Beginning Billing Workshop Pharmacy

Colorado Medicaid
2016

COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

Xerox State Healthcare

Medicaid/CHP+ Medical Providers

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - Claims processing
  - How to ensure your claims are timely
  - How to bill when other payers are involved
  - Prior Authorization Request procedures
  - Medical and Supply claims

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html?redirect=/nationalprovidentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 800-456-3203
    - 800-692-2326 TTY

What is an NPI?

- NPI and electronic claim submissions:
  - Pharmacies must include both their NPI and the prescriber's NPI on all claims

Department Website

1

www.colorado.gov/hcpf

https://www.colorado.gov/hcpf

Colorado The Official Web Portal

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COLORADO
Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers

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For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore Benefits

Apply Now

Find Doctors

Get Help

Feeling Sick?
For medical advice, call the Nurse Line:
800-283-3221

Get Covered. Stay Healthy.
colorado.gov/health

Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

The Official Web Portal

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COLORADO
Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers | For Our Stakeholders | About Us

For Our Providers

- Why should *you* become a provider?
- How to become a provider (enroll)
- Provider services (training, & more)
- What's new? (bulletins, newsletters, updates)

- CBMS Colorado Benefits Mgmt. System
- DDweb
- Web Portal
- Get Help
- Get Info
- Find a Doctor

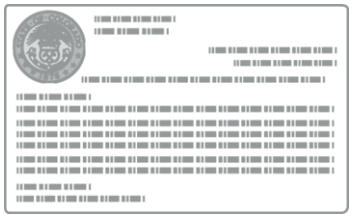
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Colorado Medical Assistance Web Portal

Fax Back 1-800-493-0920

CMERS/AVRS 1-800-237-0757



Medicaid ID Card with Switch Vendor

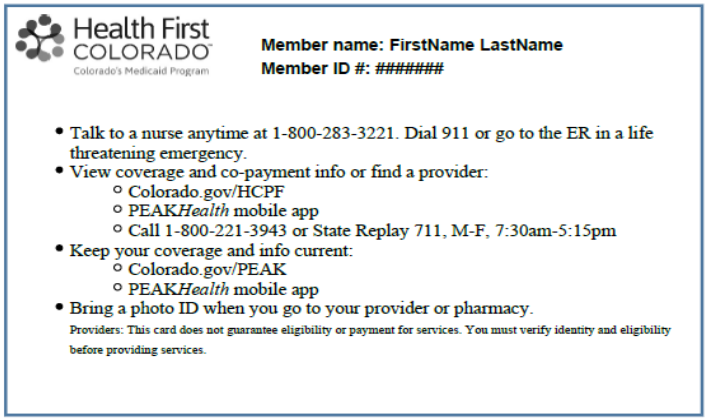
From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

Special Eligibility Types

- Undocumented Non-citizens
  - Eligible for emergency services only (pharmacy benefits are usually not included as part of eligible emergency service benefits)
- Modified Medical Program
  - (OAP State) Pharmacies can refuse to service OAP-State Only members
  - See the Department's website for current reimbursement for OAP-State members
- Child Health Plan Plus (CHP+)
  - There are several HMO options
  - Members can call 1-800-359-1991

Medicaid Identification Cards

- Provider may begin seeing the branded cards as early as 20, 2016


Health First COLORADO
Colorado's Medicaid Program

Member name: FirstName LastName
Member ID #: #######

- Talk to a nurse anytime at 1-800-283-3221. Dial 911 or go to the ER in a life threatening emergency.
- View coverage and co-payment info or find a provider:
  - Colorado.gov/HCPF
  - PEAK*Health* mobile app
  - Call 1-800-221-3943 or State Replay 711, M-F, 7:30am-5:15pm
- Keep your coverage and info current:
  - Colorado.gov/PEAK
  - PEAK*Health* mobile app
- Bring a photo ID when you go to your provider or pharmacy.

Providers: This card does not guarantee eligibility or payment for services. You must verify identity and eligibility before providing services.

- Older branded cards are valid
- Identification Card does not guarantee eligibility

Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

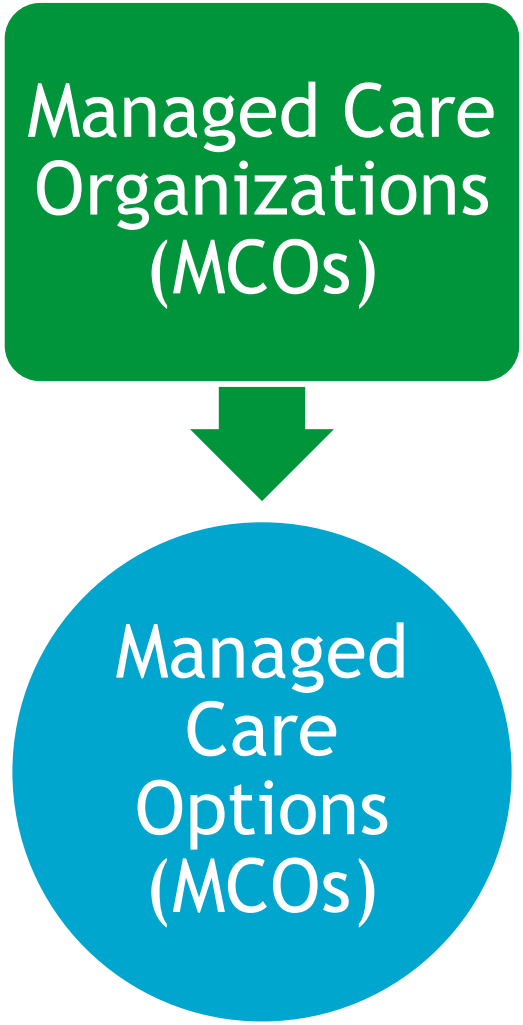
Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as "Dual Eligible"
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six (6) years

Managed Care Options



Managed Care Options

Managed Care Organization (MCO)

- Denver Health or Rocky Mountain Health Plan
  - Members do not have pharmacy benefits with fee-for-service Medicaid
  - July 2004 Bulletin (B0400179):
    - There are no Medical Assistance Program Fee-For-Service pharmacy benefits for members who are enrolled in a Medical Assistance Program MCO
    - Any drugs that are not covered by the MCO cannot be billed to the Colorado Medical Assistance Program

Medicare Part D

- As of January 1, 2006, Medicaid only pays for the 'excluded drugs' for members who also qualify for Medicare
  - A list of excluded drugs is available on the Department's website in the pharmacy section, under Medicare – Medicaid Enrollee Population
- Pharmacies must bill the Medicare Part D plan for the excluded drugs other D.O identifiers before
  - Submitting claims to Medicaid and
  - Use other insurance indicator of "3" on the claim
- Details about the Medicare benefit and drugs that are covered by the Colorado Medical Assistance Program are available in the Provider Bulletins

Medicare Part D

- February 1, 2008- Colorado Medicaid Assistance Program implemented its Preferred Drug List (PDL)
  - Dually eligible members are exempt from PDL policies
  - Prescribers should write prescription for preferred drugs whenever possible to avoid certain authorization requirements

COBManager (HMS)

- COBManager process for pharmacy claims
  - Department has a process to ensure commercial payors pay pharmacy claims prior to billing the Colorado Medical Assistance Program for members with commercial pharmacy coverage
  - With COBManager, the Department's third party liability vendor (HMS) matches pharmacy claims on a daily basis with commercial eligibility data and submit claims to the Commercial Pharmacy Benefit Manager (PBM) when there is coverage under an alternative plan

COBManager (HMS)

- When the commercial PBM is billed:
  - Pharmacy provider is paid by the commercial PBM as a separate transaction
  - HMS sends a re-bill (NCPDP B3) claim to the Colorado Medical Assistance Program showing the amount paid by the PBM for coordination of benefits
  - Pharmacy providers can search for claim activity or download transactions affected by COBManager through the secured HMS web portal "eCenter"
    - Contact HMS at 855-438-6420 for access
    - https://ecenter.hmsy.com

Member Over-Utilization Program

- Colorado Medical Assistance Program has a Member Over-Utilization Program (COUP) in place
- The COUP is a statewide utilization control program that safeguards against unnecessary or inappropriate use of care or services
- Program provides a post-payment review process allowing for the review of Medicaid member utilization profiles
- Identifies excessive patterns of utilization in order to rectify over-utilization practices of members
- COUP restricts members to **one designated pharmacy** and possibly **one designated prescribing professional** when there is documented evidence of over-utilization

Member Over-Utilization Program

- Members may be place in the COUP if:
  - Use of sixteen or more prescriptions
  - Use of three (3) or more pharmacies
  - Use of three (3) or more drugs in the same therapeutic category
    - e.g. Oxycodone, Oxycontin and Hydrocodone
  - Excessive emergency room (ER) and physician visits
  - Referral or analysis indicates possible over-utilization

Member Over-Utilization Program

- Once in the program, only one pharmacy will be allowed to submit claims
- If you are not the pharmacy (or the physician) listed, you will receive error NCPDP Reject 50 “Non-matched Provider Number” or NCPDP Reject 56 “Non-matched Prescriber ID”
- Any provider can ask for a member to be reviewed
  - Contact DHCPF at 1-303-866-3672
  - For more information see the August 2012 Bulletin (B1200325)

Mail Order Program

- April 1, 2009- qualifying members may receive outpatient maintenance medications from mail order pharmacies
- To qualify:
  - A physical hardship that prohibits them from obtaining maintenance medication from a local pharmacy
  - Third party insurance that allows the use of a mail order pharmacy to obtain their maintenance medications
    - A member or member's physician must complete and submit an enrollment form to the Department that attests the member meets one of the qualifying criteria
  - Member Mail Order Enrollment Forms are available on the Department's website in the Pharmacy Mail Order Prescriptions section

Mail Order Program

- Mail order pharmacy claims will deny if submitted without the member being enrolled in program
  - NCPDP edit 85 with text indicating that the claim did not process will post
    - Denial will appear as edit PB85 on the Provider Claim Report
  - Out-of-state mail order pharmacies are permitted to enroll as Medicaid providers
    - Only provide maintenance medications to members who have applied for the mail order pharmacy benefit
  - Local pharmacies, which are not mail order pharmacies, may occasionally mail any outpatient medication to the member without them enrolling in the mail order pharmacy benefit

Reimbursement

- Pharmacy pricing
  - Pricing methodology applies to:
    - Brand
    - Brand with Generic available
    - Generic
  - Does not apply to DME/Supply that is billed on the CMS 1500 form or via the 837P

Reimbursement Calculation

- Effective February 1, 2013, the Department moved to its current pharmacy reimbursement methodology
  - Methodology utilizes data from surveys of Colorado pharmacies to determine:
    - Professional tiered Dispensing Fees
    - Actual Acquisition Costs (AACs) for drugs dispensed to Colorado Medicaid members

Dispensing Fee Determination

- In late 2012 and again in 2013, total prescription volume surveys were distributed to all participating Colorado Medicaid pharmacies
  - Surveys are used to establish the professional dispensing fee for each pharmacy provider
    - Any pharmacy failing to respond to the survey will be reimbursed $9.31 for a professional dispensing fee under the methodology
    - Responding pharmacies will be mailed their proposed dispensing fees based upon the information they provided
    - Any new or Change of Ownership (CHOW) pharmacy provides are required to fill out an Attestation Form from the Pharmacy web page to get a dispensing fee
  - More details are available on the Pharmacy web page and in the January 2013 Bulletin (B1200332)

Dispensing Fee Determination

- The professional dispensing fees are tiered based upon the pharmacy's total prescription volume

Number of Prescriptions	Professional Dispensing Fee
Less than 60,000	$13.40
60,000 to 89,999	$11.49
90,000 to 109,999	$10.25
More than 110,000	$9.31
State determined Rural	$14.14
Governmental	$0.00

Reimbursement Pharmacy Pricing

- Average Acquisition Cost (AAC) Rate or Submitted Rate
  - Whichever is less
- If no AAC price is available for the drug, Wholesale Acquisition Cost (WAC) or Submitted Charge
  - Whichever is less
- Rural Pharmacies
  - Submitted Rates do not apply
  - Adjustment for AAC and WAC Rates may be applied for dates of service prior to February 1, 2014

Average Acquisition Cost Rates

- AAC rates are rebased monthly using invoices and/or purchase records provided to the Department through a representative group of Colorado Pharmacies
  - If the Department cannot establish a process to obtain invoices and/or purchase records on a monthly basis, the Department surveys ¼ of the Medicaid enrolled pharmacies every quarter to rebase AAC rates

Average Acquisition Cost Rates

- A pharmacy wanting to inquire about a current AAC rate:
  - Complete the Average Acquisition Cost Inquiry worksheet posted on the Department's website
  - Pharmacy will email completed worksheet to colorado.smac@hcpf.state.co.us
    - Include a copy of the receipt invoice
    - Include a copy of the billed claim for the drug in question

Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)

Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

Record Retention

- Providers must:
  - Maintain records for at least six (6) years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

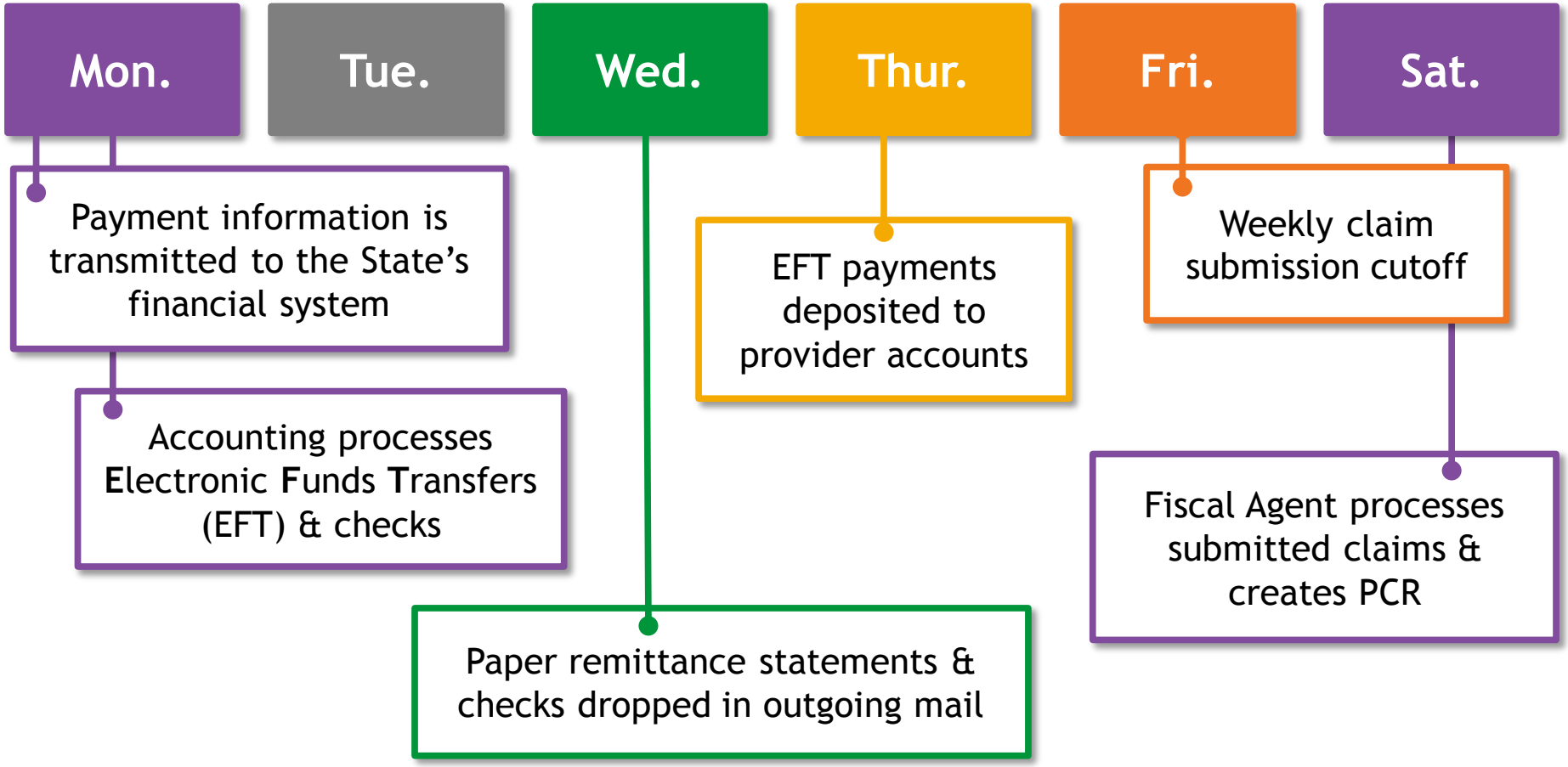
Record Retention for Pharmacies

- Providers are required to maintain prescription records as a condition of participating in the Colorado Medical Assistance Program
- Maintaining proper prescription records is important because it supports patient safety and provides an official record of a patient encounter
- The State Board of Pharmacy requires an exact duplicate of the original prescription to be available in a reproducible format

Record Retention for Pharmacies

- The Department's rules stipulate that the pharmacist shall be responsible for assuring reasonable efforts have been made to obtain, record and maintain member information from the member or his/her apparent agent for each new prescription
  - Record Requirements 10 C.C.R 2505-10, section 8.800.11
  - Refer to July 2011 Bulletin (B1100303)

Payment Processing Schedule



Common Claim Rejections

Missing/Invalid Day Supply (PB19)	• Colorado Medical Assistance Program allows a pharmacy to dispense 30 tablets or 100 day supply- whichever is less
Prior Authorization Required (PB75)	• Drug requires Prior Authorization • Drug may be Non-Preferred • PAR request are made through Pharmacy Support • 800-365-4944
Member has Other Insurance (PB41)	• Use Other Coverage Codes • Other Payor Date

Common Claim Rejections

Claim Not Processed (PB 85)

- Claim was billed by a State Identified mail Order Pharmacy and the member is not part of the State's hardship Member list and not required by the TPL to receive drugs from a Mail Order Pharmacy
- Claim has a listed Other Insurance Code of something other than 0-4
- Billing Pharmacy does not have a Dispensing Fee on file with the Department

Common Claim Rejections

Refill too Soon (PB79)

- Colorado Medical Assistance Program does not pay for vacation prescriptions. If a member has gone in and out of a Nursing Facility, or decreases in strength then the pharmacy should call the Pharmacy Helpdesk at 1-800-0365-4944 or an override
- Members can receive a once in a lifetime override for lost/stolen prescriptions
  - In these situations, contact the Department at 1-303-866-3588
  - Increases in strength should not deny claims

Other Insurance Codes

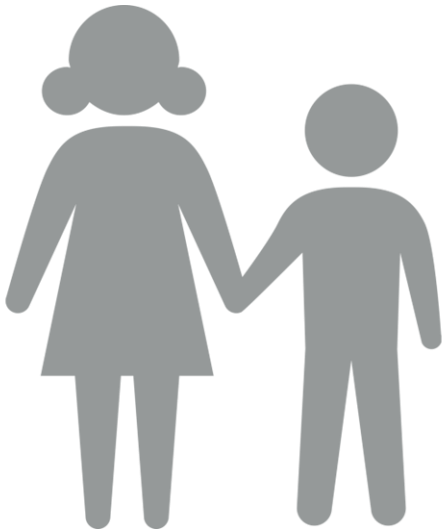
- The following are the only "Other Insurance" codes permitted on Pharmacy Claims
  - 0= Not Specified
  - 2= Other Coverage Exists- Payment Collected
  - 3= Other Coverage Exists- This Claim Not Covered
  - 4= Other Coverage Exists- Payment Not Collected
- Effective January 1, 2012, if an Other Coverage Code is not submitted with the claim, or the Other Coverage Code is something other than 0, 2, 3, or 4, NCPDP Reject Code 41 and/or 85 will post

Other Insurance Codes

- Because of the significant changes related to Other Coverage Codes and the need for further information when certain codes are submitted, refer to the following documents and websites for more information regarding additional details that must also be provided for each code:
  - January 2012 Bulletin (B1200310)
  - February 2012 Bulletin (B1200316)
  - www.colorado.gov/hcpf/billing-manuals

Co-Payment Exempt Members

Nursing Facility Residents



Children and Former Foster Care Eligible*

Pregnant Women

***former foster care eligible still has a pharmacy co-pay**

From the Noun Project:
"Nursing-Home" by Iconathon
"Children" by OCHA Visual Information Unit
"Maternity-Cycle" by HCPF

Co-Payment Facts

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Youth from birth to 18 years old are considered children
- Use appropriate values to indicate that member is co-pay exempt
  - Pregnancy- Prior Authorization Type Code 4 (for all prescriptions)
- Effective January 1, 2014 Vitamin D and Aspirin are co-pay exempt for all members
- Co-Pay amounts
  - Generic: $1.00
  - Brand: $3.00
  - HIS Pharmacies: $0.00

Paper Billing

- The Colorado Pharmacy Claim Form (PCF-2) replaced the Pharmacy Claim form (PCF-1) and the Universal Claim Form (UCF)
  - The PCF-2 is available at no charge on the Department's website in the Pharmacy Billing Procedures and Forms section
- Pharmacies may bill on paper if:
  - The pharmacy bills less than five (5) claims per month
  - The claim is a Reconsideration claim
  - The claim requires an attachment
  - Claim is outside of timely filing

Colorado Pharmacy Claim Form (PCF-2)

Colorado Medical Assistance Program
Colorado Pharmacy Claim Form (PCF-2)

I. Client Information

Client's Medicaid ID Number: _____ Group ID: Colorado Colorado Relationship Code: 1
Client's Name (Last/First/Middle Initial): _____, _____ _____
Client's Street Address: _____ Client's City: _____ Client's Zip Code: _____
Other Coverage Code: _____ Client's DOB (MM/DD/YYYY): __/__/____

II. Pharmacy Information

Service Provider ID: _____ Service Provider ID Qualifier: _____

III. Prescriber Information

Prescriber's Last Name: _____ Prescriber's Phone Number: ___-___-____
Prescriber's ID: _____ Prescriber's ID Qualifier: _____

IV. Claim Information (Claim must be for the same client as listed above)

Prescription Number: _____ Fill Number: _____ Days Supply: _____
Date Written: __/__/____ Date Filled: __/__/____ Prescription # Qualifier: _____
DAW Code: _____ PA Type Code: _____ Quantity Prescribed: _____
Product ID: _____ Product ID Qualifier: _____ Quantity Dispensed: _____
Submitted Ingredient Cost: _____ Total Charge: _____ Gross Amount Due: _____

V. Other Payer Information

Other Payer Coverage Type: _____ Other Payer Date: __/__/____
Other Payer Amount Paid: _____ Other Payer Amount Paid Qualifier: _____
Other Payer Reject Code: _____ Other Payer Patient Responsibility Amount: _____
Other Payer Patient Responsibility Amount Qualifier: _____
Compound Claim: _____ Diagnosis Code Qualifier: __ Diagnosis Code: _____
RX Override: _____ RX Override: _____ RX Override: _____

VI. Complete this Section for Compound Prescriptions Only
Limit 1 Compound Prescription Per Claim Form

Ingredient Name	NDC	Quantity	Ingredient Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: _____ Date: __/__/____

This is to certify that the foregoing information is true, accurate, and complete. This is to certify that I understand that payment of this claim will be from Federal and State funds and that my falsification or concealment of material fact may be prosecuted under Federal and State laws.

This form should be printed, completed by hand, or typed and mailed to ACS:
Please mailed completed form(s) to:
Paper Claims Submissions, P.O. Box 30, Denver, CO 80201-0030

Electronic Billing

- Effective January 1, 2012, all claims should be submitted in the NCPDP Version D.0
- D.0 Payer Sheets are available on the Department's website
  - www.colorado.gov/hcpf/billing-manuals

ICD-9 Codes

- Department allows the use of ICD-9 codes to override some prior authorizations denials
  - ICD-9 codes can be submitted on pharmacy point-of-sale claims in NCPDP Version D.0 Field 424-DO (Diagnosis Code) to override prior authorization requirements for some medications/diagnoses
    - Example: Namenda and Lyrica

ICD-10 Conversion

- Watch future Bulletins for information related to submitting ICD-10 diagnosis codes beginning October 1, 2015
  - ICD-10 codes will be submitted on pharmacy point-of-sale claims in NCPDP Version D.0 Field 424-DO (Diagnosis Code) to override prior authorization requirements for some medications/diagnoses

Refills/Splitting

- Prescriptions for other than maintenance medications
  - Dispense 30-day supply or 100 tablets, whichever is less
  - If prescriptions is less than 30-day supply, dispense amount prescribed

Over-The-Counter (OTC) and Compound Drugs

- OTC Drugs
  - may be a benefit if prior authorized
  - Insulin and Aspirin do not require prior authorization
- Compound Drugs
  - Point-Of-Sale
  - Paper claims for compounds can be submitted by using the PCF-2
  - Pharmacies can use “08” in field 420-DK to allow a compound prescription to pay for the covered drugs
  - Prenatal vitamins and Folic Acid (1 mg) are benefits and no longer require a PAR if they are rebateable and the woman is in the maternity cycle or 60 days post-partum
    - Use prior authorization type code #4 to bypass co-pay requirement

Preferred Drug List (PDL)

- Examples of Drug Classes on the PDL:
  - Proton Pump Inhibitors
  - ADHD/Stimulant Agents
  - Statins
  - Antidepressants
  - Atypical Antipsychotics
- The complete Preferred Drug List (PDL) and prior authorization criteria for non-preferred Drugs are available in the Pharmacy Preferred Drug List (PDL) section

Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective January 1, 2012

Prior Authorization Forms: available online at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132

The PDL applies to Medicaid fee-for-service clients. It does not apply to clients enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ALZHEIMER'S AGENTS *Effective 4/1/2011*	**No Prior Authorization Required** Aricept (5mg tab and ODT, 10mg tab and ODT and 23mg tab) generic donepezil tab & ODT generic galantamine and galantamine ER.	**Prior Authorization Required** COGNEX EXELON (cap, soln. and patch) NAMENDA RAZADYNE	Non-preferred products will be approved if the client has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Clients currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia. Namenda will be approved without a prior authorization if the client has a diagnosis of dementia of the Alzheimer's type. (This process will be implemented by the pharmacy entering the ICD-9 code into the point of sale pharmacy system. The four recognized codes are 331.0, 294.1, 294.10 and 294.11). A prior authorization can be obtained if the client has a diagnosis of dementia of other types.
ANTIEMETICS *Effective 1/1/2012*	**No Prior Authorization Required** ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 6 years only) ZOFRAN tablets	**Prior Authorization Required** ANZEMET EMEND KYTRIL SANCUSO ALOXI ZOFRAN suspension ZOFRAN ODT ZUPLENZ	Non-preferred products will be approved for clients who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Ondansetron suspension will be approved for clients 6 and over with a feeding tube. Emend will be approved upon verification that the client is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.**

Prior Authorization Guidelines

Appendix P
Colorado Medical Assistance Program
Prior Authorization Procedures and Criteria
For Physicians and Pharmacists

Drugs requiring a prior authorization are listed in this document. The Prior Authorization criteria are based on FDA approved indications, CMS approved compendia, and peer-reviewed medical literature.

Prior Authorization Request (PAR) Process

- Pharmacy PA forms are available by visiting: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons can not sign the PA form
- Physicians or assistants who are acting as the agents of the physicians can request a PA by phone
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- Pharmacists from long-term-care pharmacies and infusion pharmacies can request a PA by phone if specified in the criteria
- All PA's are coded online into the PA system
- Prior Authorizations can be called or faxed to the helpdesk at:

  Phone: 1-800-365-4944
  Fax: 1-888-772-9696

- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:

  Phone: 1-800-365-4944

Medical Supply Items and Medications

- All supplies, including insulin needles, food supplements and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)
- If a medical benefit requires a PA, mail the PA request to:

  Claims and PARs
  P. O. Box 30
  Denver, CO 80201-0030

  DME PAR Phone #: 303-534-0279 or toll free 1-800-237-0757

- To find out more about DME policies call: Anna Davis: 303-866-2113
- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Prior Authorization information is available in the Pharmacy Appendix P (Pharmacy Prior Authorization Policies) section

Prior Authorization Requests

- Prior Authorization Requests are processed by Pharmacy Support
  - 24 hours a day, 7 days a week
  - Toll-Free: 800-365-4944
  - Fax: 888-772-9696

Automated Prior Authorization Requests

- October 2011- SMART PA was implemented and is currently used to create system Prior Authorizations with no effort from providers when members meet eligibility criteria based on past medical or pharmacy claims
- Watch the Medicaid bulletins for more details when and what new drugs and products may be eligible for automatic PA when the point of sale claim is billed by the pharmacy
- Smart PA does not affect any DMS/Supply billing or the PAR process

3-Day Emergency Supply

- An emergency situation is any condition that is life threatening
  - Covered outpatient prescription drugs
  - Physician must request a Prior Authorization the next business day
- NOTE: Undocumented Non-Citizens are not eligible for the 72-hour emergency supply
- Prior Authorization Requests are processed by Pharmacy Support
  - Toll-Free: 1-800-365-4944
- See the January 2012 Bulletin (B1200310) for more details

Brand Name PAs

- Brand Name drugs with a generic equivalent require a Prior Authorization and a Dispense as Written (DAW) 1 on the billed claim
  - Exceptions:
    - Biologically based mental illness defined in 10-16-104 (5.5) CRS
    - Drugs for the treatment of cancer
    - Drugs for the treatment of epilepsy
    - Human immune deficiency virus and acquired immune deficiency syndrome

Brand Name Pas and DAW Codes

- July 2011 Bulletin (B1100303) provides additional clarification on Pharmacies submitting DAW codes
  - DAW 1
    - Only to be used when the prescriber requests brand name drugs
    - Code is required for brand name products that have a generic equivalent
    - Prior Authorization may be required if drug is not excluded from the generic mandate
  - DAW 2, DAW 5 and DAW 7
    - Codes have been discontinued by the Department and should never be used

Drugs Restricted from Coverage

- The Department does not cover certain drugs as a benefit
  - Non-rebateable drugs
  - Fertility drugs
  - DESI drugs
  - Cosmetic drugs
  - Weight-loss drugs
  - Sexual or Erectile Dysfunction drugs
  - Injectable drugs (including Synagis®) dispensed in a physician's office
    - Reject 70 in the POS terminal- see Bulletin B0500202

Billing Supplies

- CMS 1500 form should be used for the following:
  - Syringes
  - Test Strips
  - Nutritional Supplements (Ensure)
  - Injectable drugs (including Synagis®) dispensed in a physician's office
  - Medical supplies (oxygen, gauze, bandages)
- Colorado Pharmacy Claim form should be used for the following:
  - Drugs

Physician Administered Drugs

- Drugs administered in a practitioner's office or clinic must be billed by the practitioner using HCPCS codes on the CMS 1500 form (injectable drugs, diaphragms)
- Pharmacies cannot bill for drugs administered in a practitioner's office
  - Volume 8- 8.831
- Practitioners may not send a member to the pharmacy to obtain an injectable drug for use in the practitioner's office

Physician Administered Drugs

- Injectable drugs may be billed by a pharmacy through PDCS only when:
  - The drug is self-administered by the member in their home
  - The drug is administered by a home health nurse in the members home
  - The drug is administered in a long-term care facility where the member resides
    - See January 2011 Bulletin (B1100292), October 2011 Bulletin (B1100307) and November 2011 bulletin (B1100308)

Provider Services

Xerox
800-237-0757

- Claims/Billing/Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

Pharmacy
800-365-4944

- Electronic (POS) Claim Submission
- Drug PAR (including Synagis)
- Drug Coverage
- Preferred Drug List (PDL)
- Mail Order Program

Thank you!