Substances Regulations promulgated by the South Carolina Department of Health and Environmental Control (DHEC) for maximum quantity limitations on prescriptions for controlled substances. Additional information regarding this subject may be found earlier in this section.

NO WRITTEN RECORD OF PRESCRIPTION

Providers must maintain original prescription documents in one of the three required appropriate prescription files. These documents must be readily retrievable and retained according to Medicaid policy and State pharmacy law. Providers are reminded that all state and federal requirements must be adhered to regarding prescription documentation and authenticity of records. Prescription records function as proof of services rendered, and it is the pharmacy provider's responsibility to retain these records for auditing purposes.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

NO WRITTEN RECORD OF PRESCRIPTION (CONT'D.)

Additionally, providers are cautioned not to retroactively reproduce lost or misplaced original prescription documents. Upon proof of such activity, further administrative actions or sanctions may be taken, including recoupment of Medicaid monies and suspension or termination from the Medicaid program.

USE OF VALID PRESCRIBER IDENTIFICATION NUMBERS

It is imperative that pharmacy providers submit valid prescriber identification numbers when submitting pharmacy claims. The submission of valid prescriber identification information on pharmacy claims is a critical component of provider participation in the Medicaid program. Drug utilization review (DUR), federal drug rebate data, and various Medicaid reporting systems are dependent upon the accuracy of information submitted on pharmacy claims. Therefore, the reporting of inaccurate or invalid prescriber identification numbers adversely impacts the effectiveness and reliability of many programs. If it is determined that the provider is not complying with this policy, recoupment of Medicaid monies will result. Reference detailed information in Section 3 regarding the proper use and submission of the prescriber's designated identification number.

REFILLS

Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices. Refills must not exceed the number authorized by the prescriber. Refill documentation must be accurate and easily accessible for postpayment-payment purposes. If a refill authorization is received orally, sufficient documentation must be present on the original prescription. At least 75% of the current prescription must be used (according to the prescriber's directions) prior to submitting a refill claim for Medicaid payment. In those instances where a refill requires a new and separate prescription (*i.e.,* controlled substances), a new prescription must be issued in accordance with state and federal requirements.

Automatic Refill Programs shall not be used for SC Medicaid beneficiaries. A pharmacy provider shall not automatically generate refills for SC Medicaid beneficiaries.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

PACKAGE SIZE/UNIT-DOSE PACKAGING

Providers *must* bill Medicaid using the NDC number that reflects the actual package size from which the medication was dispensed and the original prescription or the patient profile documents such. Manufacturer rebate payments to the State are based on prescription claim payment data by NDC number. To assure that the appropriate manufacturer is billed for the rebate, it is imperative that pharmacists take care to correctly identify the NDC number (and thus the package size) of the pharmaceutical dispensed.

Providers may be required to furnish invoice documentation to substantiate claims information billed to Medicaid. Failure to adhere to this policy will result in the recoupment of Medicaid monies.

The dispensing of unit-dose packaging to the general public is strongly discouraged and should be restricted to those individuals residing in an institutional setting (*e.g.*, nursing facility, ICF-IID, residential care facility, or boarding home). Furthermore, if medication is re-packaged by the provider prior to dispensing or delivery, Medicaid beneficiaries may NOT be charged a repackaging fee.

SECTION 2 POLICIES AND PROCEDURES

POSTPAYMENT REVIEWS

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