Pharmaceutical Services Guide

Use this guide as a supplement to the Pharmaceutical Services Oregon Administrative Rules (OARs, Chapter 410 Division 121). See current Pharmaceutical Services OARs for official policies regarding billing.

As noted in OAR 410-121-0100 – Drug Use Review, also follow Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening.

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Member eligibility and enrollment

Refer to General Rules and OHP Rules for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

The OHP eligibility verification page explains how to verify eligibility using the MMIS Provider Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

Medicare-Medicaid coverage

Medicaid prescription coverage for clients with Medicare coverage is limited (see table below).

Coverage type	Medicaid coverage
Medicare Part B	After Medicare pays, the remaining balance is paid by OHA up to the Medicaid allowed amount.
Medicare Part D	Certain drugs not covered by Medicare Part D: ■ Selected agents used for symptomatic relief of cough/cold ■ Selected vitamins and minerals ■ Selected OTC drugs ■ Barbiturates ■ Benzodiazepines (quantity limit of 15 tablets/capsules per rolling 30 day period). These include estazolam, flurazepam, quazepam, temazepam, triazolam.

Medicare Part D plan information

If you need help resolving Medicare Part D billing issues, contact the DHS Medicare Hotline at 877-585-0007. Hotline hours are 8 a.m. to 5 p.m., Monday through Friday.

Prescribing controlled substances

Checking the Prescription Drug Monitoring Program (PDMP) database

OAR 410-120-1260(13) requires enrolled providers to check the PDMP as defined in ORS 431A.655 before prescribing a Schedule II controlled substance pursuant to 42 U.S.C 1396w-3a.

- OHA encourages clinicians to review the patient's history of controlled substance prescriptions using the PDMP before prescribing, and periodically during therapy for all controlled substances.
- PDMP evaluation prior to prescribing controlled substances can improve prescription management and identify drug combinations that increase the risk for overdose.

Prior authorization

The following services require prior authorization (PA):

- Durable medical equipment and supplies, including diabetic supplies prescribed in excess of OHA's utilization guidelines (DMEPOS – Division 122)
- Home Enteral/Parenteral and IV services, including oral nutritional supplements (Division 148)
- Drugs that require PA as outlined in OAR 410-121-0040, including prescriptions that exceed quantity limits as described in the Oregon Medicaid PA Criteria or Prioritized List of Health Services treatment guidelines.
- Overrides of Federal Upper Limit pricing or other requests to Dispense as Written

Refer to the program-specific administrative rules and supplemental information for specific details and required forms.

Submit prior authorization (PA) requests to OHA using the Provider Web Portal (instructions) or the MSC 3971 (DME, Home EPIV) or OHP 3978 (prescriptions and oral nutritional supplements).

- For coordinated care organization (CCO) members, contact the CCO for PA instructions.
- For complete instructions on how to submit PA requests to OHA, see the Prior Authorization Handbook.

Client hearings and exception requests

For PA request denials due to OHA criteria not being met, the right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264(10) and OAR 410-120-1860.

- This rule describes when a client may request a state hearing. Clients may request a hearing based upon information included in the PA denial notice.
- Information on how to file an appeal is attached to all PA notices to clients and providers from the Oregon Pharmacy Call Center.

Providers may contact Provider Services Unit at 800-336-6016 to file an exception request on a PA denial.

Reimbursement *See OAR 410-121-0155 for more information*

Long Term Care (LTC) clients *Also see OAR 410-121-0148 and 410-121-0625*

LTC claims for certain drugs are not covered through the pharmacy benefit and are considered part of the per diem paid to the institution.

Pharmacy Management Program *See OAR 410-121-0135 for more information*

When Pharmacy Management Program (lock-in) clients attempt to fill their prescription elsewhere than their designated pharmacy, the claim will reject with NCPDP Reject Code M2.

Providers may call the Oregon Pharmacy Call Center at 888-202-2126 for override consideration. Override is for specified date of service only.

Prepaid Health Plan (PHP) coverage *See OAR 410-141-0070 for more information*

OHA covers only the following (carve out) drugs for OHP clients enrolled in a Prepaid Health Plan (fully-capitated health plan or physician care organization):

- Therapeutic Class/Code (TC): 7 and 11
- Depakote and generic equivalents
- Lamictal and generic equivalents

Current carve-out drugs

Covered non-rebateable items

OHA reimburses pharmacies for some items not listed on the Medicaid Drug Rebate List, including:

- Oral nutritional supplements used for total nutrition
- Selected vitamins
- Vaccines
- Infant formulas
- One pill splitter/cutter per client per twelve month period billed via point of sale (POS) with a valid National Drug Code (NDC)

Age limits ***See OAR 410-121-0147 for more information***

- Fluoride (excluding vitamin combinations) is not covered if client is 19 or older.
- Plan B (emergency contraception) requires a prescription for female clients under 17 years of age. Plan B may be dispensed OTC for female clients age 17 and over. Refer to OAR 410-121-0160 for more Plan B information.
- Pharmacist-administered immunizations: Client must be 11 years or older. OHA covers up to three immunizations for one date of service. For information about the Vaccines For Children (VFC) Program please see the Medical Surgical provider guidelines.

Federal Upper Limit (FUL) ***See OAR 410-121-0300 for more information***

FUL price can be overridden if the provider enters a "1" in the DAW field, but this requires prior authorization from the prescriber.

Average Actual Acquisition Cost (AAAC) ***See OAR 410-121-0155 for more information***

This is the maximum price OHA will pay for a specific NDC. AAAC lists for brand-name and generic drugs are available in the Pharmaceutical Services provider guidelines (click on "Billing information").

If the AAAC price for a specific NDC is below the pharmacy's usual cost, the pharmacy should submit a Reimbursement Rate Review request to Myers and Stauffer, LC for review.

Providers with questions about pharmacy reimbursement rates, requests to review rates for specific drugs, or billing errors due to no pricing on file may contact Myers and Stauffer, LC in writing by email, regular mail, fax or online.

Myers and Stauffer, LC
Pharmacy Unit
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

Phone: 800-591-1183
Fax: 317-571-8481
Email: pharmacy@mslc.com

340B program

The federal 340B Public Health Services (PHS) program allows eligible safety net providers to buy drugs at very low prices. Eligible providers include federally qualified health centers, disproportionate share hospitals, and urban Indian organizations.

Billing for pharmacy services

Bill for drugs and diabetic supplies using the Provider Web Portal pharmacy claim or UCF 5.1.

Bill for medical management, Clozapine supervision, and pharmacy-based immunizations using the Provider Web Portal professional claim, 837P or CMS-1500.

- **Billing instructions** are available on the OHP provider billing tips page.
- **For information about electronic billing,** go to the Electronic Business Practices page.

Whenever possible, only use the NCPDP 5.1 Universal Claim Form (UCF) when billing for medications that cannot be billed electronically via POS or Provider Web Portal:

- Claims more than a year old (from the date of service);
- Death with Dignity claims: See OAR 410-121-0150 (8) (a-d).

340B claims

340B providers must be enrolled with provider specialty 408, using the provider IDs (OHA provider ID and NPI) they use for 340B purchasing.

- These IDs should be on the federal Medicaid Exclusion file. Only use these IDs when billing OHA for 340B drugs.
- 340B pharmacies are expected to bill actual acquisition cost for 340B drugs.
- 340B providers who choose to dispense drugs outside the 340B program (*i.e.*, "carve out" drugs) must bill for those drugs under a separate Medicaid ID and NPI.

Indian Health (Tribal) claims

Tribal pharmacies enroll with provider specialty 404. A patient attribute of Heritage Native American (HNA) is required. Copays are excluded.

Long Term Care (LTC) clients

LTC clients are exempt from copays. All PA and ProDUR alerts apply. The dispensing pharmacy must be enrolled with provider specialty 402. For CII partial fills:

- RX # will be valid for 60 days from the date of fill.
- After the 60-day time period, the claim will deny and return a supplemental message indicating that a new RX # is required.
- The provider receives the usual dispensing fee paid for each fill.

Medication Therapy Management (MTM)

Pharmacists must enroll with OHA as a professional provider to bill for MTM services. Services must be provided based on referral from a physician, licensed provider, or a Prepaid Health Plan (PHP). Use the following codes to bill for MTM services:

Code	Description	OHA rate
99605	Initial 15 minutes, new patient	$28.22
99606	Initial 15 minutes, established patient	$26.34
99607	Each additional 15 minutes	$13.17

For documentation requirements, refer to Guideline Note 64 of the Prioritized List of Health Services. For specific information on when to bill for MTM services, refer to CPT coding guidelines.

Coordination of benefits *See OAR 410-120-1280 and 410- 120-1340*

Medicaid (OHA) must be the payer of last resort whenever possible. Before billing OHA, find out if the client has other health coverage (third party liability, or TPL). If the client has TPL (including Medicare), you must bill the TPL first before billing OHA.

If any part of a claim is paid by a TPL:

- You must not charge the client for TPL copayment, coinsurance or deductible.
- OHA will pay the remainder up to the OHA allowed amount, less any OHA copayment that applies.

If TPL pays more than OHA's allowable, then OHA would pay zero and no OHA copayment applies. This is considered "payment in full." You must not charge the client for the remainder.

When billing OHA as secondary (after billing TPL):

- List all TPL payments already paid for the claim.
- If TPL denies or "zero pays," do not use Other Coverage Code 5, 6 or 8.

Note: Intentional misuse of TPL coding is fraudulent and OHA will recover all resulting overpayments.

Point of Sale (POS) information

Value Added Networks ("switches")

A Value Added Network (VAN) is a third-party service that transmits and stores EDI data in an "electronic mailbox" until it is picked up by the appropriate party. A VAN serves as a middleman, so that neither party can access the other's private network. A VAN must have a current Trading Partner Agreement with OHA in order to exchange EDI data.

OHA accepts pharmacy POS claims from the following approved VANs:

Emdeon (formerly WebMD, Envoy)	24 Hour Assistance: 1-615-231-4610 Help Desk: 800-333-6869
ERx	24 Hour Assistance: 866-erxnetwork (answering service) or itoncallpager@erxnetwork.com (on-call pager)
QS1	24 Hour Assistance: 864-253-8600 ext 7734 (pager)
RelayHealth (formerly Per-Se, NDC)	24-hour General Customer Service: 800-895-0333 24–hour Technical Assistance: 1-404-728-2570.

POS transaction types

Ability to use these transaction codes will depend upon the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (B1 transactions) and reversals (B2 transactions).

Transaction type	Description
Full Claims Adjudication (B1)	This submits the claim and returns to the pharmacy the allowed amount.
Claims Reversal (B2)	This cancels or voids a paid claim. The following fields must match on the original paid claim and on the void request for a successful claim reversal: ■ NPI (of billing provider) ■ Prescription number ■ Date of service (date filled)
Claims Re-Bill/ Adjustments (B3)	This adjusts and resubmits a paid claim. When this happens, the original claim is voided at the same time.

Required data elements

Each NCPDP transaction has ***mandatory/required, optional*** and ***not sent*** data elements specific to Oregon Medicaid. For more information, refer to the Oregon Medicaid Pharmacy Payer Sheet.

System availability

The Oregon Medicaid POS system will be available 24 hours a day, 7 days a week, except for weekly maintenance during non-peak hours over the weekend.

- The system's server counters and controls reset nightly at approximately midnight, which may cause a brief period of unavailability (less than 5 minutes).
- If for any reason the POS system is not available, wait to submit claims until the system is back online. To facilitate this process, make sure your POS software has the capability to submit backdated claims.

System error messages

Occasionally providers may receive a message that indicates their network is having technical problems communicating with the Oregon Medicaid POS system.

NCPDP	Message	Description
90	Host hung up	Host disconnected before session completed.
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
99	Host Processing Error	Do not retransmit claims.
93	Planned Unavailable	Transmission occurred during scheduled downtime.

If you get one of these messages, follow these steps. If these steps don't solve your problem, contact the Oregon Pharmacy Call Center: 888-208-2126.

Make sure your power is on and that the telephone line is working.

- Call the telephone number your modem is dialing into.
- Note the information heard (i.e., fast busy, steady busy, recorded message).
- Contact your software vendor if unable to access this information in the system.

If you have technical support staff in your organization or through a VAN, refer the problem to them. The technical support staff will coordinate with the Oregon Pharmacy Call Center to resolve the problem.

Timely filing limits

See OAR 410-120-1300 and 410-120-1570 for more information

Most providers submit their POS claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after the fact. For more information regarding timely submission of claims and/or appeals/claims reconsideration, please refer to the General Rules Program Rulebook.

B1 transactions	For all original claims, the timely filing limit for this program is 366 days from the date of service. POS claims that exceed this limit will deny.
B2 and B3 transactions	Reversals, re-bills and adjusted claims may be submitted 366 days from date of service plus the days supply on the original claim. Prescriptions for 30 days supply can be reversed through POS up to 396 days from the date of service. After these time limits have expired, you must rebill or adjust the POS claim on paper: ■ Adjustments require an Individual Adjustment Request form (OHA 1036). ■ Denied claims that are 366 days from date of service require the NCPDP 5.1 Universal Claim Form.

Data Integrity Audit Program

Based on POS data, the Oregon Pharmacy Call Center will audit inaccurate days-supply entries, metric quantities, credit return frequency, and frequent use of early refill and Pharmacy Management Program (also known as lock-in) overrides. The Call Center will report findings and recommend further investigation to OHA.

Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the OHP remittance advice page.

For information about how to adjust a claim using the Provider Web Portal or OHA 1036 form, refer to the Claim Adjustment Handbook.

When you need help

If you need help with any alert or denial messages, contact the Oregon Pharmacy Call Center: 888-208-2126 at the time of dispensing.

The Call Center can provide claims information on all error messages sent by the ProDUR system. This information includes NDCs and drug names of the affected drugs, dates of service, days supply and whether the calling pharmacy is the dispensing pharmacy of the conflicting drug or the drug was dispensed by another pharmacy.

Call Center is available 24 hours per day, seven days a week, 365 days a year, and processes PA requests within 24 hours. When calling in a PA request, have the diagnosis code ready.

- Phone: 888-202-2126
- Fax: 888-346-0178

Provider enrollment information

For information about how to enroll as an OHP provider, go to the Provider Enrollment Web page.

Pharmacy Provider Specialty Types

106 - Pharmacist
400 – Retail Pharmacy
402 – Long Term Care/Nursing Facility
404 – Indian Health Service (Tribal) Provider
405 – Mail Order Provider
406 – Specialty Pharmacy Provider
407 – Rural Health Clinic
408 – Public Health Service (340B) Provider

Vaccines for Children program - See *OAR 410-146-0100* for more information

The Vaccines for Children program (VFC) supplies federally purchased free vaccines for immunizing eligible children in public and private practices - at no cost to participating private health care providers.

- Patients through age 18 are eligible if they are enrolled in Medicaid or the Oregon Health Plan, uninsured; or American Indian/Alaskan Native.
- For more information, go to the VFC website.
- To enroll in the VFC program, call 971-673-0300 and request a “VFC Recruitment Packet.”