Washington State Health Care Authority

Washington Apple Health (Medicaid)

Prescription Drug Program Billing Guide

January 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section.	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (IMC).
What drugs, devices, and supplies are covered?	Removed information regarding OTC drugs covered without a prescription when prescribed by a smoking cessation program and added "covered when prescribed by a provider with prescriptive authority." Updated language from "smoking cessation" to "tobacco/nicotine cessation."	Program update. Consistency of language with the Physician-Related Services billing guide.
What drugs, devices, and supplies are not covered?	Removed "OTC or prescription drugs to promote smoking (tobacco) cessation."	Program update; these drugs are now covered.
Special Programs and Services	Removed counseling requirements, limitations, billing information and resources from tobacco/nicotine cessation program. Updated language from "smoking (tobacco) cessation" to "tobacco/nicotine cessation"	Duplicate information can be found in the agency's Physician-Related Services/Health Care Professional Services Billing Guide. Consistency of language with the Physician-Related Services billing guide.
How does a pharmacy bill the agency for Clozaril/Clozapine and related services?	BHO removed from description in the procedure code table.	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.

Subject	Change	Reason for Change
Does the agency reimburse for a client's prescriptions when enrolled in an agency-contracted managed care organization?	Removed "prescriptions written by dentists or related to dental health."	Effective January 1, 2020, prescriptions written by dentists or related to dental health are no longer an exclusion on the managed care contract. For clients enrolled in an agency-contracted managed care organization (MCO), these prescriptions must be billed to the client's MCO and are no longer reimbursable from fee-for-service (FFS).

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

To access policies and FAQs for pharmacy related services, go to the agency's Apple Health (Medicaid) drug coverage criteria webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).

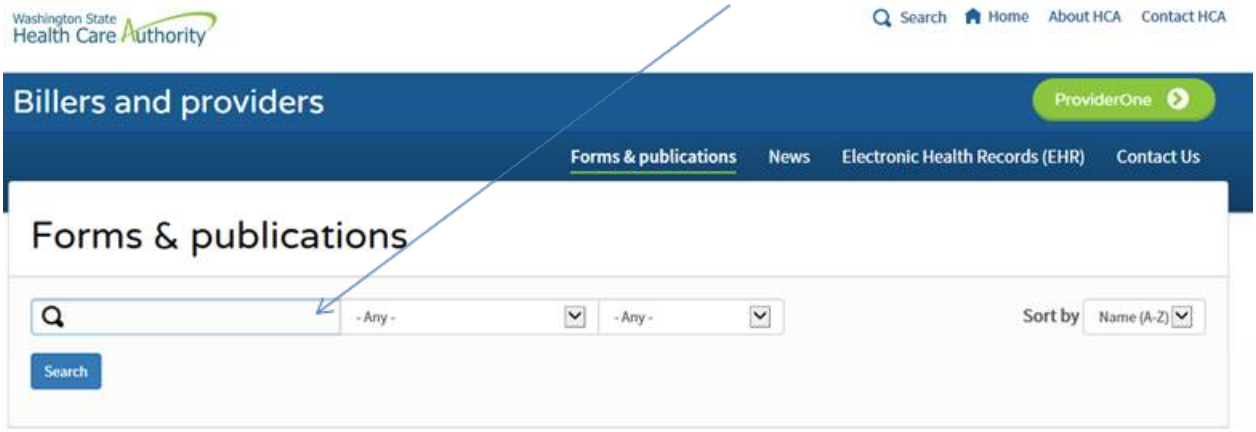

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Table of Contents

Resources Available **10**

Troubleshooting **11**

Definitions **13**

About the Program **19**

What is the purpose of the Prescription Drug Program? 19
What are the provider requirements? 20
Abuse of the program 21

Client Eligibility **22**

How do I verify a client's eligibility? 22
What types of identification prove eligibility? 24
What if a claim is denied by the point-of-sale (POS) system? 25
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible? 26
Managed care enrollment 27
Apple Health – Changes for January 1, 2020 27
Clients who are not enrolled in an agency-contracted managed care plan for physical health services 28
Integrated managed care (IMC) 29
Integrated Apple Health Foster Care (AHFC) 30

Program Restrictions **32**

How does the agency determine which drugs to cover? 32
What drugs, devices, and supplies are covered? 32
What drugs, devices, and supplies are not covered? 34
What are the exceptions to the prescription requirement? 38

Compliance Packaging **39**

What is included in compliance packaging? 39
How is it determined that a client is eligible for compliance packaging? 40
What is required when billing for compliance packaging? 41
Billing for single-dose vials 42
Does a provider need agency approval to bill for splitting single-dose vials? 42

Compounded Prescriptions **43**

What is compounding? 43
Which ingredients are not reimbursed in compounds? 43
What additional ingredients are reimbursable in compounds? 44
Is authorization required to compound prescriptions? 44
Billing for compounded prescriptions 45

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Special Programs and Services 46

Tobacco/Nicotine Cessation Program 46
How does a pharmacy bill the agency for Clozaril/Clozapine and related services? 46
What is the Patient Review and Coordination (PRC) Program? 50
What is the pharmacy's role in the PRC Program? 52
What happens if a restricted client goes to a non-assigned pharmacy? 53
How are agency-covered vaccines and vaccine administration fees billed? 54
Which vaccines are covered and are they available free from DOH? 55
How must a pharmacy bill the agency for influenza, pneumonia, and Zostavax® vaccine? 56
What diabetic supplies does the agency cover? 57
Does the agency reimburse for human papillomavirus (HPV) vaccine? 58
Does the agency reimburse for flu prevention medication? 58
What form is used to bill for pre-filling syringes? 58
ADHD (attention deficit hyperactivity disorder) safety edits 59
Second Opinion Program 59
Oral, Transdermal, and Intra-Vaginal Hormonal Contraceptives 60
Cough and cold drug coverage 60
Generics first (GF) 60
Medication assisted treatment (MAT) 62
Voluntary treatment 62
Authorization for proton pump inhibitors (PPIs) 63
What is the agency's clinical policy for opioid prescriptions? 64
Does the agency cover over-the-counter (OTC) drugs? 64
Where is information available for Synagis®? 64
What does emergency fill mean? 65
Does the agency pay for hemophilia - and von Willebrand-related products for home administration? 65
What is the criteria to become a Qualified Hemophilia Center of Excellence (COE)? 66
What annual documentation is required to remain a qualified hemophilia COE? 67
Where is information available for Alpha Hydroxyprogesterone (17P) and Makena? 67

Authorization 68

When does the agency require authorization? 68
How do I obtain authorization? 69
What information must be provided to the agency for an authorization number? 69
Who determines authorization status for drugs in the agency's drug file? 70
How is authorization status determined for drugs in the agency's drug file? 70
What authorization status may be assigned to a drug? 71
How are drugs added to the agency's drug file? 72
When can a medication be dispensed more than twice per month or filled early? 72
Can clients receive early refills or extended days' supply for travel? 74
Is authorization required for brand name drugs? 74
What is an exception to rule (ETR)? 75
What is expedited authorization (EA)? 76

Reimbursement 78

What in general does the agency need to process a reimbursement for services? 78
How does the point-of-sale (POS) system establish reimbursement rates? 79
How does the agency determine the actual acquisition cost (AAC)? 79
How are federal upper limits calculated? 80
How is the automated maximum allowable cost (AMAC) calculated? 80
When is the maximum allowable cost (MAC) applied? 80
How is tax computed? 81
What are the agency's dispensing fees? 81
Does the agency pay dispensing fees for non-drug items? 81
How is the drug rebate program used? 82

Billing 83

What are the general instructions for billing? 83
How do I bill electronically for services? 83
What is point-of-sale (POS)? 84
What do the POS rejection codes mean? 84
What is the prospective drug use review (pro-DUR) used for? 88
What is the national drug code (NDC)? 89
NCPDP Version D.0 claim format 89
What transaction segments are supported? 90
What is the requirement regarding tamper-resistant prescription pads? 92
What about emergency dispensing? 92
What about Medicaid clients with retroactive certification? 92
What are the documentation and records retention requirements? 93
What is needed for prescription transfers between pharmacies? 93
What is the time limit for billing? 93
What is the national provider identifier (NPI) requirement? 95
What is needed to bill for filling a newborn prescription? 95
When is a pharmacy allowed to bill a client? 96
Who is eligible? 96
What services are billed for hospice clients? 96
Does the agency reimburse for a client's prescriptions when enrolled in an agency-contracted managed care organization? 97
Billing for managed care clients 98
What drugs may be prescribed for Family Planning Only Program—Pregnancy Related and Family Planning Only Program (formerly known as TAKE CHARGE) clients? 99
Does the agency reimburse for skilled nursing facility (SNF) clients? 100
How are medications filled for SNF clients on leave? 100
What is a skilled nursing facility (SNF) emergency kit? 101
What unit dose delivery systems are recognized by the agency for SNFs? 101
How do pharmacies become eligible for a unit dose dispensing fee? 101
How do pharmacies bill the agency under a unit dose delivery system? 102
Who is responsible for the cost of repackaging a client's bulk medications? 102
What records do SNF pharmacies need to keep? 103
What needs to be submitted annually to the agency? 103

What additional records do pharmacies need to keep? 104

Coordination of Benefits 106

How are client resources applied? 106

Other Coverage Codes 107

Why are Other Coverage Codes important? 107
When may providers use Other Coverage Codes? 107
How is authorization obtained for non-formulary or non-covered drugs? 110

Coordination of Benefits Frequently Asked Questions 111

Why would a claim be paid at zero or denied by insurance? 112
What is a closed pharmacy network? 114
What about Medicare Part B medications 117

Therapeutic Interchange Program 120

What is the Therapeutic Interchange Program? 120
What is an endorsing practitioner? 120
What does this mean to pharmacies? 120
When are substitutions not required? 120
What if a non-endorsing practitioner issues a prescription for a non-preferred drug? 121
How does the pharmacy bill for a DAW prescription written by an endorsing practitioner? 121

Apple Health Medicaid: Fee-For-Service Preferred Drug List 122

What is the preferred drug list? 122
What is the process to obtain drugs on the preferred drug list? 122
What are the authorization criteria to obtain a non-preferred drug? 123
Where is the Apple Health (Medicaid) Fee-For-Service Preferred Drug List? 123

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Finding agency documents (e.g., Washington Apple Health billing guides, fee schedules)	
Private insurance or third-party liability (other than agency-contracted managed care)	
Authorization	
Additional Prescription Drug Program information	See the agency's Pharmacy webpage
Submitting backup documentation	Backup documentation must be mailed or faxed to: Pharmacy Authorization Section Drug Use and Review PO Box 45506 Olympia WA 98504-5506 Fax: 1-866-668-1214
Technical questions about switch vendor issues or system availability issues	Contact the switch vendor
Where can I find pharmacy document submission cover sheets?	See the agency's document submission cover sheets
Where do I find the agency's maximum allowable fees for services?	See the agency's Provider billing guides and fee schedules The prescription drug fee schedule is titled *Pharmacy Special Services, Vaccine Administration, and Compliance Packaging*
General definitions	See Chapter 182-500 WAC

Troubleshooting

If your situation or question is about:	Then you must:
Claim rejection stating "prior authorization required" Claim rejection starting with "pref" or "preferred"	Use *Pharmacy Information Authorization* (HCA 13-835A) form. See Where can I download agency forms? Fax form to 1-866-668-1214 or call 1-800-562-3022
Early refill, or refill too soon	Call the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022 When you call, you must know: • When was the last fill for this client? • Was this a change in dose from the last fill?
Find out which drugs are on the Apple Health (Medicaid) Fee-For-Service Preferred Drug List	See the Apple Health Preferred Drug List webpage
Any of the following return messages: • Prior authorization required • Expedited code required and does not meet criteria • Drug exceeds limits	Use *Pharmacy Information Authorization* (HCA 13-835A) form. Where can I download agency forms? See the Pharmacy webpage for: • Expedited authorization criteria • Special programs in this billing guide Fax form to 1-866-668-1214 or call 1-800-562-3022
Dispensed an emergency supply to a client with an emergency that could not wait	Use *Pharmacy Information Authorization* (HCA 13-835A) form Fax form to 1-866-668-1214 or call 1-800-562-3022

If your situation or question is about:	Then you must:
Claim rejection stating "client is restricted to one pharmacy"	Find out what pharmacy or doctor this client is restricted to by calling the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022. After selecting a language, say "dial now," then enter extension 15606. The MACSC will be able to help you determine the following: • How to get medically necessary medications to a client restricted to a different pharmacy • Where to report clients abusing their medications • Where to report suspected fraudulent activity
Lost or stolen medications	Find out if the client reported a lost or stolen prescription in the last six months by calling Pharmacy Authorization services at 1-800-562-3022, extension 15483.
Expedited Authorization criteria	See the agency's Expedited Authorization List
Other claim or pharmacy-related questions or situations: • What is the appropriate use of NCPDP fields in response to claim edits? • Is this client eligible? • What program is this client on? • Where can clients or doctors' offices call for questions about authorizations or drugs? • What drugs are covered? • What is the Therapeutic Interchange Program? • How do I become an endorsing prescriber? • Where do I find a list of over the counter family planning products?	Call MACSC at 1-800-562-3022 or visit the Pharmacy webpage

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Active ingredient – The chemical component of a drug responsible for a drug's prescribed/intended therapeutic effect. The agency limits coverage of active ingredients to those with a national drug code (NDC) and those specifically authorized by the agency.

Actual acquisition cost (AAC) – Refers to one of the following:

- Provider ACC – The true cost a provider paid for a specific drug or drug product in the package size purchased, including discounts, rebates, charge backs that affect the provider's invoice price, and other adjustments to the price of the drug, device, or drug-related supply, excluding dispending fees
- 340B AAC – The true cost paid by a public health service (PHS)-qualifying entity for a specific drug, excluding dispensing fees
- POS AAC – The agency-determined rate paid to the pharmacies through the point-of-sale (POS) system, and intended to reflect pharmacy provider's actual acquisition cost

Administer – the direct application of a prescription drug by injection, inhalation, ingestion, or any other means to the body of a patient by a practitioner or at the direction of the practitioner.

Apple Health (Medicaid) Fee-For-Service (FFS) Preferred Drug List – The list of preferred drugs and restrictions that apply only to FFS Medicaid clients.

Apple Health Preferred Drug List (PDL) - The list of preferred drugs and restrictions that is used by all agency-contracted managed care plans and fee-for-service (FFS).

Appointing authority – For the evidence-based prescription drug program of the participating agencies in the state-operated health care programs, the following persons act jointly: the Director of the Health Care Authority (HCA or the agency), and the director of the Department of Labor and Industries (L&I).

Automated maximum allowable cost (AMAC) – The rate established by the Medicaid agency or its designee for a multiple-source drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products, at least one of which must be under a federal drug rebate contract.

Authorization number – A number assigned by the agency that identifies a specific request for approval for services or equipment.

Authorization requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or Medicaid billing guides.

Brand name – The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Closed pharmacy network – An arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. (See WAC 182-530-7800)

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Combination drug – A commercially available drug including two or more active ingredients.

Compliance packaging – Reusable or non-reusable drug packaging containers.

Compounding – The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

Contract drugs – Drugs manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Covered outpatient drug – A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, and used for a medically accepted indication.

Dispensing fee – See "Professional dispensing fee."

Drug Enforcement Agency (DEA) – the federal agency responsible for enforcing laws and regulations governing narcotics and controlled substances.

Drug file – A list of drug products, pricing, and other information provided to the agency's drug database and maintained by a drug file contractor.

Drug rebates – Payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services.

Drug-related supplies – Non-drug items necessary for the administration, delivery, or monitoring of a drug or drug regimen.

Drug use review (DUR) – A review of covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Emergency kit – A set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the needs of each nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

Endorsing practitioner – A provider who has reviewed the Washington Preferred Drug List (PDL), enrolled (see www.rx.wa.gov) with the Health Care Authority (HCA or the agency), and agrees to allow therapeutic interchange (substitution) of a preferred drug for any non-preferred drug in a given therapeutic class on the Washington PDL.

Evidence-based practice center – A research organization designated by the federal Agency for Healthcare Research and Quality (AHRQ) to develop report and technology assessments on topics relevant to clinical and other health care organizations and delivery issues.

Federal upper limit (FUL) – The maximum allowable payment set by the Centers for Medicare and Medicaid Services (CMS) for a multiple-source drug.

Federally approved hemophilia treatment center – A hemophilia treatment center (HTC) which:

(1) Receives funding from the federal Department of Health and Human Services' Maternal and Child Health Bureau National Hemophilia Program.

(2) Is qualified to participate in 340B discount purchasing as an HTC.

(3) Has a federal Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC website.

(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington State.

(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

Immediate needs – An emergency situation when pharmacists use their professional judgment to determine the quantity to dispense to best meet the client's needs in the emergency.

Generic name – The official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

Less-than-effective drug, or Drug Efficacy Study Implementation (DESI) – Drugs that lack substantial evidence of effectiveness as determined by the Food and

Drug Administration (FDA).
(WAC 182-530-1050)

Maximum allowable – The maximum dollar amount the agency will reimburse a provider for a specific service, supply, or piece of equipment.

Maximum allowable cost (MAC) – The maximum amount that the agency reimburses for a specific dosage form and strength of a multiple-source drug product.

Medically accepted indication – Any use for a covered outpatient drug:

(1) Which is approved under the federal Food, Drug, and Cosmetic Act.

(2) The use of which is supported by one or more citations included or approved for inclusion in any of the following compendia of drug information:
   (a) The American Hospital Formulary Service Drug Information
   (b) The United States Pharmacopoeia Drug Information
   (c) DRUGDEX Information System

Medically necessary – See WAC 182-500-0005

Modified Unit Dose Delivery System (also known as blister packs or bingo/punch cards) – A method in which each patient's medication is delivered to a nursing facility:

- In individually sealed, single-dose packages or "blisters".
- In quantities for one month's supply, unless the prescriber specifies a shorter period of therapy.

Multiple source drug – A drug for which there is at least one other drug product sold in the United States that is pharmaceutically equivalent and bioequivalent, as determined by the Food and Drug Administration.

National average drug acquisition cost (NADAC) – A national benchmark published by the Centers for Medicare and Medicaid (CMS). The NADAC is based on a monthly survey of invoice costs paid by retail community pharmacies across the United States.

National drug code (NDC) –The eleven-digit numerical code that includes the labeler code, product code, and package code.

Non-contract drugs – Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Non-formulary drug – Medications that are not on the primary insurance plan's formulary (preferred) drug list.

Non-preferred drug – A drug within a therapeutic class of drugs on the Apple Health (Medicaid) Fee-For-Service preferred drug list (PDL) that has not been selected as a preferred drug.

Obsolete NDC – An NDC replaced or discontinued by the manufacturer or labeler.

Other Coverage Code – A billing code that indicates whether or not a client has other insurance coverage. If the client has coverage, use of the code identifies how the claim was processed by the insurance carrier.

Over-the-counter (OTC) drugs – Drugs that do not require a prescription under federal law before they can be sold or dispensed**.**

Pharmacist – A person licensed in the practice of pharmacy by the state in which the prescription is filled.

Pharmacy – Every location licensed by the State Board of Pharmacy in the state where the practice of pharmacy is conducted.

Point-of-sale (POS) – A pharmacy claims processing system capable of receiving and adjudicating claims online.

Poly-prescribing – Multiple prescribers duplicating drug therapy for the same client.

Practitioner – A person who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner.

Preferred drug – Drug(s) of choice within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

Prepay plan – A type of insurance coverage that requires the client to pay at the time of service, and the insurance reimbursement is made to the subscriber/client.

Privately purchased HMO – Indicates a client with a privately purchased HMO insurance policy. ProviderOne indicates that the client is enrolled in a managed health care plan. These clients must comply with the requirements of their plan and are required to use the HMO facilities for their pharmacy services.

Prescriber – A physician, osteopathic physician/surgeon, dentist, advanced registered nurse practitioner (ARNP), physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs.

Prescription – An order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices, in the course of the practitioner's professional practice, for a legitimate medical purpose.

Prescription drugs – Drugs required by any applicable federal or state law or regulation to be dispensed by prescription only, or that are restricted to use by practitioners only.

Professional dispensing fee – The fee the Medicaid agency or its designee pays pharmacists and dispensing providers for covered prescriptions. The fee pays for costs in excess of the ingredient cost of a covered outpatient drug when a covered outpatient drug is dispensed. (See WAC 182-530-1050 for full definition.)

Prospective drug use review (Pro-DUR) – A process in which a request for a drug product for a particular client is screened, before the product is dispensed, for potential drug therapy problems.

Reconstitution – The process of returning a single active ingredient previously altered for preservation and storage to its approximate original state. Reconstitution is not compounding.

Retrospective drug utilization review (Retro-DUR) – The process in which a client's drug use is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Service area – An area within 25 miles or 45 minutes from the client's residential address to the pharmacy.

Single source drug – A drug produced or distributed under an original new drug application approved by the FDA.

Skilled nursing facility (SNF) – An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care.
- Rehabilitation services for injured, disabled, or sick clients.
- Health-related care and services to people who require care which can only be provided through institutional facilities and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Systematic review – A specific and reproducible method to identify, select, and appraise all the studies that meet minimum quality standards and are relevant to a particular question. The results of the studies are then analyzed and summarized into evidence tables to be used to guide evidence-based decisions.

Terminated national drug code (NDC) – An NDC that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life.

Therapeutic alternative – A drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile when administered to patients in a therapeutically equivalent dosage.

Therapeutic interchange – To dispense a therapeutic alternative to a prescribed drug when permitted by an endorsing practitioner. See Therapeutic Interchange Program (TIP).

Therapeutic Interchange Program (TIP) – The process developed by participating state agencies under RCW 69.41.190 and 70.14.050 to allow prescribers to endorse the Washington Preferred Drug List, and in most cases, to require pharmacists to automatically substitute a preferred equivalent drug from the list.

Therapeutically equivalent – Drug products that contain different chemical structures but have the same efficacy and safety when administered to a person, as determined by:

- Information from the Food and Drug Administration (FDA).
- Published and peer-reviewed scientific data.
- Randomized controlled clinical trials.
- Other scientific evidence.

True unit dose delivery – A method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage.

Washington Preferred Drug List (Washington PDL) – The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for purchasing drugs in state-operated health care programs.

About the Program

(WAC 182-530-1000)

What is the purpose of the Prescription Drug Program?

The purpose of the Prescription Drug Program is to pay providers for outpatient drugs, devices, and drug-related supplies. The program is governed by federal and state regulations. This billing guide is intended to help providers comply with the rules and requirements of the program.

Basic things to know:
The agency reimburses for medically necessary drugs, devices, and supplies according to rules in Washington Administrative Code (WAC) and the Reimbursement section of this billing guide.

The agency covers outpatient drugs, including over-the-counter drugs listed in the agency's Apple Health Fee-for-Service Covered Over-the-Counter Drug List, when:

- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to this rule are described in this billing guide's Compounded Prescriptions section.
- Approved by the Food and Drug Administration (FDA).
- Prescribed by a provider within the scope of the provider's prescribing authority and whose core provider agreement has not been terminated or denied.
- Prescribed for a medically accepted indication.
- Prescribed for an eligible client.
- Not excluded from coverage under WAC 182-501-0050, 182-530-2100, and the Program Restrictions section of this billing guide, specifically the subsection What drugs, devices, and supplies are not covered?

The agency does not cover:

- Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927(d)(2)(K) of the Social Security Act, unless these drugs are used to treat a condition other than sexual or erectile dysfunction and these uses have been approved by the FDA.
- Drugs not approved by the FDA.

- Drugs prescribed for a non-medically accepted indication or dosing level.
- Drugs from a manufacturer without a federal rebate agreement.
- Drugs and indications excluded from coverage by WAC, such as drugs prescribed for the following:
  - ✓ Weight loss or gain
  - ✓ Infertility, frigidity, or impotence
  - ✓ Sexual or erectile dysfunction
  - ✓ Cosmetic purposes or hair growth

What are the provider requirements?

In order to be reimbursed by the agency, the pharmacy must:

- Be properly licensed.
- Have a signed core provider agreement (CPA).
- Follow the guidelines in this billing guide and applicable WAC.
- Retain documentation demonstrating that all other possible payers have been billed appropriately.

The agency may require a pharmacy to:

- Obtain authorization for a drug or product.
- Determine and document that certain diagnosis requirements are met.
- Meet other requirements for client safety and program management.

Abuse of the program

The following practices constitute an abuse of the program and a misuse of taxpayer dollars:

- **Prescription splitting –** Billing inappropriately to obtain additional dispensing fees, for example:

  - ✓ Supplying medication in amounts less than necessary to cover the days prescribed

  - ✓ Supplying medications in strengths less than those prescribed to gain more than one dispensing fee

- **Excessive filling –** Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity (except when the agency specifies a mandatory minimum of an OTC drug)

- **Prescription shorting –** Billing for a drug or supply greater than the quantity actually dispensed

- **Substitution to achieve a higher price –** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug is available (except when the agency identifies a higher-priced drug as preferred)

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What types of identification prove eligibility?

Valid types of eligibility identification:

- A copy of the benefit inquiry screen from ProviderOne
- A printout of a medical identification screen from the client's local DSHS Community Services Office (CSO), Home and Community Service (HCS) office, or the agency
- An award letter from the CSO or HCS
- Medical eligibility verification (MEV) receipt provided by an authorized MEV vendor with an "as of" date within the same month as the date of service

> **Note:** Providers enrolled with ProviderOne can check eligibility by accessing the Provider Portal and choosing eligibility inquiry from the main menu. For information on enrolling, visit the Enroll as a Provider webpage.

The computer printout or award letter may be used as valid identification since both list the eligibility information that appears in ProviderOne.

The agency recommends that providers make a photocopy of valid identification when it is presented, in order to have a copy for the file.

Check the identification for the following information:

- Beginning and ending eligibility dates
- The ProviderOne Client ID
- Other specific information (e.g., Medicare, Medicare Part D, private insurance, or managed care coverage, hospice, patient requiring regulation, etc.)
- Retroactive or delayed certification eligibility dates, if any

> **Note:** Do not accept any form of identification that appears to have been altered. Request to see another form of identification.

What if a claim is denied by the point-of-sale (POS) system?

The POS system does not solve the problem of identifying clients who are not currently in the agency's eligibility file. For clients who show as eligible in ProviderOne, but the POS system denies their claims for lack of eligibility, do one of the following:

- **FAX** a copy of the client's benefit inquiry screen in ProviderOne to 1-360-586-1403.
- Mail a photocopy of the client's benefit inquiry screen in ProviderOne attached.

The agency will update eligibility information from the copies of the client benefit inquiry screen in ProviderOne within two working days so that claims may be resubmitted.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Newborns of clients enrolled in an agency-contracted MCO are the responsibility of the mother's MCO for the first 60 days of life. If the mother changes MCOs, the baby follows the mother's MCO.

> **Note:** A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

> **Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website:

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FSS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Program Restrictions

(WAC 182-530-2000 (2))

How does the agency determine which drugs to cover?

Coverage determinations for the agency are decided by:

- The agency in consultation with federal guidelines.
- The Drug Use Review (DUR) Board.
- The agency's medical consultants and pharmacists.

If a product is determined to be covered, it will be assigned an authorization status (see Authorization.)

> **Note:** The agency evaluates a request for a drug that is listed as non-covered under the provisions of WAC 182-501-0160 related to non-covered services. The request for a non-covered drug is called a **request for an exception to rule**. See WAC 182-501-0160 for information about exception to rule.

What drugs, devices, and supplies are covered?

(WAC 182-530-2000(1))

The agency covers:

- Outpatient drugs, including over-the-counter drugs listed on the agency's Apple Health Fee-for-Service Covered Over-the-Counter Drug List, as defined in WAC 182-530-1050, subject to the limitations and requirements within this billing guide, when:
  - ✓ The drug is approved by the Food and Drug Administration (FDA).
  - ✓ The drug is for a medically accepted indication as defined in WAC 182-530-1050.
  - ✓ The drug is not excluded from coverage (see What drugs, devices, and supplies are not covered?).

- ✓ The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 182-530-7500 which details the drug rebate program.

- Family planning drugs, devices, and drug-related supplies per chapter 182-532 WAC such as:

  - ✓ Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies without a prescription when the agency determines it necessary for client access and safety.

  - ✓ Family planning drugs that do not meet the federal drug rebate requirement in WAC 182-530-7500 on a case-by-case basis.

- Contraceptive patches, contraceptive rings, and oral contraceptives, only when dispensed in at least a 12-month supply, unless otherwise indicated by the prescriber or requested by the client. If less than a 12-month supply is requested, providers may use an expedited authorization (EA) code from the Apple Health EA list to dispense less than a 12-month supply. There is no minimum quantity of emergency contraception required to be dispensed.

- Prescription vitamins and mineral products, only as follows:

  - ✓ When prescribed for clinically documented deficiencies

  - ✓ Fluoride varnish for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program

- Drug-related devices and supplies as an outpatient pharmacy benefit when they are :

  - ✓ Prescribed by a provider with prescribing authority.

  - ✓ Essential for the administration of a covered drug.

  - ✓ Not excluded from coverage under WAC 182-530-2100.

  - ✓ A product covered under chapter 182-543 WAC that the agency determines should be available at retail pharmacies.

Note: For exceptions to the prescription (prescriber's order) requirement, see Exceptions to the Prescription Requirement.

- Preservatives, flavoring, or coloring agents, only when used as a suspending agent in a compound.

- Nicotine replacement products, over-the-counter and prescription drugs to promote tobacco/nicotine cessation, *with a prescription*, when prescribed by a provider with prescriptive authority.

What drugs, devices, and supplies are not covered?

(WAC 182-530-2100 and 182-530-7500)

The agency does not reimburse under the Prescription Drug Program for drugs and drug-related supplies administered by health care professionals as a component of hospital services, physician-related services, or billed in conjunction with home health services. Reimbursement for drugs and drug-related supplies in these situations may be available when billed under the rules of the related program.

The agency does not reimburse for any of the following under the Prescription Drug Program:

- Nutritional supplements such as shakes, bars, puddings, powders, medical foods, etc. (These products may be reimbursable under the conditions of the Nondurable Medical Supplies and Equipment and Enteral Nutrition programs.)

- Drugs for which the manufacturer has **not signed a rebate agreement** with the federal Department of Health and Human Services (DHHS)

- Drugs considered **less than effective** and withdrawn by the Food and Drug Administration (FDA) as a result of the Drug Efficacy Study Implementation (DESI) review

- Free pharmaceutical samples

- Over-the-counter (OTC) drugs and drug-related supplies that have not been prescribed by a provider with prescriptive authority (with the exception of OTC family planning products)

- OTC drugs and drug-related supplies that have been prescribed by a provider whose application for a Core Provider Agreement (CPA) has been denied or whose CPA has been terminated with cause

- Drugs prescribed for:

  ✓ Weight loss or gain

- ✓ Infertility, frigidity, or impotence
- ✓ Sexual or erectile dysfunction
- ✓ Cosmetic purposes or hair growth

- Over-the-counter drugs not listed on the agency's covered over-the-counter drug list
- Drugs and drug-related supplies for multiple patient use
- Any drug regularly supplied as an integral part of program activity by other public agencies (such as drugs, vaccines, or biological products available without charge to the client from the Department of Health)
- Products or items that do not have an 11-digit national drug code (NDC)
- Drugs with NDCs which have been designated as obsolete for more than two years
- Drugs with a shelf life that has expired prior to being dispensed
- Drugs purchased under section 340B of the Public Health Service (PHS) Act when dispensed by contract pharmacies
- Drugs which have been terminated or removed from the market
- More than a 34-day supply of any product except:
  - ✓ Drugs when the smallest package size exceeds a 34-day supply
  - ✓ Drugs with special packaging instructions which would require dispense of a quantity that exceeds a 34-day supply
  - ✓ Contraceptive patches, contraceptive rings, and oral contraceptives not used for emergency contraception. These products must be dispensed at a minimum of a 12-month supply, unless otherwise indicated by the prescriber or requested by the client.
  - ✓ When the drug is specifically identified as exempt from the 34-day limit
- Any vitamin product other than:
  - ✓ Vitamins determined by the agency to be the least costly therapeutic alternative for the treatment of a client's diagnosed condition
  - ✓ When the agency agrees that the vitamin product is the least costly alternative in treating documented vitamin deficiency which has been confirmed by laboratory testing

- Fluoride preparations other than as prescribed for children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program

- Non-preferred drugs in drug classes as described in the Apple Health (Medicaid) Preferred Drug List (PDL)

- Drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

  - ✓ Diagnosis-related group (DRG)
  - ✓ Ratio of costs-to-charges (RCC)
  - ✓ OTC products supplied to skilled nursing facility (SNF) residents (unless included in the Apple Health (Medicaid) FFS PDL)
  - ✓ Managed care capitation rates
  - ✓ Block grants
  - ✓ Drugs prescribed for clients who are in the agency's hospice program when the drugs are related to the client's terminal condition

- Drugs prescribed for an indication that is not evidence-based as determined by:

  - ✓ The agency in consultation with federal guidelines
  - ✓ The Drug Use Review (DUR) Board
  - ✓ Agency medical consultants and pharmacist(s)

- Drugs that are:

  - ✓ Not approved by the Food and Drug Administration (FDA)
  - ✓ Prescribed for non-FDA approved indications or dosing, which is not otherwise supported by quality evidence in the recognized compendia of drug information
  - ✓ Unproven for efficacy or safety

- Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee

- Preservatives, flavoring, or coloring agents

- Prescriptions written on pre-signed prescription blanks completed by SNF operators or pharmacists. The agency may terminate the CPA of pharmacies involved in this practice.

- Drugs used to replace those taken from SNF emergency kits

- The cost differential between the least costly dosage form of a drug and a more expensive dosage form within the same route of administration, unless the prescriber designated the costlier dosage form as medically necessary

What are the exceptions to the prescription requirement?

(WAC 182-530-2000(4))

The agency reimburses specific OTC family planning drugs, devices, and supplies without a prescription. The following OTC contraceptives may be dispensed without a prescription to any agency client with a current Services Card:

- Condoms (including female condom)
- Vaginal spermicidal foam with applicator and refills
- Vaginal spermicidal jelly with applicator
- Vaginal spermicidal creams and gels
- Vaginal spermicidal suppositories
- OTC emergency contraception

Point-of-sale billers must:

Bill the agency fee-for-service using the Product ID Qualifier of 03 in field 436-E1, and the product-specific NDC number in field 407-D7. Use Prescriber ID Qualifier (466-EZ) 01 and Prescriber ID (407-D7) of **5123456787**. Regardless of the contraceptive, bill the NDC as stated on the package.

Compliance Packaging

The agency, the Home Care Association of Washington (HCAW), and the Washington State Pharmacy Association (WSPA) developed the following guidelines in a cooperative effort to improve drug therapy outcomes for the most **at-risk** segment of the medical assistance population.

What is included in compliance packaging?

(WAC 182-530-7400(2))

Compliance packaging includes both of the following:

- Reusable, hard plastic containers of any type (e.g., Medisets, weekly minders, etc.)
- Non-reusable compliance packaging (e.g., blister packs, bingo cards, bubble packs, etc.)

How is it determined that a client is eligible for compliance packaging?

(WAC 182-530-7400(1))

Prescribers are encouraged to communicate to high-risk clients the need for compliance packaging if, in their professional judgment, such packaging is appropriate.

Clients are considered high-risk and eligible to receive compliance packaging if they:

- **Do not reside** in a skilled nursing facility or other inpatient facility.

- Have one or more of the following representative disease conditions:

  - ✓ Alzheimer's disease
  - ✓ Blood clotting disorders
  - ✓ Cardiac arrhythmia
  - ✓ Congestive heart failure
  - ✓ Depression
  - ✓ Diabetes
  - ✓ Epilepsy
  - ✓ HIV/AIDS
  - ✓ Hypertension
  - ✓ Schizophrenia
  - ✓ Tuberculosis

-AND-

- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day.

- Demonstrate a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

Prefilling a syringe is not considered compliance packaging. See Special Programs/Services for syringe filling guidelines.

Managed care clients who meet this criteria are eligible to have compliance packaging paid for under fee-for-service (FFS) when one or more medications packaged are covered under the FFS benefit. Packaged medications may include a combination of medications paid for by the client's managed care organization and medications paid under FFS, as long as a paid FFS claim exists for at least one medication included in the packaging. To bill the agency through FFS for compliance packaging that meets these conditions, enter the appropriate expedited authorization (EPA) code on the claim. See What is required when billing for compliance packaging for additional requirements and guidelines.

What is required when billing for compliance packaging?

To bill for compliance packaging:

1. Bill electronically on an approved professional claim. See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

2. Include the NPI of the ordering practitioner in the 'referring' field. The ordering practitioner is the prescriber or pharmacist who determined the client meets compliance packaging criteria.

3. Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.

4. Use the following procedure codes in combination with the appropriate modifier. The agency will deny claims for these procedure codes without the accompanying modifier.

Short Description	HCPCS Code	Modifier	Maximum Allowable Units*
Reusable compliance device or container	T1999	UE	Limit of 4 per client, per year May be billed in combination , but not to exceed a total of 4 per year
Reusable compliance device or container, extra-large capacity	T1999	SC	
Filling fee for a reusable compliance device or container	T1999	TS	Limit of 4 fills per client, per month
Non-reusable compliance device or container	T1999	NU	Limit of 4 fills per client, per month Includes reimbursement for materials and filling time. Bill one unit each time non-reusable compliance packages are filled.

* See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

The agency does not pay for compliance packaging in excess of the limits listed above. Requests for limitation extensions will not be approved.

Note: For MCO clients who are eligible for compliance packaging through FFS, pharmacies must enter expedited authorization (EA) code 870001421 on the billing form in the *Authorization Number* field, or in the *Authorization* or *Comments* section when billing electronically.

Billing for single-dose vials

When a drug is packaged in a single-dose vial that cannot be used for multiple injections, the agency reimburses for the entire quantity of the drug or biological contained in the vial. The agency requires providers to use the smallest vial size available from the manufacturer(s) containing the amount necessary for administration. Unused product discarded as waste is covered in addition to the quantity administered, up to the maximum number of allowed units for the vial size used. The agency considers the entire vial to have been used in providing services to the client and will reimburse accordingly.

Note: The actual National Drug Code (NDC) that was dispensed must be used when submitting a claim. The number of units contained within each vial must be billed as a single claim. (See WAC 182-530-5000(1)(b).)

For information on billing for single dose vials on medical claims, see *Billing for single dose vials (SDV)* in the Physician-Related Services/Health Care Professional Services Billing Guide.

Does a provider need agency approval to bill for splitting single-dose vials?

Yes. Providers must obtain agency approval to bill for splitting single dose vials. To receive agency approval, submit the following documentation by fax to the attention of the Pharmacy Administrator, at 1-360-725-1328:

- Documentation showing all requirements of the United States Pharmacopeia General Chapter 797, Pharmaceutical Compounding - Sterile Preparations regulations are met, including the date of the last laminar flow hood inspection and through date of the certification
- The policy the provider has established regarding IV admixture preparations
- The policy the provider has established regarding when single dose vials are split and how the remainder is to be used
- The billing NPI(s) of the requesting provider

The agency will provide an approval or denial of the provider's request within 10 business days.

Compounded Prescriptions

(WAC 182-530-7150)

What is compounding?

(WAC 182-530-7150(1)(3))

Compounding is the act of combining two or more **active** ingredients or the medically necessary adjustment of therapeutic strengths and/or forms by a pharmacist for a single active ingredient. The agency does not consider drug reconstitution to be compounding. The agency reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and forms of the medically necessary drug.

Note: All compound ingredients must be billed on one claim. Each ingredient must be separately detailed using the National Council for Prescription Drug Programs (NCPDP) Compound Segment. The agency's point-of-sale (POS) system does not accept **highest cost ingredient** compound billing.

Note: The pharmacist must document in the client's file the need for the adjustment of the drug's therapeutic strength or form, or both.

Which ingredients are not reimbursed in compounds?

(See WAC 182-530-7150(2))

- Coloring agents, preservatives, and flavoring agents used in compounded prescriptions **except** when they are necessary as a complete vehicle for compounding (e.g., simple syrup)
- Any product which would not be reimbursable when used outside of a compound, except as detailed on the following page

What additional ingredients are reimbursable in compounds?

- Bulk chemicals which are active ingredients and are considered non-drug items when used outside of a compound

- Vehicles or suspending agents necessary for the completion of the compound

The agency reimburses for compounding ingredients from the following chemical supply companies who have not signed Federal Rebate agreements:

Labeler Code	Company
00395	Humco Labs
00802	Emerson Labs

Note: Other chemical suppliers' products are reimbursable only if they have been reported to the agency's current drug file contractor with a valid 11-digit national drug code (NDC) and the manufacturer has signed a Federal Rebate agreement.

Is authorization required to compound prescriptions?

(WAC 182-530-7150(5)(b) and (c))

No. The agency does not require authorization to compound prescriptions.

Individual ingredients requiring authorization still require authorization when used in a compound, except as previously noted.

The need for authorization of any single ingredient within a compound will cause the entire compound claim to be rejected until authorized, but only the individual ingredient actually requires authorization.

Billing for compounded prescriptions

(WAC 182-530-7150(4) and (5))

- Pharmacies must bill each ingredient used in compounded prescriptions using the 11-digit NDC for each ingredient.
- Bill the **appropriate** quantity used for each ingredient on one claim. **Do not bill the combined total quantity.**
- The agency pays a dispensing fee for each payable ingredient. The agency does not pay separate fees for compounding time or preparation fees.

Note: If a compound is rejected, pharmacies may elect to accept reimbursement for any payable ingredient within the compound by entering an **8** in the Submission Clarification Code field (420-DK).

Point-of-sale billers must:

- Enter a Compound Code (field 406-D6) of 2 in the Claim Segment.
- Enter a Product/Service ID Qualifier (436-E1) of 03 in the Claim Segment.
- Enter a Product/Service ID (407-D7) of **00000-0000-00** in the Claim Segment.
- Enter the separate ingredient details using the Compound Segment.

Special Programs and Services

Tobacco/Nicotine Cessation Program

For eligibility and coverage requirements, see the *Behavior change intervention-tobacco/nicotine cessation* section in the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Pharmacists with a collaborative practice agreement may provide tobacco/nicotine cessation counseling and prescribe for clients. For counseling requirements, limitations, billing information, and resources, see the *Physician-Related Services/Health Care Professional Services Medicaid Billing Guide*.

How does a pharmacy bill the agency for Clozaril/Clozapine and related services?

The agency reimburses pharmacies for Clozaril/Clozapine plus pays a dispensing fee. Bill Clozaril/Clozapine using the appropriate national drug code (NDC) on either the point-of-sale (POS) system or electronically through ProviderOne. See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

Any licensed or registered pharmacy with clinical experience in monitoring patient mental and health status may provide and bill for case coordination (medication management) for clients receiving Clozaril/Clozapine.

Persons providing case coordination serve as a focal point for the client's Clozaril/Clozapine therapy. All services must be documented and are subject to quality assurance review. When providing case coordination, providers must:

- Coordinate a plan of care with the:
  - ✓ Client
  - ✓ Client's caregiver
  - ✓ Prescriber
  - ✓ Pharmacy
- Assure services are provided to the client as specified in the plan of care.

- Assure blood samples are drawn according to the Food and Drug Administration (FDA) labeling, blood counts are within normal range, and the client is compliant with the plan of care.
- Follow-up with the client on missed medical appointments.
- Maintain detailed, individual client records to document the client's progress.
- Provide feedback to the prescriber on the client's progress, immediately report abnormal blood counts, and client noncompliance.
- Assure smooth transition to a new case coordinator, when necessary.

See the agency's ProviderOne Billing and Resource Guide for general billing instructions. Use the following procedure codes to bill for Clozaril/Clozapine related services on an approved electronic professional claim:

Procedure Code	Modifier	Description	Reimbursement
36415		Routine venipuncture	Per the Resource-Based Relative Value Scale (RBRVS) fee schedule
99605	HE	Case coordination for new clients	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule
99606	HE	Case coordination for returning clients.	

Note: Due to close monitoring requirements, the agency allows up to five fills per month.

Emergency contraceptive pills (ECP)

The agency reimburses for emergency contraceptive pills (ECP) through the POS system for female clients in eligible programs. ECP that is not over-the-counter (OTC) requires a prescription to be dispensed. OTC ECP may be dispensed with or without a prescription.

Levonorgestrel (OTC) does not require a prescription.
Ulipristal requires a prescription.

To receive reimbursement for OTC ECP that does not require a prescription and was not prescribed, pharmacies must bill the agency fee-for-service (FFS) using the specific NDC and Prescriber ID number **5123456787**. It is common practice to dispense two packages at a time, especially for clients using barrier contraceptive methods. Pharmacies are instructed to dispense the quantity requested by the client. Pharmacies that are members of, or subcontract with, an agency-contracted managed care organizations (MCO) and are serving an MCO must bill the prescription cost to the plan. The agency reimburses pharmacists for ECP plus pays a dispensing fee. Bill for ECP using the appropriate NDC.

See the Family Planning Billing Guide for more information on covered products and services.

Emergency contraception (EC) counseling

When a pharmacist with an EC protocol approved by the Board of Pharmacy prescribes ECPs, the pharmacy may bill the agency for the counseling portion.

Pharmacists performing EC counseling must ensure that a copy of the pharmacist's current approved protocol certificate from the Board of Pharmacy is on file at the pharmacy where the service was performed. Performing EC Counseling without a currently approved protocol is subject to sanction by the Board of Pharmacy. Billing the agency for EC Counseling without a current, approved protocol **on file** is subject to recoupment of payment.

The counseling is a service-related item, not a drug, and must be billed on an approved electronic professional claim. See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

BILLING ON A PROFESSIONAL claim

- Use diagnosis code Z30.09 (contraceptive management).
- Use the following procedure code and modifier to bill for EC counseling:

Procedure Code	Modifier	Description	Maximum Allowable Fee
99605	FP	EC Counseling	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

What is the Patient Review and Coordination (PRC) Program?

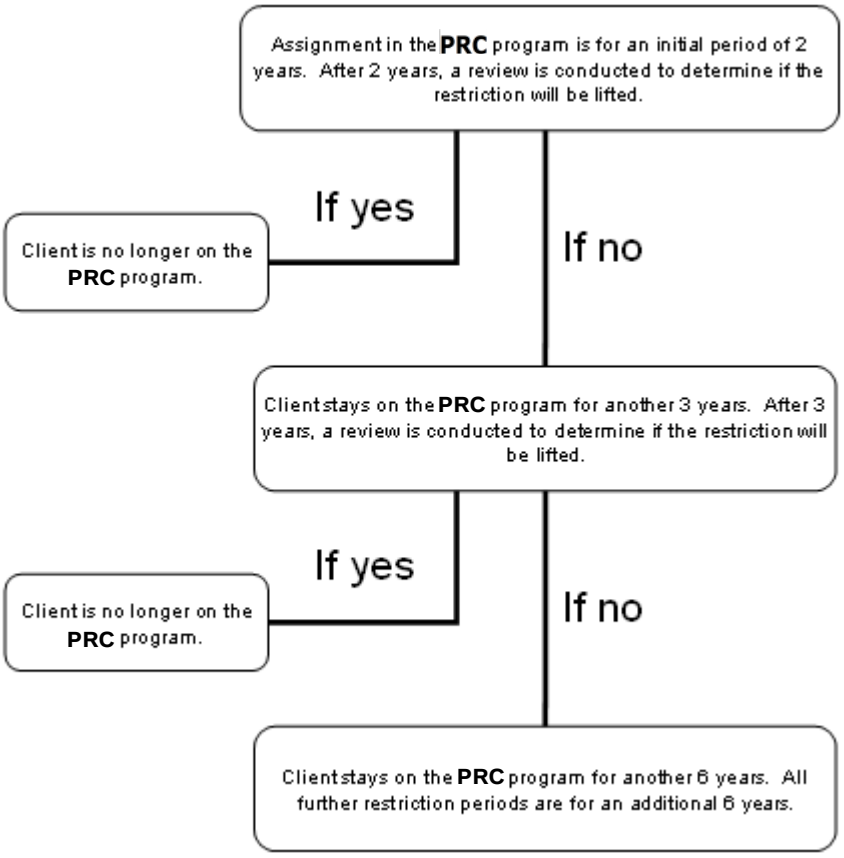
(WAC 182-501-0135(8)(a))

PRC is a health and safety program for fee-for-service (FFS) and managed care clients needing help in the appropriate use of medical services.

Clients assigned to the PRC program are identified as such in ProviderOne.

When a client is initially placed in the PRC program, the agency or managed care organization (MCO) places the client for no less than 24 months with one or more of the following types of health care providers:

- Primary care provider (PCP)
- Pharmacy for all prescriptions
- Prescriber of controlled substances
- Hospital for nonemergency services unless referred by the assigned PCP or a specialist. A client may receive covered emergency services from any hospital
- Another qualified provider type, as determined by the agency or MCO staff on a case-by-case basis



PRC criteria

Agency or MCO staff use the following usage guidelines to initiate a review for PRC placement. A client may be placed in the PRC program when either the client's medical history or billing history, or both, documents any of the following:

- Any two or more of the following conditions occurred for the client in a period of 90 consecutive calendar days in the previous 12 months:

  - ✓ Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice
  - ✓ Had prescriptions filled by four or more different pharmacies
  - ✓ Received ten or more prescriptions
  - ✓ Had prescriptions written by four or more different prescribers not located in the same clinic or practice
  - ✓ Received similar services on the same day not located in the same clinic or practice
  - ✓ Had ten or more office visits

-OR-

- Any one of the following occurred for the client within a period of 90 consecutive calendar days in the previous 12 months:

  - ✓ Made two or more emergency agency visits
  - ✓ Exhibits **at-risk** usage patterns
  - ✓ Made repeated and documented efforts to seek health care services that are not medically necessary
  - ✓ Was counseled at least once by a health care provider, or an agency or an MCO staff member with clinical oversight, about the appropriate use of health care services

-OR-

- The client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the 90-day review period.

-OR-

- The client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous 12 months:

  - ✓ Using health care services in a manner that is duplicative, excessive, or contraindicated

  - ✓ Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice

  - ✓ Being on substance abuse programs such as the alcohol and drug abuse treatment and support act (ADATSA)

(See WAC 182-501-0135(6)(a)-(d))

What is the pharmacy's role in the PRC Program?

The assigned pharmacy is a key player in managing the client's prescriptions. The pharmacist will be able to alert the client's primary care physician (PCP), narcotic prescriber, or the agency's PRC staff of misuse or potential problems with the client's prescriptions.

Since pharmaceuticals are an agency-covered service, do not accept cash from clients except for drugs not covered by the agency under WAC 182-502-0160.

A major focus of the PRC Program is education. Educating the client on appropriate use of prescriptions, drug interactions, the importance of maintaining one PCP and pharmacy to manage and monitor one's care are key elements in helping the client appropriately use services.

Clients who have been in the PRC program have shown a 33% decrease in emergency room use, a 37% decrease in physician visits, and a 24% decrease in the number of prescriptions.

What happens if a restricted client goes to a non-assigned pharmacy?

If a restricted client goes to a **non-assigned pharmacy**, the POS system will reject the claim. In the case of a non-emergency situation, the client should be referred back to their assigned pharmacy.

Washington State has the **prudent layman's** law, in which clients can go to the emergency room **if they think** they have a problem and must be seen by the emergency room staff. However, emergency room prescriptions cannot be overridden in the POS system by a non-assigned PRC pharmacy. In this situation, the pharmacist may call the PRC referral line during regular business hours (Monday-Friday, 8 a.m. – 5 p.m.) at 1-360-725-1780 to request an override.

At their discretion in an emergency situation, pharmacists may fill all medications except scheduled drugs, unless verification is made with the prescriber that there is a legitimate medical necessity. Justification for the emergency fill must be provided to the PRC Program the next business day in order for an override to be completed.

For more information, or to report over-utilization of services, contact:

Patient Review and Coordination (PRC) Program
PO Box 45530
Olympia, Washington 98504-5532
Phone: 1-800-562-3022, ext. 15606
FAX: 1-360-725-1969

Visit the agency's Patient Review and Coordination (PRC) Program webpage.

How are agency-covered vaccines and vaccine administration fees billed?

- All covered vaccines other than influenza, pneumonia, and Zostavax® must be billed on a professional claim. See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

- Administration fees must be billed on a professional claim (including influenza, pneumonia, and Zostavax® for clients age 18 and younger). The POS does not have the capability to reimburse for professional services other than dispensing fees.

- The agency reimburses qualified pharmacists for the administration of all agency-covered vaccines for clients on eligible programs.

- The agency does not reimburse for any vaccine available free from the Department of Health (DOH).

- Influenza and pneumonia vaccines for adults (age 19 and older) are reimbursed through the POS system only.

Clients age 18 and younger

The agency pays **only the administration fee** for any vaccine available at no cost from the DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program.

Which vaccines are covered and are they available free from DOH?

To check which vaccines are **free from DOH,** refer to the Professionally Administered Drug Fee Schedule.

Billing for the administration of a vaccine available free from DOH

Bill for the administration of these vaccine(s) with the appropriate procedure code for the vaccine and use modifier SL (e.g., 90707 SL).

Billing for vaccines that are not free from DOH

- Bill for the cost of the vaccine with the appropriate procedure code for the vaccine.
- Bill for the vaccine administration using CPT® codes 90471 (first vaccination) and 90472 (additional vaccinations). The agency limits reimbursement to a maximum of one unit of 90471 and one unit of 90472 per client, for the same date of service.
- The administration codes must be billed on the same claim as the procedure code for the vaccine.
- DO NOT use modifier SL with these vaccines.

How must a pharmacy bill the agency for influenza, pneumonia, and Zostavax® vaccine?

Pharmacists must bill for flu and pneumonia vaccines for clients age 19 years and older with national drug codes (NDCs) through the point-of-sale (POS) system, and for the administration on a professional claim as follows:

Billing for vaccine administration

The agency pays pharmacists for administering influenza, pneumonia, and Zostavax® (shingles) vaccinations only if they have an immunization collaborative practice protocol on file with the Washington State Department of Health (DOH), State Board of Pharmacy. When billing for the administration of an agency-covered vaccine, the pharmacist's NPI must be entered in the **Prescriber ID** field (411-DB).

Note: Pharmacies may **not** use their Pharmacy Location NPI as the Provider NPI.

Procedure Code	Description	Maximum Allowable Fee
G0008	Administration of influenza virus vaccine	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule
G0009	Administration of pneumococcal vaccine	
90471	Administration of Zostavax® vaccine	

The agency pays pharmacies for procedure codes G0008, G0009 and 90471 (administration codes) when billed with place of service 01 (pharmacy).

Bill the agency for the vaccine administration using only an approved electronic professional claim. See the agency's ProviderOne Billing and Resource Guide for general billing instructions. Vaccine administrations **cannot** be billed through the pharmacy POS system.

Note: When billing on an electronic professional claim, use the NPI – **do not** use the NCPDP number. Continue to bill the influenza, pneumonia, or Zostavax® vaccine itself through the POS system using the NDC.

What diabetic supplies does the agency cover?

The agency covers diabetic supplies through the pharmacy point-of-sale system as follows:

- Omnipods for diagnosis of type 1 diabetes. PA is required. Limited to 15 units per 30 days.

- Diabetic test strips and lancets:

  - ✓ For children, age 20 and younger, as follows:

    - ➢ Insulin dependent, 300 test strips and 300 lancets per client, per month. EPA is required.
    - ➢ Noninsulin dependent, 100 test strips and 100 lancets per client, per month.

  - ✓ For adults age 21 and older:

    - ➢ Insulin dependent, 100 test strips and 100 lancets per client, per month. For pharmacy POS, EPA is required.
    - ➢ For noninsulin dependent, 100 test strips and 100 lancets per client, every 3 months.

  - ✓ For pregnant women with gestational diabetes or had diabetes prior to pregnancy, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to 60 days postpartum. For pharmacy POS providers, Expedited Authorization required.

- Syringes and needles.

- Alcohol wipes.

- For other covered diabetic supplies, see the Medical Equipment and Supplies Billing Guide for more information on covered products and services related to diabetic supplies.

For expedited codes and criteria, see the agency's Expedited Authorization List.

Does the agency reimburse for human papillomavirus (HPV) vaccine?

GARDASIL®
The agency reimburses for GARDASIL® (HPV (Types 6,11,16,18) Recombinant Vaccine). See the Immunizations in Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

Does the agency reimburse for flu prevention medication?

The agency reimburses for oseltamivir, without prior authorization (PA).

PA is required for all other flu prevention medications.

What form is used to bill for pre-filling syringes?

Fees for pre-filling syringes may be billed on an approved electronic claim professional claim.

These fees are not billable on POS.

- Each unit billed must be for a two-week supply
- The maximum number of units allowed per month is three

Use the following HCPCS code:

Description	HCPCS Code	Maximum Allowable
Pharmacy compounding and dispensing services (to be used for pre-filling syringes)	S9430	See the Pharmacy Special Services, Vaccine Administration, and Compliance Packaging fee schedule

ADHD (attention deficit hyperactivity disorder) safety edits

The agency promotes the safe and effective use of attention deficit hyperactivity disorder (ADHD) medication. The agency requires PA for prescriptions for clients receiving ADHD drugs when exceeding the recommended maximum dosage limits or when ADHD therapy duplications occur.

For clients age 17 and younger, see the agency's Second Opinion Program webpage for more information on additional PA requirements.

Second Opinion Program

The Second Opinion Program is designed to improve prescribing practices for children ages 17 and younger. In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, the agency established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers.

The guidelines include, but are not limited to, the following:

- Alpha-agonist age and dose limits
- Antidepressant therapy duplications
- Antipsychotic age and dose limits
- Antipsychotic therapy duplications
- Attention deficit hyperactivity disorder (ADHD) age and dose limits
- ADHD therapy duplications
- Insomnia medications
- Mental Health Polypharmacy (medication therapy includes five or more mental health drugs)

As part of the authorization process, a prescriber must engage in a telephone consultation with an agency-designated mental health specialist from the Second Opinion Network (SON). A SON representative will contact the prescriber to schedule the required phone consultation. To receive payment for the telephone consultation with SON, bill the agency using procedure code 99441 on the claim.

At the time of the authorization request, the agency will approve continuation of pre-existing drug therapy until the SON consultation process is complete. Agency authorization decisions will be based on the recommendations to the agency by the SON mental health specialist.
For more information on the second opinion program and the pediatric mental health guidelines, see the agency's Second Opinion Program webpage.

Oral, Transdermal, and Intra-Vaginal Hormonal Contraceptives

The agency requires oral, intra-vaginal, and transdermal hormonal contraceptives to be dispensed in a 12-month supply (See WAC 182-530-2000 (1)(b)(iii)), unless otherwise indicated by the prescriber or requested by the client. For the purposes of dispensing these contraceptive products, **12-month** means a 365-day supply. If less than a 12-month supply is indicated or requested, providers may use an expedited authorization code from the Apple Health EA list to dispense less than a 12-month supply. There is no minimum quantity of emergency contraception required to be dispensed.

> **Note:** When submitting a claim with an EA code, you must document on the prescription the code that was used and the reason.

Cough and cold drug coverage

The agency restricts coverage of drugs used to treat cough and colds to those drugs listed on the Covered Cough/Cold Product List. The agency bases its decision on which drugs to place on this list using evidence of efficacy and safety and current best practices.

OTC drugs used to treat cough and colds which are not on the **Covered Cough/Cold Product List** are non-covered and may be billed directly to the client as a non-prescribed OTC. **Prescription drugs** used to treat cough and colds which are not on the **Covered Cough/Cold Product List** may be purchased by the client with a signed waiver. (See **Billing the Client**, WAC 182-502-0160 and Coordination of Benefits.)

Generics first (GF)

The agency requires that a preferred generic drug be used as a client's first course of treatment within specific drug classes on the Apple Health (Medicaid) Fee-For-Service Preferred Drug List (PDL). Only clients who are new to a drug class will be required to start on a preferred generic product. When a client has not received a drug in one of these drug classes within 180-days prior to the date of the fill, the agency's POS system will reject claims for both non-preferred and preferred brand name drugs as well as non-preferred generic drugs.

If the brand name drug has been prescribed by a non-endorsing practitioner, or by an endorsing practitioner who has not indicated Dispense As Written (DAW), the brand will **not** be covered by the agency. If the prescriber is an endorsing practitioner, and Therapeutic Interchange is allowed in the drug class, the product should be switched to a preferred drug. Otherwise, when requested to do so by POS return messaging, contact the prescriber to request a change of the prescription to a preferred generic drug.

If the prescription is signed "DAW" by an endorsing practitioner for a drug within a GF drug class, contact the agency to request authorization. The agency will provide the endorsing practitioner with an opportunity to justify the medical necessity for starting the client on a brand name drug or a non-preferred generic as their first course of therapy.

The agency will cover only preferred generic drugs as a client's first course of therapy within the following drug classes:

- ACE inhibitors
- Attention Deficit Hyperactivity Disorder (ADHD) drugs
- Beta blockers
- Estrogens
- Estrogen – progestin combinations
- Long-acting opioids
- Nasal corticosteroids
- Newer antihistamines
- Newer sedative/hypnotics
- Nonsteroidal anti-inflammatory drugs (NSAIDS)
- Overactive bladder/urinary incontinence
- Proton pump inhibitors (PPI)
- Second generation antidepressants
- Second generation antipsychotics
- Skeletal muscle relaxants
- Statin-type cholesterol-lowering agents

Medication assisted treatment (MAT)

The agency's Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (MAT) and links to the Medication Assisted Treatment request forms can be found on the agency's Apple Health (Medicaid) Drug Coverage Criteria webpage.

Voluntary treatment

For clients eligible in a voluntary recipient aid category (RAC), some prescriptions for related treatment will require retro-authorization. To request payment for prescriptions related to voluntary treatment that require authorization, contact applehealthpharmacypolicy@hca.wa.gov and include the following information:

- Client name (first and last)
- Client date of birth
- Client ProviderOne ID
- Date of service
- Drug name
- Drug NDC
- Drug quantity, days supply, and directions for use
- Prescriber name and NPI
- Pharmacy name and NPI

For more information on voluntary treatment and voluntary RAC, please see the agency's Mental health services billing guide.

Authorization for proton pump inhibitors (PPIs)

The agency limits proton pump inhibitors (PPIs) to one tablet/capsule per day for 60 days during any 12-month period. The agency may authorize more than 60 days per 12-month period and/or more than one tablet/capsule per day for patients taking certain medications or who have one of the following chronic medical conditions:

Chronic medical conditions include:

- Pathological gastric acid hypersecretion, such as Zollinger-Ellison syndrome
- Barrett's esophagus
- Esophageal stenosis/stricture or Schatzki ring
- Recent erosive/ulcerative esophagitis or duodenal/gastric ulcer

Concurrent medications include:

- Chronic NSAID use (including aspirin greater than or equal to 325 mg per day)
- Chronic low-dose aspirin with history of a GI bleed
- Chronic high-dose systemic steroid
- Antiplatelet or anticoagulant
- Bisphosphonate where there are pre-existing esophageal disorders
- Pancreatic enzyme
- Cancer Therapies

Prescribers should:

- Re-evaluate therapy for patients diagnosed with GERD.
- Gradually reduce the dose of the PPI over 30 days and discontinue, using an H2RA (e.g. ranitidine 400 mg daily) to reduce the occurrence of rebound acid reflux.
- Discuss with their patients the guidelines on the management and treatment of GERD.
- Consider endoscopy for patients unable to control symptoms caused by GERD after 8 weeks of PPI treatment followed by a 30-day cross-taper to an H2RA.

The American College of Gastroenterology (ACG) guidelines recommend the following for the treatment of GERD:

- Weight loss
- Head of bed elevation
- Avoidance of meals 2-3 hours before bedtime
- PPI for 8 weeks

For the complete Apple Health (Medicaid) PPI policy and sample taper plan, please visit the Apple Health (Medicaid) Drug Coverage Criteria webpage.

What is the agency's clinical policy for opioid prescriptions?

For information and resources regarding the agency's Apple Health (Medicaid) opioid clinical policy, refer to the agency's Opioid webpage.

Does the agency cover over-the-counter (OTC) drugs?

The agency has reviewed and determined that the OTC drugs on the "Covered Over-the-Counter Drug List" list are the least costly therapeutic alternatives for medically accepted indications. (See WAC 182-530-2000(1)(d))

Visit the Medicaid Coverage Lists for more information.

Note: OTC family planning products and OTC drugs used to treat cough and colds are governed under different rules and have their own coverage lists.

OTC drugs not included on any agency Covered Drug List are non-covered and may be billed directly to the client as a non-prescribed OTC.

Where is information available for Synagis®?

For information on Synagis, see the *Drugs Professionally Administered* section in the agency's current Physician Related Services/Health Care Professional Services Billing Guide.

What does emergency fill mean?

Emergency fill means that the dispensing pharmacist used their professional judgment to meet a client's urgent medical need and dispensed the medication to the client prior to receiving reimbursement from the agency.

The agency guarantees payment on claims for emergency fills. The agency will authorize rejected claims upon request if the medication was dispensed as an emergency fill.

For more information and guidelines on emergency fills, see the agency's Emergency Fill Policy.

Does the agency pay for hemophilia - and von Willebrand-related products for home administration?

(WAC 182-531-1625)

The agency does not pay for hemophilia- and von Willebrand-related products for administration in the home when dispensed through and billed by retail or specialty pharmacies. The agency pays for hemophilia- and von Willebrand-related products shipped to fee-for-service clients **only** when the products are provided through a qualified hemophilia treatment center of excellence (COE).

> **Note:** If a client has not yet established a care relationship with a qualified hemophilia COE, but an initial appointment has been scheduled, specialty pharmacy providers may contact the agency to request an authorization to continue to dispense product to the client. The pharmacy must call the agency's Pharmacy Authorization Section at 800-562-3022, extension 15483.

What is the criteria to become a Qualified Hemophilia Center of Excellence (COE)?

To become a qualified hemophilia COE, a hemophilia center must meet all of the following:

- Have a current core provider agreement in accordance with WAC 182-502-0005
- Be a federally approved hemophilia treatment center (HTC) as defined in Definitions and meet or exceed all Medical and Scientific Advisory Council (MASAC) standards of care and delivery of services
- Participate in the public health service 340B provider drug discount program and be listed in the Medicaid exclusion files maintained by the federal Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA)
- Submit a written request to the agency to be a qualified hemophilia treatment center of excellence and include proof of the following:
  - ✓ U.S. Centers for Disease Control (CDC) and prevention surveillance site identification number
  - ✓ Listing in the hemophilia treatment center (HTC) directory
  - ✓ Receive written approval including the conditions of payment and billing procedures from the agency

To be recognized as a qualified hemophilia COE, submit a written request to:

Hemophilia Treatment COE
Health Care Authority – Health Care Services
PO Box 45506
Olympia WA 98504-5506

What annual documentation is required to remain a qualified hemophilia COE?

To remain a qualified hemophilia COE, the hemophilia COE must annually submit both of the following to the agency:

- Copies of grant documents and reports submitted to the Maternal and Child Health Bureau/Human Resources and Services Administration/Department of Health and Human Services, or to their designated subcontractors

- Proof of continued federal funding by the National Hemophilia Program and listing with the regional hemophilia network and the CDC

To view the list of qualified Centers of Excellence (COE) for hemophilia treatment, see the agency's current Physician-Related Services/Health Care Professional Services Billing Guide

Where is information available for Alpha Hydroxyprogesterone (17P) and Makena?

For information on Alpha Hydroxyprogesterone (17P) and Makena, see the *Drugs Professionally Administered* section in the agency's current Physician Related Services/Health Care Professional Services Billing Guide.

Authorization

Note: Authorization does not guarantee payment. All administrative requirements (client eligibility, claim timeliness, etc.) must be met before the agency can reimburse a claim.

When does the agency require authorization?

(WAC 182-530-3000)

Pharmacists are required to obtain authorization for some drugs and drug-related supplies **before** providing them to the client. Other drugs require authorization only when specific limits on dosage, quantity, usage, or duration of use are exceeded. The agency may also require **situational** authorization that is not directly related to the product being dispensed. These situations include, but are not limited to:

- Early refills
- Therapeutic duplications
- Client's whose usage patterns are under review
- More than four prescriptions or prescription refills per calendar month for the same product in any of the following categories:
  - ✓ Antibiotics
  - ✓ Anti-asthmatics
  - ✓ Schedule II and III drugs
  - ✓ Anti-neoplastic agents
  - ✓ Topical preparations
  - ✓ Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations
- More than two prescriptions or prescription refills per calendar month for any other product

The agency reviews authorization requests for medical necessity. The requested service or item must be covered within the scope of the client's program.

Exception: In emergency situations, pharmacists may fill prescription drugs that require authorization without receiving an authorization number prior to dispensing.

Note: To receive reimbursement, justification for the emergency fill must be provided to the agency no later than seven days after the fill date.

How do I obtain authorization?

To obtain authorization for drug products requiring authorization, providers may:

- Fax a *Pharmacy Information Authorization* form 13-835A to the agency at 1-866-668-1214.

- Call the agency at 1-800-562-3022.

What information must be provided to the agency for an authorization number?

When calling or faxing to request authorization, the following information must be provided:

- Previous authorization number, if available
- Pharmacy NCPDP #
- Pharmacy NPI#
- Rx #
- Quantity and day's supply
- Tried and failed
- Client's ProviderOne Client ID
- National Drug Code (NDC) being dispensed
- Prescriber's name and specialty (if known)
- Prescriber's phone and fax number
- Date(s) of dispense
- Justification for the requested service:

    ✓ The medical need for the drug and/or dosing (sig)
    ✓ The diagnosis or condition of the client
    ✓ Other therapies that have been tried and failed in the treatment of the same condition

The agency may request additional information, depending on the drug product.

If the request for authorization is missing any required information, it will be considered invalid, and the agency may not process the request.

Who determines authorization status for drugs in the agency's drug file?

(WAC 182-530-3100(1))

For drugs included in the Apple Health (Medicaid) Preferred Drug List (PDL), authorization status is determined by, but not limited to, its designation as preferred or non-preferred.

For drugs **not** included in the PDL or drugs that require authorization beyond PDL requirements, agency pharmacists, medical consultants, and the Drug Use Review Team evaluate drugs to determine authorization status of the drug file. The agency may consult with an evidence-based practice center, the Drug Use Review (DUR) Board, or participating agency providers in this evaluation.

How is authorization status determined for drugs in the agency's drug file?

(WAC 182-530-3200(2) and (3))

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the agency pharmacist(s) a written request and all of the following supporting documentation:

- Background data about the drug
- Product package information
- Any pertinent clinical studies
- Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process
- Any additional information the manufacturer considers appropriate

The agency evaluates a drug based on, but not limited to, the following criteria:

- Whether the manufacturer has signed a federal drug rebate contract agreement
- Whether the drug is a less-than-effective drug
- The drug's risk/benefit ratio
- Whether like drugs are on the agency's drug file and a less costly therapeutic alternative

- Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage
- The drug's potential for abuse
- Whether outcome data demonstrate that the drug is cost effective

What authorization status may be assigned to a drug?

The agency may determine that a covered drug is:

- Covered without restriction
- Requires authorization
- Requires authorization when exceeding the agency-determined limitations

Decisions regarding restrictions are based on, but are not limited to:

- Client safety
- FDA-approved indications
- Quantity
- Client age and/or gender
- Cost

Note: For drugs with age or dose limitations, physicians and pharmacists should monitor the use of these drugs and counsel patients when they exceed limits. Authorization is required to exceed age and dose limits.

How are drugs added to the agency's drug file?

(WAC 182-530-3000(2) and (3))

The agency's drug file is maintained by Medi-Span® (a drug file contractor). Manufacturers must report their products to Medi-Span® for them to be included in the agency's drug file for potential coverage and reimbursement.

When can a medication be dispensed more than twice per month or filled early?

(WAC 182-530-3000(5)(b))

The agency allows medications to be dispensed more than twice per month under the following circumstances:

- Up to four prescription fills or refills per calendar month for the same product in any of the following categories:

  - ✓ Antibiotics
  - ✓ Anti-asthmatics
  - ✓ Schedule II and III
  - ✓ Anti-neoplastic agents
  - ✓ Topical preparations

- Up to six prescription fills or refills per calendar month of products containing buprenorphine which are FDA indicated for treatment of opioid dependence.

- The prescription is written for short days-supply because the client's prescriber is monitoring the client (examples: a client is suicidal, at-risk for potential drug abuse, suffers cognitive impairment that makes medication management difficult, or has compliance issues)

A pharmacy may allow multiple fills or early refills under the following circumstances:

- A client's prescription has been lost, stolen, or destroyed (only once every six months, per medication)

- A client needs a supply of medication due to travel (up to a 34-day supply once every 6 months, per medication). For more information on early fills for medication travel supplies, see Can clients receive early refills or extended days' supply for travel?

- A client needs a take-home supply of medication for school or camp, or for skilled nursing facility clients

- A client needs a refill sooner than originally scheduled due to a dosage change by the prescriber, and it does not require a third fill in the month, a pharmacist may override a "refill too soon" reject using DUR codes. The pharmacist must document the dosage change. For more information on the use of DUR codes, see What is the prospective drug use review (pro-DUR) used for?

For any other circumstance, the provider must contact the agency's Pharmacy Authorization Section to request approval and an authorization number. (See Resources Available.)

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If clients residing in a skilled nursing facility (SNF) have their prescription lost or stolen, the replacement prescription is the responsibility of the SNF. Clients who have trouble managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

Point-of-Sale billers must enter one of the following codes in both the **Claims Segment, Prior Authorization Type** Code (461-EU) field and the **Claims Segment, Prior Authorization Number Submitted** Code (462-EV) field.

Justification Description	**Code**
Lost or Stolen Drug Replacement	5
School or Camp	8
Monitoring	8
Suicidal Risk (SR)	8
Take Home Supply (Skilled Nursing Facility Client)	8

Can clients receive early refills or extended days' supply for travel?

(WAC 182-530-3000(5)(b))

The agency will allow an early refill up to a 34-day supply once every six months, per medication. The pharmacy must contact the agency's Pharmacy Authorization Section to request approval and an authorization number. (See Resources Available)

It is also possible to help clients who will be out of the area to receive refills covered by the agency at a time they are due for a regular refill. Providers may assist clients with any of the following options:

- If clients will not be out of state, they may have their prescription filled at any agency-contracted pharmacy throughout Washington or border areas of Idaho and Oregon.
- A pharmacist or a dispensing medical practitioner may mail medications that are not considered to be controlled substances to clients under their care. (See Title 21, Section 802(6) U.S.C. for the definition of controlled substances and the U.S. Postal Service website for additional restrictions and guidelines for mailing medications.) The agency does not cover the cost of shipping. The pharmacy is responsible for the cost of shipping. Clients must not be billed for shipping or postage costs. (WAC 182-502-0160(9)(c)).
- Some chain stores have the ability to "transfer stock," billing the prescription from a local Washington pharmacy, while having the medication dispensed from a store in another part of the country.

Is authorization required for brand name drugs?

Prescribers and pharmacies should prescribe and dispense the generic form of a drug whenever possible. Authorization is required for brand name drugs when any generic therapeutic equivalent is available. If the brand name drug is prescribed instead of a generic therapeutic equivalent, the prescriber must provide medical justification for the use of the brand name drug. Authorization is based on medical need, such as clinically demonstrated, observed, and documented adverse reactions which have occurred when generic therapeutic equivalents have been used.

Substitute generic drugs for listed brand name drugs when both of the following are true:

- They are approved by the FDA as therapeutically equivalent drugs.
- They are permitted by the prescribing physician under current state law.

To request authorization, call the agency at: 1-800-562-3022.

What is an exception to rule (ETR)?

The process used by the agency to consider the appropriateness of a non-covered item when that service is specifically needed for that client because their clinical needs are so different than the rest of the population.

Providers may request an ETR to request coverage for a non-covered service by contacting the agency and providing the necessary information for the program to make a decision in each client's individual case.

For detailed requirements regarding ETR requests for a non-covered product (see WAC 182-501-0160).

What is expedited authorization (EA)?

(WAC 182-530-3200(4))

The agency's EA process is designed to eliminate the need to request authorization from the agency. The intent is to establish authorization criteria and associate these criteria with specific codes, enabling providers to create an "EA" number when appropriate.

How is an EA number created?

To bill the agency for drugs that meet the expedited authorization criteria on the following pages, the pharmacist must create an 11-digit EA number. The first 8 digits of the EA number must be **85000000.** The last 3 digits must be the code number of the diagnosis/condition that meets the EA criteria.

> **Point of Sale billers** must enter the EA Number in the **Claims Segment, Prior Authorization Number Submitted** field.
>
> **Example:** The 11-digit EA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **85000000002** (85000000 = first eight digits, 002 = diagnosis/condition code).

Reminder: EA numbers are only for products listed in the Expedited Authorization Code and Criteria Table. EA numbers are not valid for any of the following:

- Other drugs requiring authorization through the Prescription Drug Program.
- Waiving the State Maximum Allowable Cost (MAC) or Automated Maximum Allowable Cost (AMAC) price.
- Authorizing the third or fifth fill in the month.

> **Note:** Use of an EA number does not exempt claims from edits, such as per-calendar-month prescription limits or early refills.

EA guidelines:

- **Diagnoses -** Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet the conditions for EA. Drug claims submitted without an appropriate diagnosis/condition code for the dispensed drug are denied.

- **Unlisted Diagnoses -** If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EA list, additional justification is required. The pharmacist must request authorization by either one of the following:

  - ✓ Phone 1-800-562-3022
  - ✓ Fax 1-866-668-1214

- **Documentation** - Dispensing pharmacists must write both of the following on the original prescription:

  ✓ The full name of the person who provided the diagnostic information
  ✓ The diagnosis/condition and/or the criteria code from the attached table

Reimbursement

What in general does the agency need to process a reimbursement for services?

- **Remember** the agency is a taxpayer-funded program and the payer of last resort - meaning providers must pursue all other possible medical coverage first. See Coordination of Benefits for more information.

- The agency is required to be a prudent purchaser on behalf of the taxpayer. Drug reimbursements are subject to federal upper limit (FUL) payment rules (see Reimbursement), and the agency is permitted to pay for outpatient drugs only when the manufacturer has a signed drug rebate contract with the federal Department of Health and Human Services (DHHS). See Drug Rebate Program for more information.

- Bill the agency the usual and customary charge using the complete 11-digit national drug code (NDC) from the dispensing container.

- Accurately report the quantity dispensed, using the appropriate metric or metric decimal quantity for the product.

- Delivery of a service or product does not guarantee payment. For example, the agency does not reimburse when:

  - ✓ The request for payment is not presented within the 365-day billing limit. (See Billing)
  - ✓ The service or product is not medically necessary or is not reimbursable by the agency.
  - ✓ The client has third party coverage and the third party pays as much as, or more than, the agency allows for the service or product.
  - ✓ The service or product is covered in the managed care capitation rate.
  - ✓ The service or product is included in the Nursing Home per diem rate.
  - ✓ The client is no longer eligible or isn't eligible for the drug being dispensed.
  - ✓ A prescription has been used to meet a client's financial obligation towards spenddown.

How does the point-of-sale (POS) system establish reimbursement rates?

(WAC 182-530-7000)

The point-of-sale (POS) actual acquisition cost (AAC) is adjudicated by the payment system based upon the available prices in the drug file. Depending on the status of the drug, POS reimburses at the lowest of the available rates using the following price points:

- National average drug acquisition cost (NADAC)
- Maximum allowable cost (MAC)
- Federal upper limit (FUL)
- Automated maximum allowable cost (AMAC)
- Provider's usual and customary charge to the non-Medicaid population
- AAC for drugs purchased under section 340 B of the Public Health Services (PHS) Act and dispensed to medical assistance clients.

Note:

- If the pharmacy provider offers a discount, rebate, promotion or other incentive that directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to the agency for the prescription. (Example: A $5.00 off coupon for purchases elsewhere in the store.)
- Any drug or product provided free to the general public must also be provided free to the Medicaid customer.

How does the agency determine the actual acquisition cost (AAC)?

(WAC 182-530-8000)

The agency uses the following sources to determine point-of-sale actual acquisition cost (POS AAC) including, but not limited to:

- National average drug acquisition cost (NADAC) published by the Centers for Medicare and Medicaid Services (CMS)
- Acquisition cost data made available to the agency by audits from state or federal agencies, other state health care purchasing organizations, pharmacy benefit managers, individual pharmacy providers, other third-party payers, drug file databases, actuaries and other consultants.

How are federal upper limits calculated?

(WAC 182-530-8050)

Federal upper limits (FUL) for multiple source drugs are calculated by DHHS, Centers for Medicare and Medicaid (CMS). The agency is required to comply with the federal limits.

FUL rules are being revised in response to the federal Deficit Reduction Act and are currently in draft circulation for comment.

> **Note:** For more information, see CMS Federal Upper Limits.

Drugs subject to FUL may also be subject to other agency pricing methodologies. The agency reimburses the lower of AAC, MAC, AMAC, FUL, or usual and customary charges.

How is the automated maximum allowable cost (AMAC) calculated?

(WAC 182-530-8150)

The agency establishes the automated maximum allowable cost (AMAC) reimbursement for all products within a generic code number sequence at the actual acquisition cost (AAC) of the lowest priced rebate-eligible product in the sequence. AMAC is recalculated each time there is a pricing update to a product in the sequence.

When is the maximum allowable cost (MAC) applied?

(WAC 182-530-8150)

The maximum allowable cost (MAC) may be applied to specific, equivalent multiple-source drugs. If applied, the agency reimburses both the brand name and generic drugs at the MAC price.

The MAC may be waived for:

- Preferred drugs
- Some **Dispense as Written** (DAW) prescriptions
- Limited other circumstances

Visit the most up-to-date MAC list.

How is tax computed?

Tax is computed by the point-of-sale (POS) system for items that the Washington State Department of Revenue determines to be taxable.

What are the agency's dispensing fees?

(WAC 182-530-7050)

The agency uses a three-tier dispensing fee structure with an adjusted fee allowed for pharmacies that participate in the Unit Dose programs. Listed below are the agency's dispensing fee allowances for pharmacies:

High-volume pharmacies (over 35,000 Rx/yr) $4.24/Rx
Mid-volume pharmacies (15,001-35,000 Rx/yr) $4.56/Rx
Low volume pharmacies (15,000 Rx/yr and under) $5.25/Rx
Unit dose systems $5.25/Rx

A provider's dispensing fee is determined by the volume of prescriptions the pharmacy dispenses for all customers, not just Apple Health (Medicaid) clients.

Providers are required to respond to an annual prescription count survey.

Return the annual prescription count survey to:
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562

Does the agency pay dispensing fees for non-drug items?

(WAC 182-530-7050)
The agency does not pay a dispensing fee for non-drug items, devices, or supplies unless the agency determines that the drug file is not maintaining prices sufficient to cover product cost.

How is the drug rebate program used?

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates that states claim federal financial participation (FFP) **only** for outpatient prescription drugs supplied by a drug manufacturer who has entered into a **drug rebate contract** with the Department of Health and Human Services.

> **Note:** Providers must bill the actual and complete 11-digit NDC for the drug dispensed and the actual quantity, using the appropriate unit of measure.

Using an incorrect NDC or inaccurate reporting of a drug quantity will cause the agency to report false drug rebate calculations to manufacturers.

> **Note:** To download the agency's version of the Federal List of Drug Manufacturers Participating in the Centers for Medicare and Medicaid (CMS), visit the agency's Pharmacy webpage and download the Participating Drug Rebate Manufacturers List.

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general instructions for billing?

- Providers must follow the billing requirements found in the agency ProviderOne Billing and Resource Guide.
- Bill the agency your usual and customary charge using the complete 11-digit NDC from the dispensing container.
- Report the actual quantity dispensed using the appropriate metric or metric decimal quantity for the product.
- Remember that the agency is the payer of last resort. See "Coordination of Benefits" later in this section. **(Claims paid inappropriately when other coverage is available may be recouped.)**
- Clients who are enrolled in an agency-contracted managed care organization (MCO) are eligible for pharmacy services under their designated plan. **Bill the client's MCO first.**

Note: When another insurer or an agency-contracted MCO requires authorization for a drug, perform all steps necessary to obtain the authorization. Requiring authorization is not the same as a denial of coverage.

How do I bill electronically for services?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, under Webinars.

See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

What is point-of-sale (POS)?

The agency's POS system is a real-time pharmacy claims processing system which uses the National Council for Prescription Drug Programs (NCPDP) version D.0 format. Each claim submission, reversal, or re-bill that is successfully transmitted via a switch vendor is captured and appears on the weekly Remittance and Status Report (RA). Track each transaction and reconcile the RA completely before contacting the agency.

What do the POS rejection codes mean?

The agency's POS system uses NCPDP D.0 reject codes. Although these codes have meaning within the NCPDP standard, the agency's POS system returns a message of explanation with any claim rejection. As the complexity of prescription drug benefit management increases, it is important for the agency to provide clear explanations of denial in real time. It is also important for pharmacies to read these messages so they can take appropriate action when serving mutual clients. The agency returns reject messages up to 80 characters in length, viewable within most POS applications. If providers do not know how to access these reject messages, they must contact their software vendor for assistance.

Agency providers cannot accept payment from clients for any service potentially covered under the client agency benefit. See the Billing section within this guide. **It is important for providers to understand that a claim rejection through the POS system is not necessarily a denial of service.** Some claim rejections represent a final denial by the agency, while others may indicate additional steps are necessary to determine coverage for the product or service.

The chart below outlines categories of potential reasons for claim rejection, rather than specific rejection messages.

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
The message starts with 'TIP'	Therapeutic Interchange Program is required under Senate Bill 6088; Chapter 29, Laws of 2003 See the Therapeutic Interchange Program and the Apple Health (Medicaid) Fee-For-Service Preferred Drug List section in this guide	The pharmacist must substitute a preferred drug for the non-preferred drug prescribed, unless the prescription is ordered Dispense As Written (DAW)	Not a denial of service If the prescription is a DAW, resubmit claim with Product Selection Code of 1 If not DAW, dispense a preferred therapeutic alternative within the same drug class
The message starts with "Non-Preferred or NonPref"	Product prescribed is non-preferred for agency clients	See the Apple Health (Medicaid) Fee-For-Service Preferred Drug List Consult prescriber to determine whether a preferred alternative can be prescribed If the medication cannot be changed to a preferred alternative, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency
Detail of missing or invalid codes. (Any standard NCPDP D.0 reject code which states "M/I")	A required field has been left blank, or an invalid value has been submitted in a field that could affect claim adjudication	Correct claim and resubmit	Not a denial of service. A claim must be re-submitted with valid values to determine coverage

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
Drug Use Review (DUR) edits (NCPDP D.0 reject code 88)	Pro-DUR editing has found a potential therapy problem	If claim information is correct, the pharmacist should use professional judgment or confer with the prescriber to determine the appropriateness of therapy If therapy is appropriate, NCPDP pro-DUR codes can be used to indicate what professional intervention occurred	Dependent on result of professional services If appropriate, DUR codes have been entered, and the claim is still rejected, call Pharmacy Authorizations at 1-800-562-3022 to request assistance An agency representative will determine whether authorization is required, or if service has been denied
Labeler Has No Federal Rebate Agreement	The manufacturer has not chosen to make its products available for dispense to agency clients	Dispense an equivalent product from a manufacturer who participates in the Federal Rebate Program	Not a denial of service An equivalent product must be substituted and the claim resubmitted with the new NDC

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
States 'Maximum' or 'Minimum' in relation to quantity, days supplied, client age, fills per month, etc.	The agency has established therapeutic parameters for the use of the product. Claims may be authorized outside of those conditions	Verify accuracy of the submitted claims information. If all information is accurate, contact prescriber to consider alternate therapies within FDA indications. If prescriber still feels that the product should be dispensed as prescribed, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency
States that a product is 'not billable through POS', states 'Bill as a professional service'; or 'Refer to DME/Non-DME Washington Apple Health billing guides	The product is a potentially covered benefit, but not considered part of the client's prescription drug benefit	Consult appropriate Washington Apple Health billing guide and bill as a professional service on a professional claim, or comparable HIPAA compliant electronic claim format	Not a denial of service Benefit may be payable as Durable Medical Equipment, Enteral Nutrition, or a professional service
Expedited Authorization Code Required	See Authorization. The product has an expedited code available for authorization if specific criteria are met	Consult Expedited Authorization List in Authorization. If criteria are met, resubmit claim with appropriate EA code in the Prior Authorization Number Submitted field (462-EV). If criteria are not met, contact Pharmacy Authorization	Not a denial of service, unless authorization is requested and denied in writing by the agency

Rejection Message Description	Reason	Required Action	Service Denial by the Agency?
States that a product or situation is **NONCOVERED and** does not provide a toll free number	The product or situation is not a covered benefit for the client	Work with the client's prescriber to find an alternate covered therapy which meets the client's medical needs	Yes. The requested service is denied. If originally prescribed therapy has not been changed, POS denial as non-covered can be considered final
States PA required.	Product or situation requires authorization or other review by the agency	Pharmacy calls the toll free number indicated to request authorization or assistance	Not a denial of service, unless the request for authorization is denied in writing by the agency

What is the prospective drug use review (pro-DUR) used for?

The agency provides pro-DUR screening as a feature of the POS system. Early Refill, High Dose, Low Dose, and Therapeutic Duplication edits post and claims are rejected when potential drug therapy problems are identified. Once pharmacists have conducted their professional review, the agency-recognized NCPDP DUR Reason for Service, Professional Service, and Result of Service codes can be used to respond to the pro-DUR edits.

When appropriate, enter one of the NCPDP DUR codes from each of the categories in the appropriate POS field. Entering DUR codes will not automatically bypass DUR screening. The agency considers different codes to be appropriate for different situations. Only a combination of codes appropriate to address the potential therapy problem will satisfy the DUR screening process.

By placing the information on the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. POS claim coding is subject to review and audit by the agency.

The agency does not provide additional reimbursement for DUR services. DUR coding is supported for the purpose of ensuring potential drug therapy problems are addressed by a health care professional.

What is the national drug code (NDC)?

The NDC is an 11-digit code assigned to all pharmaceutical products by the labeler or distributor of the product under FDA regulations. (See WAC 182-530-1050.)

> **Note:** When submitting claims to the agency the provider must use the actual, complete 11-digit NDC from the dispensing container.
> (See WAC 182-530-5000(1)(b))

The agency accepts only the 5-4-2 NDC format. **All 11 digits, including zeros, must be entered**. The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

NCPDP Version D.0 claim format

In order to comply with the Health Insurance and Accountability Act (HIPAA) requirements, **the agency requires all pharmacy providers to use NCPDP Version D.0 claim format** when submitting point-of-sale (POS) claims. See the Payer Specification Sheet for more information.

General information

The NCPDP Version D.0 claim format:

- Defines the record layout for real-time prescription claim transactions between providers and processors.
- Is a variable format.
- Accepts up to four transactions per transmission (except when billing compounds, only one transaction is allowed per transmission).

What transaction segments are supported?

Transaction header segment
The transaction header segment is mandatory on all transactions and all fields within the segment are mandatory. The transaction header segment tells the system where to send the claim, what type of submission it is, how many transactions, who is submitting the claim, date of service, and the vendor certification number.

Patient segment
The patient segment is mandatory for all transaction types. The NCPDP standard requires the submission of Date of Birth (304-C4) and Patient Gender Code (305-C5) fields. The agency requires submission of the Patient Residence (384-4X) field depending on the situation. When appropriate and necessary for claim adjudication, use the following values in the Patient Residence field:

01 - To indicate the client resides at home, in an assisted living facility, group home, or adult family home
02 - To indicate the client resides in a skilled nursing facility
11 - To indicate a hospice patient whose claim is unrelated to their terminal condition
12 - To indicate an ITA claim

Insurance segment
The insurance segment is mandatory on all transactions except reversals (B2).

This segment contains data describing the ProviderOne Client ID. The client's ProviderOne Client ID is required in the Cardholder ID field, and Patient Relationship Code should be set to 1.

Claim segment
The claim segment is mandatory on all billing (B1, B2, B3), and some authorization (P1, P2) transactions. This segment contains data relating to the dispensing of the actual prescription, or when authorization is requested. Some fields are required only for billing transactions. The claim segment is also used to identify a partially filled prescription, and some fields are required only when submitting a partial fill.

Prescriber segment
The prescriber segment contains data describing the prescriber and is required on all authorization (P1, P2, P3, P4) or billing transactions with the exception of Reversals (B1, B3). The mandatory/required fields are the Segment Identification, Prescriber ID Qualifier, and Prescriber ID. For authorization transactions, prescriber last name and phone number are also required.

COB/other payment segment
This segment may be required in some situations when billing or rebilling if the pharmacist or the agency indicates other coverage. The COB/Other Payments Segment contains information indicating the presence of other payers or insurers.

Use the Other Coverage Code field in the Claim Segment to indicate insurance coverage information. Refer to Other Coverage Codes.

DUR/PPS segment
The DUR/PPS segment contains data for the resolution of DUR rejections.

Pricing segment
The pricing segment is required on all incoming billing and rebilling transactions (B1, B3). This segment contains data describing how the product is to be priced. The mandatory fields are: Segment Identification, Ingredient Cost Submitted, Usual and Customary Charge, and Gross Amount Due.

Compound segment
This segment is required for the multi-line submission of compounds. The compound segment may only be submitted on billing or rebilling. This segment is not sent on claim reversals. Information describing the compound ingredients is included here. If the segment is submitted the following fields are required: Segment Identification, Compound Dosage Form Description Code, Compound Dispensing Unit Form Indicator, Compound Ingredient Component Count, Compound Ingredient Drug Cost, and Compound Ingredient Basis of Cost Determination. The following fields are also required, and may be repeated for multiple ingredients: Compound Product ID Qualifier, Compound Product ID, and Compound Ingredient Quantity. The agency will reimburse a dispensing fee for each payable ingredient. Each line will be adjudicated separately and will be subject to all applicable edits, including authorization. Compounds may not be submitted as a partial fill. If a pharmacy chooses to receive reimbursement only for the payable ingredients within a compound, a value of 8 in the Submission Clarification Code field from the claim segment must be entered.

Prior authorization segment
The prior authorization segment is situational and only required on authorization transactions (P1, P2, P3, P4). When submitting an authorization transaction, the following fields are required: Segment Identification, Request Type, Request Period Date-Begin, Request Period Date-End, and the Basis of Request. No other fields within this segment are captured or supported.

What is the requirement regarding tamper-resistant prescription pads?

(RCW 18.64.500)

All written prescriptions, including OTC medications, must be written on a tamper-resistant prescription pad or paper that has been approved by the Pharmacy Quality Assurance Commission for use. Both RCW 18.64.500 and 42 U.S.C. 1936b(i)(23) require prescription pads and paper to have at least one feature from **each** of the below characteristics to be considered tamper-resistant to prevent the prescription from being changed:

- **No copying:** For example, pantographs that reveal the word "VOID" when copied
- **No altering:** For example, chemical stains or an altered background reveal attempts at ink or toner removal
- **No counterfeiting:** For example, pads have a watermark and cannot be reproduced

Prescription pads and paper that have met all industry-recognized characteristics have a seal of approval affixed to the paper. This requirement must be met for all written prescriptions, regardless if the client is enrolled in an agency-contracted managed care organization.

Prescriptions that are telephoned, faxed, or sent electronically to the pharmacy are exempt from the state and federal requirements. Pharmacists receiving non-compliant, written prescriptions are encouraged to verify the prescription with the prescriber.

What about emergency dispensing?

Pharmacists are allowed to dispense a prescription written on noncompliant paper as long as the pharmacy receives verification from the prescriber by telephone, fax, or email within 72-hours of filling the prescription. Federal controlled substance laws must continue to be met when prescribing or dispensing Schedule II drugs.

What about Medicaid clients with retroactive certification?

To submit a claim for a Medicaid client retroactively certified for Medicaid, a pharmacy must reimburse the client in accordance with WAC 182-502-0160.

What are the documentation and records retention requirements?

The pharmacist must document that the prescriber was contacted by telephone, fax, or email to verify that the legitimacy of the prescription written on non-compliant paper **before** it was dispensed. Prescription records, including documentation for non-compliant prescriptions, must be kept for six years according to WAC 182-502-0020.

What is needed for prescription transfers between pharmacies?

The pharmacy accepting a prescription transfer from another pharmacy only needs to obtain a telephone call or fax from the transferring pharmacy in order to confirm the authenticity of the tamper-resistant prescription.

What is the time limit for billing?

(WAC 182-502-0150)

The agency requires providers to submit initial claims and adjust prior claims in a timely manner. The following are the agency's timeliness standards for initial claims, resubmitted claims, and for claim adjustments in the Prescription Drug Program. For more information on timelines for billing, refer to the agency ProviderOne Billing and Resource Guide.

Medicare Part B crossover claims

If Medicare Part B allows the claim, it is no longer billable as a Prescription Drug Program claim through the point-of-sale (POS) system. A claim allowed by Medicare Part B is billable as a crossover claim on a professional claim within six months of the date that Medicare processes the claim. Providers can rebill or resubmit a crossover claim up to two years from Medicare's process date. If Medicare denies payment of the claim, the agency requires the provider to meet the agency's initial 365-day requirement for the initial claim. If a provider has billed Medicare but has not received a response, the provider must still bill the agency within 365 days of the date of service to establish timeliness.

Resubmitted claims and adjustments

The agency allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within 15-months of the date the service was provided to the client. Claims may be resubmitted, modified, or adjusted by the pharmacy electronically for 456 days from the date dispensed. After 15-months, the agency does not accept a prescription drug claim for resubmission, modification, or adjustment.

Reversals
The agency allows pharmacies to reverse any prescription drug claim with a timely TCN within 15 months of the date the service was provided to the client. Claims may be reversed electronically for 456 days from the date the claim was dispensed. If a pharmacy wishes to reverse a transaction that can no longer be reversed electronically from the pharmacy's own system, a request may be submitted to the agency for reversion only under the following circumstances:

- "Lost" transactions (paid claim not found in the pharmacy's own system)
- Claims older than the pharmacy's own system will allow them to reverse

If one of the above circumstances applies, a pharmacy may request a reversal by submitting a help ticket via email to MMIShelp@hca.wa.gov, with a subject line: POS claim reversal. The email must include:

- Client name and ProviderOne ID number
- Drug name and NDC
- Claim number
- Date of fill
- Provider NPI
- Prescription number

If unable to submit a help ticket via email, pharmacies may also fill out a *Pharmacy Adjustment Request* (HCA 13-715) form and fax it to 360-507-9074. See Where can I download agency forms?

Overpayments that must be refunded to the agency
The 15-month period allowed for resubmission of claims above **does not apply** to overpayments that a prescription drug provider must refund to the agency. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. Questions regarding overpayments may be directed to the MPA Cash Control at 360-725-1279.

Client's responsibility
The agency does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements, resulting in the claim not being paid by the agency. (See When is a pharmacy allowed to bill a client?)

What is the national provider identifier (NPI) requirement?

Pharmacy providers are required to provide the pharmacy and prescriber National Provider Identifiers (NPIs) on all prescription drug claims.

The agency requires a prescriber to provide its individual NPI (Type 1) with prescription drug orders that are written, transmitted, called in, or faxed. This NPI requirement applies to all providers who write prescription orders for drugs.

The prescriber NPI must be for an individual (Type 1) rather than an organization (Type 2). The ProviderOne POS does not recognize Type 2 NPIs for organizations (such as hospitals) as valid prescribers.

The following are examples of how to report the practitioner's individual NPI (Type 1) with prescription orders:

- An emergency room practitioner must report his or her individual NPI (Type 1), not the supervising practitioner's NPI with a prescription order.

- Each practitioner in a teaching hospital must report his or her individual NPI (Type 1) with a prescription order that is submitted to the dispensing pharmacy.

Point-of-Sale billers:

- Enter 01 in the Service Provider ID Qualifier field (202-B2)
- Enter your NPI in the Service Provider ID field (201-B1)
- Enter 01 in the Prescriber ID Qualifier field (466-EZ)
- Enter the prescribers NPI in the Prescriber ID field (411-DB)

What is needed to bill for filling a newborn prescription?

Pharmacies can submit prescription claims for newborns using the mom's ProviderOne Client ID and the mom's birthdate.

Point-of-Sale billers: Enter "**2**" in the **Insurance Segment, Eligibility Clarification Code field.**

When is a pharmacy allowed to bill a client?

(WAC 182-502-0160)

A pharmacy may bill a fee-for-service client for a noncovered prescription if the client and provider complete and sign an *Agreement to Pay for Healthcare Services* (HCA 13-879) form. See Where can I download agency forms?

The provider may NOT bill the client for any service which is potentially covered with prior authorization, unless that authorization has been requested and denied.

The agency asks that pharmacists use their professional judgment when accepting cash for non-covered services. If the pharmacist believes that a prescription may not be medically necessary for the client (such as a non-covered early refill for large volumes of narcotics), the pharmacist has no obligation to accept cash payment and may refuse service to the client.

> **Note:** A common billing complaint is the pharmacist misinterpreting a POS message as a denial and charging the client instead of calling the agency for authorization. Remember that it is the pharmacist's responsibility to call the agency for authorization when the pharmacist receives an authorization message from the POS system.

Who is eligible?

The POS system does not solve the problem of identifying clients who are not currently in the agency's eligibility file. It is not appropriate to charge a client cash if the client is currently eligible on the Benefit Inquiry Screen in ProviderOne. For a client whose benefit inquiry screen in ProviderOne shows that the client is eligible, but claims deny in the POS system for lack of eligibility, **FAX** a copy of the client's benefit screen from ProviderOne to Claims Entry at 866-668-1214. The benefit inquiry screen in ProviderOne will be updated within two working days in order for claims to be resubmitted. Do not fax **claims** to this number.

See Billing the Client WAC 182-502-0160.

What services are billed for hospice clients?

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated by the designated hospice agency (be sure to call the hospice agency to find out what must be billed under hospice) and attending physician **only**.

Services **not** related to their terminal illness may be provided to clients on a fee-for-service basis. When billing for hospice clients and the service is **not** related to the terminal illness (be sure to

call the hospice agency to find out what medications are not related to the hospice diagnosis or end-of-life care needs), use the following billing procedures:

> **Point-of-Sale billers** must enter "**11**" in the **Patient Segment, Patient Residence** (384-4X) field.

Do not use this procedure for dates the client is not on hospice services. Be sure to check with the hospice agency before using the "11".

Does the agency reimburse for a client's prescriptions when enrolled in an agency-contracted managed care organization?

Eligible medical assistance clients enrolled in an agency contracted managed care organization (MCO) must have their prescriptions filled at a pharmacy contracted with the MCO. If a pharmacy is not contracted with the MCO, the client must be referred to an MCO-contracted pharmacy.

The agency reimburses for drugs dispensed to clients enrolled in an agency-contracted MCO **only** when a managed care contract excludes the drug or pharmaceutical supply and the product is otherwise reimbursable fee-for-service (FFS). The following may be billed FFS to the agency:

- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed **following a voluntary termination of pregnancy;**
- Hemophilia and von Willebrand-related products when used for administration in the home;
- Immune modulators and anti-viral medications to treat chronic Hepatitis C virus (HCV) infection;
- Compliance packaging when one or more medications packaged are paid under the fee-for-service benefit. Refer to Compliance Packaging for more information.
- Professionally administered drugs. See the Physician-Related Services Billing Guide for a full list.
- Prescriptions written by practitioners working for a non-MCO-contracted health department, or a non-MCO-contracted Family Planning agency with the therapeutic classifications listed below:

Family planning clinics may prescribe contraceptives, drugs for sexually-transmitted diseases (STD), excluding HIV, when related to the client's family planning method, and drugs related to a sterilization procedure within the following therapeutic drug classes:

- Analgesics
- Antibiotics
- Anti-emetics
- Antifungals
- Anti-infectives
- Anti-inflammatories
- Contraceptive drugs/devices

Health departments may prescribe drugs for STD (excluding HIV), tuberculosis, and prescription contraceptives within the following therapeutic drug classes:

- Antibiotics
- Anti-emetics
- Anti-infectives
- Contraceptive drugs/devices
- Tuberculosis drugs

Billing for managed care clients

Point-of-Sale billers must enter "**2**" in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

Pharmacists must document on the original prescription the reason for billing fee-for-service. All fee-for-service rules apply, including authorization requirements.

What drugs may be prescribed for Family Planning Only Program—Pregnancy Related and Family Planning Only Program (formerly known as TAKE CHARGE) clients?

The following drugs related to family planning and contraceptives may be dispensed within the following therapeutic drug classes for Family Planning Only Program—Pregnancy Related or Family Planning Only Program (formerly known as TAKE CHARGE) clients:

Contraceptives and Drugs	
Contraceptives, oral, including emergency contraception	Macrolides
Contraceptives, injectables	Antibiotics, misc. other
Contraceptives, transdermal	Quinolones
Contraceptives, intravaginal	Cephalosporins – 1st generation
Contraceptives, intravaginal, systemic	Cephalosporins – 2nd generation
Contraceptives, implantable	Cephalosporins – 3rd generation
Vaginal spermicides	Absorbable Sulfonamides
Condoms	Nitrofuran Derivatives
Diaphragms/cervical caps	Antifungal Antibiotics
Intrauterine devices	Antifungal Agents
Vaginal antifungals	Anaerobic antiprotozoal – antibacterial agents
Vaginal Sulfonamides	
Vaginal Antibiotics	
Tetracyclines	

The agency covers anti-anxiety medications before a sterilization procedure and pain medications after a sterilization procedure for Family Planning Only Program—Pregnancy Related and Family Planning Only Program (formerly known as TAKE CHARGE) clients as follows:

Anti-anxiety Medication – Before Sterilization Procedure

Medication	Maximum Number of Doses
Diazepam	2
Alprazolam	2

Pain Medication – After Sterilization Procedure

Medication	Maximum Number of Doses
Acetaminophen with Codeine #3	12

Oxycodone HCl/Acetaminophen 5/500	12
Hydrocodone Bit/Acetaminophen	12
Oxycodone HCl/ Acetaminophen	12

When billing for the covered preoperative anti-anxiety medications and postoperative pain medications for Family Planning Only Program—Pregnancy Related or Family Planning Only (formerly known as TAKE CHARGE) clients:

Point-of-Sale billers must enter "**6**" in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

See the Family Planning Billing Guide for more information on covered products and services for Family Planning Only—Pregnancy Related and Family Planning Only (formerly known as Take Charge) clients.

Does the agency reimburse for skilled nursing facility (SNF) clients?

The agency does not reimburse for over-the-counter (OTC) drugs when the client resides in an SNF unless the drugs are on the Apple Health (Medicaid) Fee-For-Service Preferred Drug List or the agency's Apple Health Fee-for-Service Covered Over-the-Counter Drug List. Reimbursement for OTC drugs is included in the SNF per diem.

How are medications filled for SNF clients on leave?

SNF clients on leave should have their additional maintenance prescriptions filled for the duration of the leave. If the client leaves weekly, prescriptions should be filled for a one-month supply.

SNFs should determine which one of the following methods will be followed when a SNF client goes on leave:

- The client may take the prescription medication home and keep it there for use during SNF absences.
- The client may return the prescription medication to the SNF following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

Both of these practices are in accordance with state pharmaceutical regulations.

Point-of-sale billers: Enter 8 in the **Claim Segment, Prior Authorization Type Code** (461-EU) field.

What is a skilled nursing facility (SNF) emergency kit?

The **emergency kit** is a set of limited pharmaceuticals furnished to an SNF by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each SNF's client population and is for use during those hours when pharmacy services are unavailable.

Medications supplied from the emergency kit are the responsibility of the SNF.

What unit dose delivery systems are recognized by the agency for SNFs?

(WAC 182-530-7350)

The agency recognizes two types of **Unit Dose Delivery Systems** for SNFs:

- True Unit Dose Delivery System
- Modified Unit Dose Delivery System

Eligible unit dose providers receive the unit dose dispensing fee when dispensing in-house unit dose prescriptions. The term **in-house unit dose** applies to bulk pharmaceutical products that are packaged by the pharmacy for unit dose delivery. Providers receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to Reimbursement for agency Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?

(WAC 182-530-5100(1))

To be eligible for a unit dose dispensing fee from the agency, a pharmacy must:

1. Notify the agency in writing of its intent to provide unit dose service
2. Specify the type of unit dose service to be provided
3. Identify the SNF or facilities to be served
4. Indicate the approximate date unit dose service to the facility or facilities will commence

5. Sign an agreement to follow the agency requirements for unit dose reimbursement

For information on becoming a unit dose provider, contact Provider Enrollment (see Resources Available).

How do pharmacies bill the agency under a unit dose delivery system?

(WAC 182-530-5100(2), (3), and (4))

Under a unit dose delivery system, a pharmacy must bill the agency only for the number of drug units actually used by the agency client in the skilled nursing facility (SNF).

It is the unit dose pharmacy provider's responsibility to coordinate with the SNFs to ensure that the unused drugs the pharmacy dispensed to the facility for distribution to an agency client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment form or claims reversal of the charge to the agency for the cost of all unused drugs returned to the pharmacy from the SNF on or before the 60th day following the date the drug was dispensed. This adjustment must conform to the SNF's monthly log.

Exception:

Unit dose providers are not required to credit the agency for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

Point-of-sale billers: Enter "3" in the **Claim Segment, Unit Dose Indicator** (429-DT) field.

Who is responsible for the cost of repackaging a client's bulk medications?

(WAC 182-530-5100(5))

The cost of repackaging is the responsibility of the SNF when repackaging is done for either of the following reasons:

- To conform to the SNF's delivery system
- For the SNF's convenience

Pharmacies may not charge clients or the agency a fee for repackaging a client's bulk medications in unit dose form.

What records do SNF pharmacies need to keep?

(WAC 182-530-5100(6) and (7))

The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each SNF served, including, but not limited to the following information:

- Facility name and address
- Client's name and ProviderOne Client ID
- Drug name/strength
- National Drug Code (NDC)
- Quantity and date dispensed
- Quantity and date returned
- Value of returned drugs or amount credited
- Explanation for no credit given or nonreusable returns
- Prescription number

Upon request, the pharmacy must submit copies of these monthly logs to the agency. The agency may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to the agency?

(WAC 182-530-5100(8))

When the pharmacy submits the completed annual prescription volume survey to the agency, it must include an updated list of SNFs served under unit dose systems.

What additional records do pharmacies need to keep?

(WAC 182-530-5000)

In addition to the record keeping requirements found in the ProviderOne Billing and Resource Guide, pharmacies must comply with the following:

Provision of prescription drugs

Keep any specifically required documents for the provision of prescription drugs, including but not limited to:

- Authorizing an order (prescription)
- Name of person performing the service (dispensing pharmacist)
- Details of medications and/or supplies prescribed or provided including NDC, name, strength, and manufacturer
- Drug Use Review (DUR), intervention, and outcome documentation
- Expedited authorization (EA) documentation
- Proof of fill

Proof of delivery

- When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery including signature, client’s name, and a detailed description of the item(s) delivered.
- When a provider mails an item to the client, the provider must be able to furnish proof of delivery, including a mail log.
- When a provider uses a delivery/shipping service to deliver items, the provider must be able to furnish the following proof of delivery documentation:
  - ✓ The delivery service tracking slip with the client's name or a reference to the client's packages, the delivery service package identification number, and the delivery address
  - ✓ The supplier's shipping invoice with the client's name, the shipping service package identification number, and a detailed description

- When a client or the client's authorized representative picks up the prescription, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the items delivered.

- Make proof of delivery records available to the agency, upon request.

Coordination of Benefits

How are client resources applied?

The agency is required by federal regulation to determine the liability of third-party resources available to agency clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, the agency may make reimbursement for the balance if the insurance payment is less than the agency's allowed amount.

It is the provider's responsibility to bill the agency appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated in ProviderOne.
- The point-of-sale (POS) system alerts the provider to a client's insurance.
- The provider believes insurance is available.
  (See WAC 182-501-0200)

The Insurance Carrier List and carrier information is available in the ProviderOne Billing and Resource Guide. The information can be downloaded and printed or used as a reference.

The agency's billing time limit is 365 days, but an insurance carrier's time limit to bill may be different. It is the provider's responsibility to meet the insurance carrier's billing time limit prior to receiving any payment by the agency. The provider should not bill the agency with an **Other Coverage Code** if the claim was denied by the insurance carrier for late filings.

Other Coverage Codes

Why are Other Coverage Codes important?

The agency POS system alerts a provider when a client has other insurance. When a provider submits a claim through the POS system, and the agency files indicate that a client has insurance, **the agency will deny the claim. Then the provider must bill the client's insurance before using the Other Coverage Codes.**

The provider's weekly Remittance and Status Report (RA) show that the claim is denied with the Explanation of Benefits (EOB) 090. The EOB states **"Bill your claim to the insurance company as instructed. For questions call 800-562-3022."** The insurance carrier information is printed on the RA for the provider's reference.

When may providers use Other Coverage Codes?

The following chart lists situations in which other insurance is available, gives some direction to the provider, and explains which **Other Coverage Codes** to enter. In all of the situations described below, the pharmacy must bill the other insurance **before** using an **Other Coverage Code.**

The chart also provides information about documentation. Pharmacy providers who submit their claims through the POS system are not required to submit third-party documents. However, the provider must have these documents available for audit purposes. **Examples of the documentation that would justify the provider's use of an Other Coverage Code are listed below.**

Contact Coordination of Benefits (COB) at 800-562-3022 for any situations that are not listed below. See POS for values and definitions of the **Other Coverage Codes.**

A removable summary of the following table is available at the end of the Coordination of Benefits Frequently Asked Questions section.

Situations	Explanation/ Solution	Other Coverage Code
The insurance has made payment to the pharmacy **(An EOB or electronic transmission from insurance identifying the insurance paid amount)**	Bill balance to the agency	**2**
Insurance allowed amount of the prescription is less than or equal to the copay **(An EOB or an electronic transmission from insurance identifying both the insurance allowed and co-pay amounts)**	Bill the agency	**4**
The prescription must be filled by mail order **(Contract verification that the prescription must be filled by mail order; or denial from insurance stating mail order)**	Bill the agency	**3**
The plan only covers a new prescription **(An EOB or electronic transmission from insurance showing only new prescriptions covered)**	Bill refills to the agency	**3**
The insurance carrier applied the claim charges to the client's deductible **(An EOB or electronic transmission from insurance identifying the claim amount was applied to the deductible)**	Bill the agency	**4**
The client's insurance plan maximum annual benefit has been met **(An EOB or electronic transmission from insurance identifying the annual benefit has been met)**	Bill the agency	**4**
The insurance denied the medication as a non-covered drug. Clarify if denial is for non-covered or non-formulary drugs. If non-formulary, third-party payment procedures must be followed **(An EOB or electronic transmission identifying the drug is non-covered or include a copy of the contract drug exclusion list)**	Bill the agency	**3**
The client has a discount card **(Verification of discount card or denial from insurance stating "discount card")**	Bill the agency	**3**
Capitated service agreement with insurance carrier **(Group Health and Kaiser pharmacies only)**	Bill the agency	**8**
Medicare Part D copay The agency does not provide coverage for Medicare Part D medication copayments. Medicare Part D copayments is the responsibility of the client **(For questions, call the agency Customer Service Center at 1-800-562-3022)**		

Note: For questions on the use of **Other Coverage Codes** or acceptable documentation, call Coordination of Benefits at 1-800-562-3022.

If one of the previously listed situations occurs, providers may resubmit the claim entering an **Other Coverage Code** into the POS system to bypass the edit for other insurance coverage.

Inappropriate use of Other Coverage Codes may result in an audit of your POS claims and recoupment of improper payments.

Note: In instances where the primary insurance has made payment, the normal 34-day supply limit may be exceeded.

Clients with privately purchased HMO insurance

A client with privately purchased health maintenance organization (HMO) insurance will have an **HI, HO, or HM** identifier on the client benefit inquiry screen in ProviderOne. The client is required to use the HMO facilities for pharmacy services. If services are provided that are not covered by the HMO plan, the claim may be submitted to the agency for processing.

Situations may occur when a client is out of the HMO service area or HMO coverage is not accessible, a pharmacy provider may proceed to meet the client's immediate needs.

Billing

Pharmacy providers who submit their claims through the POS system are not required to submit insurance EOB documents. **However, documentation must be retained and kept by the provider for audit purposes.** (See WAC 182-502-0020)

Primary insurance billing exceptions

Primary insurance billing exceptions listed below are examples of third-party situations and how they are processed in the POS system. All amounts billed to the insurance and to the agency must be usual and customary charges, except for capitated copayments.

What does the provider do if a third-party liability question arises after COB hours?
Situations may occur when a client is asking to fill a prescription, a question arises and it is outside of COB's regular business hours. After making reasonable attempts to access the primary insurance coverage, proceed with filling what is necessary to meet the client's immediate needs. "Immediate needs" means pharmacists using their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. The pharmacy must contact COB within seven days for billing assistance.

Examples may include:

- The agency indicates that the patient has insurance, but the coverage cannot be identified and the patient does not provide it.

- The patient has HMO private insurance or has a closed pharmacy network.

What does the provider do if the client's coverage is prepay?
Contact COB for billing assistance if the client's coverage is prepay. Prepay means the client's identified insurance coverage policy requires the client to pay at the time of service, and the insurance reimbursement is made only to the subscriber. Do not bill the insurance and do not bill the agency with an **Other Coverage Code**. Prepay is defined on a case-by-case basis.

How is authorization obtained for non-formulary or non-covered drugs?

Pharmacists are required to obtain prior authorization from the insurance carrier for non-formulary drugs before providing the drugs to the client. When the denial reason is related to a non-formulary drug, the pharmacy may need to coordinate with the prescriber and/or the insurer to authorize an alternative drug or get the insurer to cover the prescription as prescribed. **Do not use an Other Coverage Code**. The pharmacy must meet all third-party billing requirements prior to billing the agency.

Non-covered drugs are not to be confused with non-formulary drugs. It is the provider's responsibility to correctly determine if the drug is non-covered or non-formulary with the primary insurance carrier. Non-covered drugs may be billed to the agency using the **Other Coverage Code 3.**

Coordination of Benefits Frequently Asked Questions

How is prescription drug coverage verified and who processes the prescriptions?
Ask the client for an insurance card, Services Card, or both. If the client benefit inquiry screen indicates the client has an insurance carrier and you do not know where to submit the claims, contact the insurance carrier. Verify there is retail prescription coverage with the insurance carrier and ask where to submit claims. When you submit a claim through the POS system and no **Other Coverage Code** has been entered, you will be notified if the client has prescription coverage.

To find insurance carrier contact information, see the ProviderOne Billing and Resource Guide.

What if a client's insurance states there is no coverage or the insurance coverage has ended?
If there is no coverage or the coverage has ended, notify COB at 800-562-3022.

What if a client's insurance plan cannot identify the client?
If the insurance carrier cannot identify the client, contact COB at 800-562-3022 to verify the cardholder identification and the plan being billed are the same as on file with COB. We will assist you with verifying the client's prescription coverage or update COB records if the client does not have coverage.

What is discount only or mail order only coverage?
Discount only or mail order only coverage means insurance does not reimburse for any prescriptions filled at retail pharmacies.

- If a client has **discount only or mail order only** benefits, the agency does not consider this a primary insurance. Bill the agency.

- If you bill the agency and we deny the claim to bill the insurance carrier, and you believe the client has **discount only** coverage, contact COB.

Note:

- Some clients have **mail order only** on certain prescriptions, requiring them to use mail order when they refill prescriptions on an ongoing or regular basis.

- Insurance carriers may refer to mail order as "maintenance". For example, some plans consider mail order to be maintenance when a certain prescription is refilled more than two times. Bill the insurance carrier first. If the claim is denied by insurance to use mail order, then bill the agency with an **Other Coverage Code 3**.

Why would a claim be paid at zero or denied by insurance?
If the reason the claim was paid at zero cannot be verified, contact the insurance carrier and find out why the claim was paid at zero or denied. If there are questions about why the claim was denied or paid at zero after contacting the insurance carrier, contact COB.

What if the insurance states copay is 100% or claim is paid at zero?
Contact the insurance carrier. Examples of when the insurance states copay is 100% are:

- A prepay plan. **Prepay** means the client's insurance coverage requires the client to pay at the time of service, and the insurance reimbursement is made to the subscriber. In this instance, reverse your billing to the primary insurance, and call COB for billing assistance at 1-800-562-3022. Do not bill the insurance, and do not bill the agency with an **Other Coverage Code.**

- Less than copay, benefits are exhausted, or any other paid at zero response. Bill the agency using **Other Coverage Code 4.**

How are after hour services billed?
After hours services means prescriptions filled outside of COB regular business hours. After making reasonable attempts to meet the primary insurance carrier's billing requirements, proceed with filling what is necessary to meet the client's immediate needs.

What is "meeting client's immediate needs?"
Immediate needs means pharmacists are to use their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. Contact COB within 7 days for billing assistance. Examples may include:

- The agency indicates the client has insurance, but you cannot identify the coverage.
- The client has HMO private insurance or has a closed pharmacy network.

What is the service area?
Service area means the nearest pharmacy that accepts the insurance within 25 miles or 45 minutes in one direction from the client's address.

What if POS will not accept an Other Coverage Code, or a field is not provided to enter an Other Coverage Code?
Contact your pharmacy software or switch vendor.

Why does a claim get a rejection code missing/invalid code?
If there is a rejection code DV, you have indicated that insurance made payment by entering 2 in the Other Coverage Code field, but the payer amount was entered as 0.00.

If there is a rejection code E8, an insurance payment was entered, but a 2 in the Other Coverage Code field was not.

Verify the insurance carrier has made payment, and enter the amount in the **other payer** amount field. If there is no insurance payment, **do not enter a 2** in the Other Coverage Code field; contact the insurance carrier to find out why the payment was not made. If you have verified the insurance amount paid and the payment amount is not displayed on the POS system, contact your software or switch vendor.

If the claim does not go through, is entering $.01 in the insurance paid field allowed?
No. Enter an amount only if $.01 or another amount is the actual amount paid by the insurance. Entering any amount paid by the insurance carrier other than the actual amount paid could be considered fraudulent.

When can Other Coverage Code 8 be used?
For non-Medicare Part D billing, the agency allows only pharmacy providers that have a capitated service agreement with an insurance carrier to use this **Other Coverage Code**. At this time, only Group Health and Kaiser are known to have capitated service agreements.

How is a claim submitted to the agency when the insurance allowed amount is less than or equal to the copay amount?
The copay is the amount that private insurance has determined the person with the private insurance coverage is expected to pay per prescription.

Note: Eligible Medicaid clients with private insurance are not expected to pay a copay. When the insurance allowed or payable amount is less than or equal to the copay amount, the insurance non-payment reason is less than the copay. Bill the agency, after you bill the insurance. Use a 4 in the **Other Coverage Code** field.

What is a closed pharmacy network?
A closed pharmacy network means an insurer restricting prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy not included on the exclusive list. The agency may pay for the prescription without requiring the client to use a participating network pharmacy ONLY in the following situations:

- When the prescription is not covered by the policy.
- If the client is out of the service area.
- If you provided medications to meet a client's immediate need for services.

If you are not a participating pharmacy, do not bill with an **Other Coverage Code** prior to contacting COB.

Does the agency require clients to use pharmacy providers that are contracted with the client's private insurance carrier?
The agency requires clients to use pharmacy providers contracted with their private insurance carrier. Clients with managed care private insurance will have an HM, HI, or HO identifier on the client benefit inquiry screen in ProviderOne.

If the insurance carrier provides pre-pay plan coverage for non-contracted pharmacy providers, contact COB for billing assistance.

If a pharmacy is not contracted and the coverage is not pre-pay, the agency may pay for the prescription without requiring the client to use a contracted pharmacy ONLY in the following situations:

- When the prescription is not covered by the policy
- If the client is out of the service area
- If you provided medications to meet a client's immediate need for services

Do not bill with an **Other Coverage Code** prior to contacting COB.

What if a client's insurance coverage requires paper billing and the pharmacy only bills electronically?
The pharmacy must meet all third-party billing requirements prior to billing the agency.

If the insurance coverage is a pre-pay plan for paper billers, contact COB for billing assistance. Do not bill with an **Other Coverage Code** prior to contacting COB.

If the client is enrolled in an agency-contracted MCO and private insurance, is the MCO billed for the service or the private insurance?
If a client is enrolled in an agency-contracted managed care organization (MCO) **and** also has private insurance for the date of service, the pharmacy bills the MCO. Contact the MCO for billing assistance and information about the primary coverage.

If I bill the insurance carrier and the denial reason is "plan limits exceeded," can I bill the agency with an Other Coverage Code?
If the client has exceeded their insurance benefit, it is appropriate to bill the agency with an **Other Coverage Code 3**. The pharmacy must meet all third-party billing requirements prior to billing the agency.

How do I bill if the insurance carrier requires authorization?
The primary insurance carrier requirements must be met. Contact the insurance carrier for authorization review, and to determine if, and how the medication is covered by the insurance plan. If the primary insurance carrier's authorization process has been followed to completion and authorization is denied, bill the agency with **Other Coverage Code 3**.

The insurance carrier requires authorization. The prescriber will not provide information to the pharmacy or insurance carrier and authorization cannot be obtained. Can the agency be billed directly?
No. The insurance carrier requirements must be met. It is not appropriate to bill the agency with an **Other Coverage Code** unless the billing conditions of the insurance carrier have been met.

How long does documentation need to be kept? (WAC 182-502-0020)
Providers are required to make documentation available to the agency for six years from the date of service. Pharmacy providers who submit their claims through the POS system are not required to submit third-party EOB documents. However, the provider must retain documentation for audit purposes.

The client has insurance coverage through multiple carriers. Am I required to bill all potential payers? (WAC 182-502-0150)
Yes. It is the provider's responsibility to seek timely reimbursement from a third-party when a client has available third-party resources.

How do you bill clients who are eligible for both Medicare and Medicaid?
Some Medicaid clients are also eligible for Medicare Part B or Part D benefits. Bill Medicare first. The following instructions will assist in billing for dual eligible clients.

Medicare Part B

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Medicare Part B cover some drugs and drug-related supplies. When you have a client who is eligible for both Medicaid **and** Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier **first**. Medicare is the primary payer of claims.

The agency cannot make direct payments to clients to cover the deductible and coinsurance amount of Medicare Part B. The agency **can** pay these costs to the provider on behalf of the client when:

- The provider accepts assignment.
- The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount.

The agency will pay up to Medicare's allowable, or the agency's allowable, whichever is less.

ProviderOne will indicate whether or not the client is Medicare-eligible.

What about clients covered under the Categorically Needy Program or Medically Needy Program, as well as Qualified Medicare Beneficiaries?

- If Medicare ***and*** Medicaid cover the service, the agency will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If Medicare **and not Medicaid** pays for the product, the agency will pay the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicaid covers the service and Medicare does not cover the service, the agency will reimburse for the service.

Part B—Medical Insurance

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and are furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service, it may not be covered by Part B. Medicare Part B also covers a limited number of other types of drugs. (Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision.) For more information visit the Medicare coverage database website.

What about Medicare Part B medications (that are not covered through Part D)?
After Medicare Part B has processed the claim, and if Medicare has allowed the medication, in most cases Medicare will forward the claim to the agency for any supplemental Medicaid payment. When the words, **"Claim information forwarded to Medicaid,"** appear on the Medicare remittance notice, it means that the claim has been forwarded to the agency or a private insurer.

- If **Medicare Part B has paid** for a medication and the Medicare crossover claim does not appear on the agency Remittance and Status Report within 30 days of the Medicare statement date, bill the agency.

  Providers have six months from the Medicare process date to submit their initial crossover claim, and two years from Medicare's process date to re-bill or resubmit a crossover claim.

- If **Medicare Part B has denied** a medication:

  ✓ Retail and specialty pharmacies may bill the agency through the POS system using the appropriate DUR result of service code.

  ✓ For professionally administered drugs, bill the agency electronically through ProviderOne and include the Explanation of Benefits (EOB) or Medicare denial letter as supporting documentation. See the agency's ProviderOne Billing and Resource Guide for general billing instructions.

Note: When Medicare denies a service that requires authorization, the agency waives the **prior** requirement, but authorization is still required.

Medicare Part D

Are copayments covered?
Medicare Part D copayments are the responsibility of the client.

What prescription drugs are covered?
Medicare Part D-covered drugs are:

- Biological products
- Insulin and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze)
- Vaccines
- Drugs that are:
  - ✓ Available only by prescription
  - ✓ Used and sold in the United States
  - ✓ Used for a medically accepted indication

Certain drugs or classes of drugs, or their medical uses, are excluded by law from Medicare Part D coverage. Visit the Medicaid Covered Drugs for Part D Dual Eligibles for more information.

While these drugs or uses are excluded from basic Medicare Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare.

What if Medicare denies a prescription as non-formulary?
When the client is covered by Medicare Part D, Medicaid does not pay for any prescriptions that are the responsibility of Medicare Part D. Contact the prescription drug plan for authorization for non-formulary drugs. Due process under the Medicaid appeal rules such as an administrative hearing and Exception to Rule are not available to the client under this circumstance.

Helpful hyperlinks

- List of medications that the agency will cover
- Medicare Part D website
- SHIBA website
- CMS website

Agency Other Coverage Code Summary

Situations	Explanation/Solution	Other Coverage Code
The insurance has made payment to the pharmacy	Bill balance to the agency	**2**
Insurance allowed amount of the prescription is less than or equal to the copay	Bill the agency	**4**
The prescription must be filled by mail order	Bill the agency	**3**
The plan only covers a new prescription	Bill refills to the agency	**3**
The insurance carrier applied the claim charges to the client's deductible	Bill the agency	**4**
The client's insurance plan maximum annual benefit has been met	Bill the agency	**4**
The insurance denied the medication as a noncovered drug. Clarify if denial is for noncovered or non-formulary drugs. If non-formulary, third-party payment procedures must be followed.	Bill the agency	**3**
The client has a discount card	Bill the agency	**3**
Capitated service agreement with insurance carrier	Bill the agency	**8**
Medicare Part D copay	**Medicare Part D is not covered**	

Note: For questions on the use of **Other Coverage Codes** or acceptable documentation, call the agency at 1-800-562-3022.

Therapeutic Interchange Program

(Senate Bill 6088; Chapter 29, Laws of 2003)

What is the Therapeutic Interchange Program?

The Therapeutic Interchange Program (TIP) is a process developed by the Department of Social and Health Services, the Health Care Authority (HCA or the agency), and Labor and Industries to allow physicians and other prescribers to endorse the Washington Preferred Drug List (PDL). TIP is intended to streamline administrative procedures and make prescription drugs more affordable to Washington residents and state health care programs. TIP applies only to drugs in drug classes on the Washington PDL prescribed by an endorsing practitioner and not to other drugs requiring authorization.

What is an endorsing practitioner?

An **endorsing practitioner** is a provider who has reviewed the Washington PDL, signed up as an endorsing provider, and agrees to allow therapeutic interchange of a preferred drug for any non-preferred drug in a given therapeutic class on the Washington PDL. (See http://www.rx.wa.gov)

What does this mean to pharmacies?

When an endorsing practitioner issues a prescription to a medical assistance client for a non-preferred drug in a drug class on the Washington PDL, the filling pharmacist must dispense the preferred drug in that therapeutic class in place of the non-preferred drug. When this therapeutic interchange is made, the pharmacist must notify the endorsing practitioner of the specific drug and dose dispensed.

When are substitutions not required?

In some instances, the endorsing practitioner may determine that the non-preferred drug is medically necessary and instruct the dispensing pharmacist to dispense the non-preferred drug as written (DAW). When an endorsing practitioner indicates "**DAW**" on a prescription for a non-

preferred drug, the agency will not require authorization, and the dispensing pharmacist will dispense the non-preferred drug as prescribed.

Exemptions from TIP

Senate Bill 6088 exempts the following drug classes from TIP when the drug classes are placed on the Washington PDL:

- Antipsychotic
- Antidepressant
- Chemotherapy
- Antiretroviral
- Immunosuppressive
- Immunomodulator/antiviral drugs used to treat hepatitis C for which an established, fixed duration of therapy is prescribed for 24-weeks but no more than 48 weeks. (See RCW 69.41.190)

Not all of these drug classes are on the Washington PDL, and unless the drug class is on the Washington PDL, it is not eligible for the continuation of therapy privilege.

Continuation of therapy privilege for exempted drug classes

Pharmacists must not substitute a preferred drug if the prescription is for a refill or continuation of therapy in any of the exempted drug classes on the Washington PDL.

What if a non-endorsing practitioner issues a prescription for a non-preferred drug?

When a **non-endorsing** practitioner issues a prescription for a non-preferred drug, the agency requires authorization, and the dispensing pharmacist must fax a completed *Pharmacy Information Authorization* (HCA 13-835A) form (see Where can I download agency forms?) to 866-668-1214, or call the agency at 800-562-3022 to request authorization by providing medical justification. See the agency's Pharmacy website for further information.

How does the pharmacy bill for a DAW prescription written by an endorsing practitioner?

Point-of-sale billers must enter "**1**" in the Dispense as Written (DAW)/Product Selection Code field.

Apple Health Medicaid: Fee-For-Service Preferred Drug List

What is the preferred drug list?

(WAC 182-530-4100)

The Health Care Authority (the agency) has developed a list of preferred drugs within a chosen therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness. The drugs within a chosen therapeutic class are evaluated by the Drug Use Review Board, which makes recommendations to the agency regarding the selection of the preferred drugs.

The Apple Health Preferred Drug List (PDL) will be used by Apple Health managed care plans and the Fee-For-Service program. The Apple Health (Medicaid) Fee-For-Service Preferred Drug List includes additional classes and restrictions that pertain only to Fee-For-Service Medicaid clients. The Therapeutic Interchange Program (TIP) only applies to drug classes that are also included on the Washington Preferred Drug List (PDL).

What is the process to obtain drugs on the preferred drug list?

- Prescription claims for **preferred drugs** submitted to the agency are reimbursed without authorization requirements unless the drug requires authorization for the following:

  - ✓ Safety criteria
  - ✓ Special subpopulation criteria
  - ✓ Limits based on age, gender, dose, or quantity

- Prescription claims for **non-preferred drugs** submitted to the agency are reimbursed only after all authorizing criteria are met.

- Prescription claims submitted to the agency for **non-preferred drugs** that are subject to the Therapeutic Interchange Program (TIP) are reimbursed without authorization requirements when written by an endorsing practitioner who has indicated "DAW" on the prescription, unless the drug requires other restrictions as listed above. See WAC 182-530-4150.

- **Pharmacies** must call the agency for authorization when required. Call 1-800-562-3022.

What are the authorization criteria to obtain a non-preferred drug?

- For most drug classes, the authorization criteria is that the client must have tried and failed, or is intolerant to, at least two preferred drugs within the drug class unless contraindicated, not clinically appropriate, or only one drug is preferred within the drug class. Drugs may have criteria that go beyond these basic criteria.

The agency requires pharmacies to obtain authorization for non-preferred drugs when a therapeutic equivalent is on the Apple Health Medicaid: Fee-for-Service PDL.

Where is the Apple Health (Medicaid) Fee-For-Service Preferred Drug List?

See the agency's Apple Health (Medicaid) Fee-for-Service Preferred Drug List webpage.