5.0 Pharmacy

This section contains contact information, to include telephone numbers, mailing addresses, and website addresses, which will provide a point of contact for almost any question that requires a response, and provides a quick reference and definitions for essential Pharmacy billing information. Providers must utilize this section in conjunction with the Administrative Code Title 23: Medicaid. You may refer to the Administrative Code and fee schedules for issues concerning policy and the specific procedures for which Medicaid reimburses. Fee schedules can be found on the DOM web site at http://www.medicaid.ms.gov.

		Telephone #	**Fax #**
Conduent	Fiscal Agent	800-844-3222	601-206-3059
Automated Voice Response System (AVRS)	Eligibility	866-597-2675 or 601-206-3090	
Division of Medicaid (DOM)	Pharmacy Services	800-421-2408 or 601-359-5253	601-359-9555
Pharmacy Prior Authorization Unit	Prior Authorizations	877-537-0722	877-537-0720
Pharmacy Helpdesk	Fiscal Agent	800-884-3222	888-495-8169

340B Covered Outpatient Drugs

340b Pharmacy Providers are required to report a value of '08" in NCPDP field # 423 DN when billing POS claims for drugs purchased through the 340b drug program. The actual acquisition cost of the drug must be submitted in the 'Ingredient Cost' field.

72 Hour Emergency Supply

Federal law requires that a 72-hour emergency supply of a prescribed drug be dispensed without delay when prior authorization (PA) is not available. The rule applies to non-preferred drugs and any drug that is affected by clinical or PA edits which require prior approval. The 72-hour emergency procedure should only be used in emergencies and not routinely for continuous overrides.

Enter a value of '3' in NCPDP Field 418-DI (Level of Service) and a value of '3' in Field 405-D5 (Day Supply). The quantity submitted in Field 442-E7 (Quantity Dispensed) should not exceed a three day supply. These claims count toward the monthly service limits.

For products in unbreakable packaging the same procedure should be used including entering the full

quantity dispensed and either entering the correct days' supply or a '3' day supply.

If/when a PA is issued for the drug, the 72-hour emergency claim should be reversed and the claim resubmitted for the full days' supply.

Beneficiary Eligibility

A beneficiary's MS Medicaid blue card should be checked at every pharmacy visit to validate current identification number. Eligibility status can be verified through the AVRS system at 866-597-2675 or 601-206-3090. Pharmacists should use professional discretion to verify patient identity.

Retroactive Eligibility

Retroactive Pharmacy Claims can be processed electronically through the POS system for up to one calendar year from the original date of service on a Medicaid beneficiary. Retroactive pharmacy claims older than 12 months may be processed via paper submission on a MS Medicaid Pharmacy Claim Form or via the web portal, as long as the claim submission date is not more than 24 months from the original date of service. See **Web Portal Pharmacy Claims** submission for detailed instructions for submitting Retro Pharmacy Claims.

Claim Payments to Providers

Providers who wish to inquire about their check amount are referred to AVRS at 866-597-2675 or 601-206-3090.

Co-Payments

Co-pays for all drugs (Brand, Generic or OTC) are $3.00 per prescription.

Use the following Exemption Codes following the Medicaid ID number
Children under age 18-**C**
Family Planning Beneficiaries-**F** (yellow card holders)
Infants (newborns only) – K; See K-baby section
Long Term Care Beneficiaries-**N**
Pregnant women – a '**P**' must be written on the prescription

Cycle Billing- Automatic Refill

DOM does not allow prescriptions to be automatically refilled for MS Medicaid beneficiaries. The refill of a prescription must be initiated by the beneficiary.

Days Supply

Beneficiaries are limited to a maximum of a 31-day supply based on the daily dosage for all prescriptions. MS Medicaid allows a 90 day supply on a limited number of maintenance medications. For the current 90 day maintenance list, go to: http://www.medicaid.ms.gov/Documents/Pharmacy/90DayMaintenanceList.pdf click on 90 day maintenance list. A day supply greater than 31 is also allowed for some drugs supplied in unbreakable packaging. Examples include, but are not limited to cyanocobalamin injection, Femring, and Sesonale.

Dispense as Written (DAW) Codes

(See Narrow Therapeutic Index Drugs – DAW 7 located in this section)

Dispensing Fee

The dispensing fee is $3.91 for branded products and $4.91 for generic products. Dispensing fee for beneficiaries residing in a Long Term Care facility is $3.91 for all drugs.

Drug Limits

Beneficiaries are entitled to five prescriptions per month, of which, two may be brand products. *Long term care residents are exempt from this limit.*

Beneficiaries under the age of 21 may receive more than the prescription limit, if medically necessary, through expanded EPSDT services with prior authorization.

Dual Eligibles

Dual eligibles are those beneficiaries who are eligible under both Medicare and Medicaid and receive primary drug coverage under Medicare Part D**.** Medicare Part D payment is considered payment in full and should not be submitted to Medicaid.

For drugs not covered by Medicare Part D, Medicaid offers limited coverage of some drugs.

Durable Medical Equipment (DME)/Medical Supplies

DOM does not process any DME/medical supply claims via POS. Pharmacies may be DME providers; however, in order for DOM to reimburse for DME/medical supplies, the pharmacy must enroll as a MS Medicaid DME provider. All DME items and/or medical supplies must be filed on a CMS-1500 claim form. See the CMS 1500 section of this manual for further instructions.

Fraud

If you suspect a case of fraud, please call MS Medicaid Program of Integrity 1-800-880-5920 or 601-576-4162 or via the web at http://www.medicaid.ms.gov/PI/FraudAbuse/WebFormFraudAbuse.aspx.

Health Information Portability and Accountability Act (HIPAA)

All POS transactions submitted to MS Division of Medicaid must be HIPAA compliant. Data must now be encoded to comply with NCPDP 5.1 format.

Hospice Drug Coverage

Medicaid beneficiaries enrolled in Hospice Services are covered under a per diem rate which covers all services for that beneficiary. For those beneficiaries receiving Medicaid Hospice Services, all palliative therapy, or drugs used to treat beneficiary's terminal illness, is to be billed to the Hospice provider. Medicaid will only pay for drugs used for an indication not directly related to the beneficiary's terminal illness that are within the applicable Medicaid prescription service limits. Since plans of care are specific for beneficiaries, it is the responsibility of the dispensing pharmacy to bill the Hospice Provider or Medicaid appropriately. The dispensing pharmacy must retain documentation regarding Hospice Service drug coverage for beneficiaries which is easily retrievable for auditing purposes.

All Medicaid policies and procedures such as prior authorization requirements and limits are still applicable. Pharmacy providers must maintain the explanation of benefits (EOB) from other insurance companies (or payers, i.e., Hospice). These records must be available to Medicaid upon request.

How to Bill a Non-Covered Hospice Drug

Pharmacy may override electronically by entering a '3' in the 'Other Coverage Code" field. It is the responsibility of the pharmacy to have documentation and proof that Hospice was billed first and that they received a denial of 'drug not covered' in case of an audit.

When Hospice Is No Longer In Effect

Hospice Providers must submit a disenrollment form (DOM-1166) to ACS, Medicaid's Fiscal Agent, for Medicaid beneficiaries who are no longer receiving care by that Hospice Provider. Disenrollment forms may be found at http://www.medicaid.ms.gov, Provider Manual under Hospice, and should be mailed to the Fiscal Agent at the address noted on top of the form. Forms may also be faxed to Conduent's Provider Beneficiary Relations at 601-206-3015.

For additional information regarding Hospice, refer to the Hospice Provider Manual, at http://www.medicaid.ms.gov, Provider Manuals, and select Hospice.

K-Baby

K-babies are newborns born to a Medicaid beneficiary without an assigned Medicaid ID. When billing for prescription drugs for a K-baby, use the mother's Medicaid ID number followed by the letter 'K' with the baby's name, date of birth and gender.

Lock-In

Beneficiaries can be locked into a specific pharmacy provider and/or prescriber(s) which mean they can only receive their prescriptions from an assigned provider. If they attempt to have their

prescriptions written or filled at a provider other than the one assigned, their claims will deny. MS Office of Program Integrity administers this program and can be reached at 1-800-880-5920 or 601-576-4162.

Long-Term Care (LTC)

Long-term care beneficiaries are exempt from the prescription drug limits. The dispensing fee for all drugs dispensed to a patient in LTC is $3.91. Drugs in tamper-resistant packaging that were prescribed for a resident in a LTC facility, but never administered, can be returned to the pharmacy and should not be billed to Medicaid in accordance with Mississippi State Board of Pharmacy laws.

Lost/Stolen Medications

Mississippi Medicaid does not generally reimbursed for replacement of prescriptions that are not lost, stolen, or otherwise destroyed. Prior Authorization may be granted on a case by case basis.

Max Daily Dose

The max daily dose sets a DUR edit for High Dose, if the daily dose exceeds the max daily dose on the drug file. If a beneficiary's medical condition requires a higher dose, DOM allows the beneficiary to have the higher unit dose with prior approval.

Medicare Part B

Beneficiaries with Medicare Part B services are allowed minimal prescription drug coverage. DME pharmacy providers may submit Medicare crossover claims to Medicaid using a CMS-1500 claim form. Refer to the CMS-1500 section of the Billing Manual for further instructions.

DOM does not process any Medicare Part B claims via POS.

Medicare Part D

Medicare Part D is the portion of Medicare that covers prescription drugs. Any Medicaid beneficiary eligible for Medicare Part A and B is eligible for Medicare Part D and **MUST** enroll for coverage. Medicare Part D must be billed before Medicaid in all circumstances. Medicare Part D payment is considered payment in full and should not be submitted to Medicaid for additional payment. Remember Medicaid is always the payor of last resort.

For drugs not covered by Medicare Part D, Medicaid offers limited coverage of some drugs.

Narrow Therapeutic Index Drugs – DAW 7

DOM recognizes some drugs as narrow therapeutic index (NTI) drugs in which the generic mandate does not apply. Claims must be submitted with a DAW equal to "7". MS Medicaid considers the following five drugs as NTI drugs:

- Coumadin
- Dilantin
- Lanoxin

- Synthroid
- Tegretol

The prescriber must indicate one of the following on a written or faxed prescription in order for the pharmacist to submit the DAW 7:

- Brand name medically necessary **or**
- Dispense as written **or**
- Do not substitute.

Over the Counter (OTC) Drug Coverage

Medicaid covers certain over-the-counter (OTC) drugs pursuant to a written, faxed or verbal order prescription. Covered OTC products must be manufactured by pharmaceutical companies who are participating in the Federal Drug Rebate Program. OTC drug prescriptions are included in the monthly drug benefit limit. DOM may not cover ALL available package sizes.
A current listing of the covered OTC products can be found at
http://www.medicaid.ms.gov/Pharmacy.aspx click on the "OTC List".

Paper Claims

All paper claims are processed by Conduent. Pharmacists should submit paper claims to the following address:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, Mississippi 39225

Refer paper claim questions to Conduent at 800-884-3222. See the billing forms section of this manual for a copy of the Pharmacy Paper Claim and instructions.

Payer Sheet

A separate NCPDP Payer sheet can be located at the following link:
http://www.medicaid.ms.gov/Documents/Pharmacy/MS%20NCPDP.pdf.

Pharmacy Disease Management

Pharmacy Disease Management services are those provided by specially credentialed pharmacists for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anticoagulation therapy, or other disease states as defined by the Mississippi State Board of Pharmacy. The pharmacist providing DM services must have an individual MS Medicaid Provider Number and NPI. Claims filed for these services must be submitted on a CMS 1500 form and not billed through POS.

For more information go to:
http://www.medicaid.ms.gov/Manuals/Section%2031%20-%20Pharmacy/Section%2031.19%20-%20Pharmacy%20Disease%20Management.pdf.

Pharmacy Providers

All providers dispensing medications to MS Medicaid beneficiaries must be a Mississippi Medicaid provider. Pharmacists must use their National Provider Identifier (NPI) to bill POS pharmacy claims to Mississippi Medicaid.

Providers who have questions about remittance advice statements, check inquiries, billing medical supplies, publications, and beneficiary eligibility can call the Provider Inquiry Unit: 800-884-3222.

Providers can also utilize the Mississippi Medicaid Web Portal for the most current information. Providers can enroll online, check claim status, check eligibility, and check policy through the web portal. Once registered as a provider, pharmacies can also submit claims (CMS 1500 claims, Retro eligibility and TPN claims) online, through the Envision web portal. The web portal is a one-stop shop for Medicaid providers. The Web Portal address is: https://ms-medicaid.com.

Prescription Benefits

Description	Prescription Benefits
Regular Beneficiaries	Full Prescription Benefits
Long-Term Care Beneficiaries	Full Prescription Benefits
Dually Eligible – Qualified Medicare Beneficiary (QMB)	Medicare Part D
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Children under 21	Full Prescription Benefits
Family Planning Beneficiaries	Limited Prescription Benefits
Dually Eligible – Specified Low Income Medicare Beneficiary (SLMB)	Medicare Part D
K- Baby (newborns without a Medicaid ID number)	Full Prescription Benefits

Preferred Drug List (PDL)

The mandatory Preferred Drug List for Mississippi Medicaid was implemented March 1, 2005. The PDL is updated quarterly, with the majority of changes being made every January 1st.. To view the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx. The PDL is maintained by Goold Health Systems, an Emdeon Company.

Prescriber's NPI

Beginning January 2, 2008, pharmacies should submit claims using the prescriber's National Provider Identifier. For a list of prescriber NPIs, go to:
https://ms-medicaid.com/msenvision/prescribingProviderList.do or
https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Effective 1-1-2014, in accordance with Federal guidelines, prescribers who write prescriptions for Medicaid beneficiaries must be enrolled as MS Medicaid providers. Prescribers who do not bill Medicaid for professional services, but write prescriptions for Medicaid patients must enroll as an Ordering, Referring, Prescribing (ORP) provider type.

It is the pharmacist's responsibility to ensure that the NPI number submitted on a claim is that of the prescriber on the prescription. Any other NPI used is considered fraud.

Prior Authorizations

The Mississippi Division of Medicaid requires prior authorization for reimbursement of pharmacy claims under certain circumstances. The prior authorization (PA) process is designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid fee for service (FFS) beneficiaries. The Pharmacy PA Unit can be contacted by telephone. Telephone lines are staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays.

The staff is available to providers through the following contact information:

Telephone and FAX Numbers
Telephone: 1-877-537-0722 Facsimile: 1-877-537-0720

Refill- too-Soon (Early Refill)

The refill-too-soon or early refill logic is set up to allow a beneficiary the opportunity to get their prescriptions filled no more than 25% early for regular legend drugs and no more than 15% early for controlled drugs.

- DUR overrides do not stop the early refill edits from posting.
- Early refill requests require prior authorization.

Reimbursement

For the current DOM reimbursement methodology, visit the DOM website at: http://www.medicaid.ms.gov/Manuals/Title23Part214PharmacyServicesChapter1Rule1.31.41.6and1.12eff.07.01.2013.pdf

Suspended Claims

Mississippi Medicaid does not suspend any pharmacy POS claims. Claims pay or deny. Exceptions are some claims entered through the web portal. See **Web Portal Section** for specific information.

Third Party Liability (TPL)

Mississippi Medicaid Pharmacy Point of Sale- How to bill other insurance (cost avoidance)

Pharmacy providers are required to bill prescription claims to private third party insurance carriers for those beneficiaries covered by both Medicaid and other third party insurance.

MS Medicaid Electronic Billing Procedure for Cost Avoidance

A. Beneficiaries whose data on file with Medicaid indicates other third party coverage OR beneficiaries whose data on file indicates no coverage, but provider is aware of other insurance coverage:

Provider must report the beneficiary's other insurance to Medicaid. Follow steps under "B" below.

1. Pharmacy sends electronic claim to fiscal agent and it is rejected with NCPDP Reject Code "41" which will display the message, "Submit Bill to Other Processor or Primary Payer". The text of the rejection message (NCPDP Field# 504-F4) will also state the Third Party payer information including name, address and telephone number.
2. Pharmacy sends claim to Third Party Payer.

a. **Third Party Payer pays 100% of the Medicaid allowable charge** – Claim may be resubmitted to Medicaid but no payment will result.

b. **Third Party Payer pays less than 100% of the Medicaid allowable** – Claim should be resubmitted to Medicaid.

i. **Enter the total amount paid by Third Party Payer in the "TPL Amount Paid" Field** (NCPDP Field # 431-DV – 'Other Payer Amount Paid')

ii. **Enter '02' in 'Other Coverage Code' Field** (#308-C8-Other Coverage Exists-Payment Collected)

iii. **Submit claim to Medicaid fiscal agent for the full usual and customary amount. DO NOT SUBMIT COPAY AMOUNT ONLY.**

iv. Resulting payment will be Medicaid allowable minus TPL Amount Paid.

Example of claim submission to Medicaid **AFTER OTHER INSURANCE has been billed:**

- Claim Submitted to BCBS with a total submitted Charge of $200.00 (Usual and Custormary)
- Blue Cross Blue Shield Pays Pharmacy $100.00 and receipt states that Patient must pay $100.00 Deductible.
- Submit Secondary claim to Medicaid –
  - **i.** Submit a **Total Charge of $200.00**
  - **ii.** Enter a '02' in the "Other Coverage Code" field (NCPDP 308-C8)
  - **iii.** Enter $100.00 in the 'TPL AMOUNT PAID' field (NCPDP 431-DV) **Do not bill only the copay amount to Medicaid.**

c. **Third Party Payer sends back a 0.00 Paid Amount* Rejection or Denial)**

*Valid Values for 'Other Payer Reject Codes' (Field# 472-6E) received from other insurance are:
40 = Pharmacy Not Contracted with Plan on Date of Service
65 = Patient is Not Covered
67 = Filled Before Coverage Effective
68 = Filled After Coverage Expired
69 = Filled After Coverage Terminated
70 = Product/Service Not Covered
73 = Refills are Not Covered
76 = Plan Limitations Exceeded

i. **Enter $0.00 in the 'TPL Amount Paid' Field 431-DV** (this field is optional when Field #308-C8 'Other Coverage Code' = 01, 03, or 04)
ii. In Field **#308-C8,'Other Coverage Code'** one of the following applicable values **should** be entered:

01 = No Other Coverage Exists (Ex: Claim denies due to coverage expired)
03 = Other Coverage Exists – Claim Not Covered (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)
04 = Other Coverage Exists – Payment Not Collected

Examples:

- Beneficiary has insurance coverage (ex:70-30), which requires the beneficiary to pay for the prescription, then the insurance company would reimburse the beneficiary a certain percentage of the claim
- Pharmacy submits claim to other payer. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payer applies the claim to the beneficiary's deductible for

the other insurance. The provider then submits the usual and customary charge to Medicaid.

- Other insurance requires prior authorization for claim submitted. The prior authorization process should be initiated by the provider. Should the access of the beneficiary's prescription be delayed due to this process, the pharmacy may submit the claim to Medicaid. Once the prior authorization is acquired, the claim must be reversed then coordinated with the insurance carrier.

  05 = Managed Care Plan Denial – Not an acceptable value
  06 = Other Coverage Denied – Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber is out of the insurance company's network.
  07 = Other Coverage Exists – Not in Effect on Date of Service
  08 = Billing for Copay – Not an acceptable value

iii. Submit claim to Medicaid fiscal agent
iv. Claim will pay Medicaid Allowable

B. Provider must report the beneficiaries' other insurance to Medicaid. Provider may report changes in beneficiaries' insurance coverage as follows:

- FAX information to: (601) 359-6294 (PREFERRED)
- CALL Third Party Recovery – Division of Medicaid – (601) 359 6095
  Email or mail form – Visit MS Medicaid Website -
  http://www.medicaid.ms.gov/UpdateHealthInsuranceInformation.aspx

Notes:
Pharmacy providers must keep explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request.

If a beneficiary tells the provider that his/her insurance policy is no longer in effect, the policy never existed, or the policy is for something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes: the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Third Party Recovery. Upon receipt of this information, the patient's statement will be researched and, if necessary, the third party resource file will be updated.

Remember, Medicaid is always the payer of last resort.

Timely Filing Limits

Providers must submit claims within 365 days.

Total Parenteral Nutrition (TPN)

Claims for TPN (hyper-alimentation, IDPN, and IPN) solutions must be submitted as follows:

- Claims are to be billed preferably via the web portal or on a paper Mississippi Medicaid Pharmacy Claim form and sent to DOM. **See Web Portal Section of this document and Section 5.2 of this billing manual for specific instructions.**
- Claims are to be billed monthly for no more than a max 31-day supply.
- Claims should list the actual NDC number(s) with the quantity of each ingredient used beginning with the most costly ingredient.
- The provider should bill for the number of milliliters of TPN that were dispensed to the beneficiary during the billing period.
- The maximum dispensing fee shall not exceed $30.00 per liter.
- The quantity for those non-covered NDCs will not be included in the total liter quantity to determine the dispensing fee.
- For dually eligible beneficiaries, Mississippi Medicaid will not cover TPNs. Such claims should not be submitted to DOM.
-

Vacation Supply

DOM does not allow for a vacation supply.

Web Addresses

Division of Medicaid (DOM)	http://www.medicaid.ms.gov
Goold Health Systems	http://ghsinc.com
Conduent	https://ms-medicaid.com

Web Portal Claims Entry

DOM allows certain claims to be submitted for reimbursement through the web portal at https://ms-medicaid.com/msenvision/index.do .

- Regular POS pharmacy claims in emergency situations
- Retroactive eligibility claims older than 12 months
- TPN- Total Parenteral Nutrition claims

Please refer to the Web Portal Pharmacy Claim section of this manual for explicit instructions for submitting these claims.