

# Pharmacy Billing Workshop

## Colorado Medicaid 2014

February 2013





Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing



**Medicaid**

Medicaid/CHP+ Medical Providers



Xerox State Healthcare



# 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

- Claim processing
- How to ensure your claims are timely
- How to bill when other payers are involved
- Prior Authorization Request procedures
- Medical and Supply Claims



# Provider Services

## Xerox

**1-800-237-0757**

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

## Pharmacy

**1-800-365-4944**

Electronic (POS) Claim Submission

Drug Pas (including Synagis)

Drug coverage

Preferred Drug List (PDL)

Mail Order Program

# 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



# Use your NPI

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



# NEW! Department Website

1.

<https://www.colorado.gov/hcpf>

[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)

**COLORADO**

Department of Health Care  
Policy & Financing

Home

For Our Members

**For Our Providers**

For Our Stakeholders

2.

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](http://colorado.gov/health)



# NEW! Provider Home Page

Find what you need here

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

The screenshot shows the website's header with the Colorado Department of Health Care Policy & Financing logo and name. A navigation bar includes links for Home, For Our Members, For Our Providers (highlighted), For Our Stakeholders, and About Us. The main content area is titled 'For Our Providers' and contains four columns of information:

- Why should you become a provider?** (Icon: hands holding a cross)
- How to become a provider (enroll)** (Icon: green document with a cross)
- Provider services (training, & more)** (Icon: dollar sign with horizontal lines)
- What's new? (bulletins, newsletters, updates)** (Icon: radio tower)

Below these columns are three service tiles:

- Get Help** Dept. Fiscal Agent 1-800-237-0757 (Icon: person with a plus sign)
- Get Info** FAQs & More (Icon: question mark)
- Find a Doctor** Are you a client looking for a doctor? (Icon: person with a plus sign)



# Verifying Eligibility

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



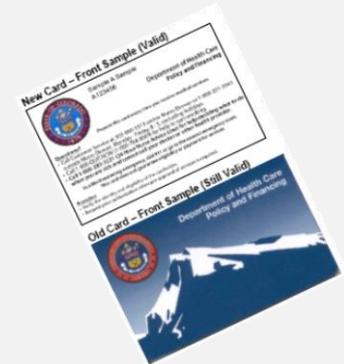
Web Portal



Fax Back  
1-800-493-0920



CMERS/AVRS  
1-800-237-0757



Medicaid ID Card  
with Switch  
Vendor



# 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.

# 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 years**



# Managed Care

- Types of Managed Care include
  - Managed Care Organizations (MCOs)
    - Denver Health or Rocky Mountain Health Plan- members do not have pharmacy benefits with fee-for-service Medicaid



# Managed Care Organization - MCO

- 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

MCO Member=  **FIS**

# 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 the excluded drugs is available on the Department’s Web site in the Pharmacy section, under Medicare - Medicaid Enrollee Population
- Pharmacies must bill the Medicare Part D plan for the excluded drugs other D.0 identifiers before
  - Submitting claims to Medicaid and
  - Use other insurance indicator of “3” on the claim and appropriate
- Details about the Medicare benefit and drugs that are covered by the Colorado Medical Assistance Program are available in the December 2005, July 2008, and December 2012 Provider Bulletins (B0500202, B0800250, and B1200331) located in the Provider Services, Provider Bulletin section



# More Medicare Part D

- On February 1, 2008, Colorado Medicaid 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)

- **COB Manager Process for Pharmacy Claims**

- The 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 a commercial plan.



# COB Manager (HMS)

- Once the Commercial PBM is billed:
  - The pharmacy provider is then 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.”
- Pharmacy providers may contact HMS for access or for information regarding eCenter by calling 855-438-6420.
  - HMS staff provides the necessary information to log into the eCenter Web portal.
  - COBManager Web Portal is located at: [ecenter.hmsy.com](http://ecenter.hmsy.com)
- Please check the Pharmacy Web page of the Department Web site
  - [colorado.gov/pacific/hcpf/billing-manuals](http://colorado.gov/pacific/hcpf/billing-manuals)
  - August 2012 Bulletin (B1200325)



# 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.
- This program provides a post-payment review process allowing for the review of Medicaid member utilization profiles.
- It identifies excessive patterns of utilization in order to rectify over-utilization practices of members.
- The COUP will restrict members to one designated pharmacy and possibly one designated prescribing professional when there is documented evidence of abuse or over-utilization of allowable medical benefits.



# Member Over-Utilization Program

- Medicaid members that meet any one of the following criteria during a three-month period may be placed in the COUP:
  - Use of sixteen or more prescriptions;
  - Use of three or more pharmacies;
  - Use of three or more drugs in the same therapeutic category, e.g., Oxycodone, Oxycontin, Hydrocodone;
  - Has excessive Emergency Room (ER) and physician visits;
  - A 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 by contacting DHCPF at 303-866-3672
- See the August 2012 Bulletin (B1200325) for more information



# Mail Order Program

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



# Mail Order Program

- **If a mail order pharmacy submits a pharmacy claim for a Medicaid member that has not enrolled for the mail order benefit, the claim will deny**
- The NCPDP edit that will appear at the point-of-sale is an 85, with text indicating that the claim did not process. This denial will appear as edit PB85 on the Provider Claim Report
- Out-of-state mail order pharmacies are permitted to enroll as Medicaid providers but may only mail maintenance medications to members who have applied for the mail order pharmacy benefit



# Mail Order Program

- Local pharmacies, which are not mail order pharmacies, may continue to occasionally mail any type of outpatient medication to any fee-for-service Medicaid members without the members having to enroll for the mail order pharmacy benefit.
- For more information on the Mail Order Program visit the **Pharmacy Mail Order Prescriptions** section and March 2009 bulletin B0900264 in the **Provider Services Bulletins** section.



# Reimbursement

- Pharmacy Pricing

- ▶ Pricing Methodology applies to Brand, Brand with Generic available and Generic Drugs
- ▶ Does not apply to DME/Supplies billed 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 then again in 2013 total prescription volume surveys were sent out by the Department to all participating Colorado Medicaid pharmacies.
  - The surveys are used to establish the professional dispensing fee for each pharmacy provider.
  - All pharmacies failing to respond to the surveys are reimbursed \$9.31 for a professional dispensing fee under the methodology.



# Dispensing Fee Determination

- The Department mails pharmacy providers who responded, their proposed dispensing fee based upon the information provided.
  - More details are available on the Pharmacy Web page and the January 2013 Provider Bulletin (B1200332)
- All new or change of ownership (CHOW) pharmacy providers are required to fill out an Attestation Form from the Pharmacy Web page, submit it to the Department and the new provider will be provided a Dispensing Fee.



# Dispensing Fee Determination

- The professional dispensing fees are tiered based upon the pharmacy's total prescription volume. Pharmacies with a volume:

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



# Reimbursement Pharmacy Pricing

- AAC (Average Acquisition Cost) Rate or Submitted Rates whichever is less
- If no AAC price is available for the drug, Wholesale Acquisition Cost (WAC) or Submitted Charges, whichever is less, will apply.
- For Rural Pharmacies Submitted Rates do not apply and an adjustment for AAC and WAC Rates may be applied for Dates of Service before February 1, 2014.



# AAC 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  $\frac{1}{4}$  of the Medicaid enrolled pharmacies every quarter to rebase AAC rates.



# AAC Rates

- A pharmacy wanting to inquire about a current AAC rate shall complete the Average Acquisition Cost Inquiry Worksheet posted on the Department's Web site ([colorado.gov/hcpf](http://colorado.gov/hcpf))
- Pharmacy will email completed worksheet
  - Include: Copy of the receipt invoice and
  - Medicaid billed claim for the drug in question
    - Send to [Colorado.SMAC@hcpf.state.co.us](mailto:Colorado.SMAC@hcpf.state.co.us) for Department review



# 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
  - CO 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in the Remarks



# 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 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.

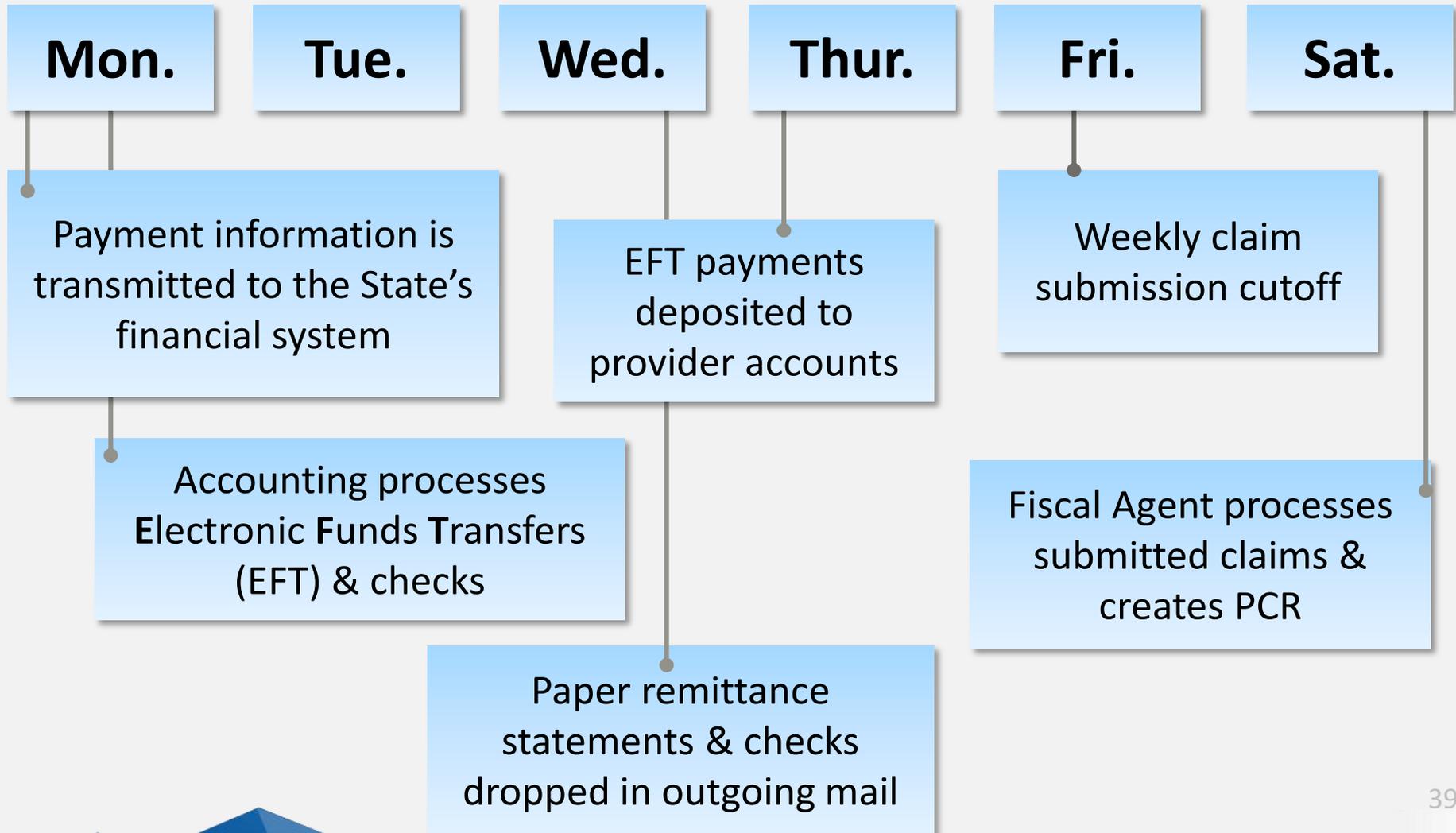


# Record Retention for Pharmacies

- The Department's rules stipulate that the pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record and maintain member information from the member or his/her apparent agent for each new prescription and these records must be stored for six years. Providers can view the rules regarding Prescription Record Requirements at 10 C.C.R 2505-10, Section 8.800.11.
- Refer to July, 2011 Provider 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
  - Contact PA Helpdesk for assistance with the member's PA 1-800-365-4944



# Common Claim Rejections

- **Member Has Other Insurance (PB41)**

- Use Other Coverage Codes
- Other Payor Date

- **Claim Not Processed (PB85)**

- Claim was billed by a State Identified Mail Order Pharmacy and the member is not part of the State's Hardship Member List nor is required by their 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

- **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 800-365-4944 for an override. Members can receive a once in a lifetime override for lost/stolen prescriptions. In these situations, contact the Department at 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
  - 1= No other coverage identified
  - 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 0-4 NCPDP, Reject Code 41 and/or 85 will post.
- Refer to OCC Quicksheet and Flow Chart in the Pharmacy Billing Procedures and Forms section on the Web site for more information.



# Other Insurance Codes Training

- 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 and February 2012 Bulletins (B1200310 and B1200316)
- [colorado.gov/hcpf/billing-manuals](http://colorado.gov/hcpf/billing-manuals)



# Co-Payment Exempt Members



**Nursing Facility  
Residents**



**Children**



**Pregnant  
Women**

# Co-Payment Facts

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- Collect from member at time of service
- 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 Web site in the Pharmacy Billing Procedures and Forms section.
- Pharmacies may bill on paper if:
  - The pharmacy bills less than five (5) claims per month (requires prior approval)
  - 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: <u>Colorado</u>	Colorado Relationship Code: <u>1</u>	
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): <u> / /</u>		
II. Pharmacy Information			
Service Provider ID: _____		Service Provider ID Qualifier: _____	
III. Prescriber Information			
Prescriber's Last Name: _____		Prescriber's Phone Number: <u>- -</u>	
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: <u> / /</u>	Date Filled: <u> / /</u>	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: <u> / /</u>		
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: <u>  </u>	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:
  - [colorado.gov/hcpf/billing-manuals](http://colorado.gov/hcpf/billing-manuals)



# ICD-9 Codes

- Department allows the use of ICD-9 codes to override some prior authorization 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

***If you have any questions regarding this process, please call the Colorado Medicaid Pharmacy Services Help Desk at 1-800-365-4944***



# ICD-9 Conversion to ICD-10

- **Watch Bulletins for Information related to submitting ICD-10 diagnosis Codes beginning in October 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 similar to how ICD-9 is currently used.

***If you have any questions regarding this process and the changes from ICD-9 to ICD-10, please call the Colorado Medicaid Pharmacy Services Help Desk at 1-800-365-4944***



# Refills/Splitting

- Prescriptions for other than maintenance medications
  - Dispense 30-day Supply or 100 tablets, whichever is less
  - If prescription 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 a prior authorization.
- Compound Drugs – POS
  - 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. (B0900272)



# The Preferred Drug List (PDL)

- Examples of Drug Classes on the PDL:

- Proton Pump Inhibitors
- ADHD/Stimulant Agents
- Statins
- Antidepressants
- Atypical Antipsychotics


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

[Prior Authorization Forms](http://www.colorado.gov/Info/Satellite/HCPF/HCPF1201642571132), available online at <http://www.colorado.gov/Info/Satellite/HCPF/HCPF1201642571132>

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.)
<b>ALZHEIMER'S AGENTS</b> <i>Effective 4/1/2011</i>	<b>No Prior Authorization Required</b> Aricept (Cing tab and ODT, 15mg tab and ODT, and 23mg tab), generic donepezil tab & ODT, generic galantamine and galantamine ER	<b>Prior Authorization Required</b> COGNEX, EXELON (top, w/o, and patch), NAMENDA, RALADINE	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 ICD9 code into the point of sale pharmacy system. The four recognized codes are 311.0, 294.1, 294.10 and 294.11). A prior authorization can be obtained if the client has a diagnosis of dementia of other types.
<b>ANTIEMETICS</b> <i>Effective 1/1/2012</i>	<b>No Prior Authorization Required</b> ondansetron tablets, ondansetron ODT, ondansetron suspension (clients under 6 years only), ZOFIRAN tablets	<b>Prior Authorization Required</b> ANZEMET, EMEND, FTYREL, SANCTUSO, ALOXI, ZOFIRAN suspension, ZOFIRAN 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 vertiginous and/or SOT management. Verification may be provided from the prescriber or the pharmacy.  Zuplenz 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.

- The complete Preferred Drug List (PDL) and prior authorization criteria for non-preferred drugs are available in the Pharmacy Preferred Drug List (PDL) section.



# Prior Authorization Guidelines

COLORADO MEDICAID PROGRAM

APPENDICES

## 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.

Revision Date: 1/12

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Prior Authorization information is available in the Pharmacy Appendix P

- [Colorado.gov/hcpf/billing-manuals](http://Colorado.gov/hcpf/billing-manuals)

# Prior Authorization Requests

- Prior Authorization Requests processed by Department's Fiscal Agent available 24 hours a day, 7 days a week
  - Toll-Free: 1-800-365-4944
  - Fax: 1-888-772-9696



# Automated Prior Authorization Requests

- In 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 an automatic PA when the Point of Sale claim is billed by the Pharmacy
- Smart PA does not affect any DME/Supply Billing or Prior Authorization process



# Three-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 72-hour emergency supply.
- Request Prior Authorization from Xerox 24/7 PA line 1-800-365-4944.
- See the January 2012 (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 to the rule:
  - 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

- The July 2011 Bulletin (B1100303) provides some additional clarification on Pharmacies submitting DAW Code
  - **DAW 1**
    - DAW 1 is only to be used when the prescriber requests brand name drugs to be provided. This code is required for brand name products that have a generic equivalent to override Federal Upper Limit (FUL) reimbursement. A prior authorization may also be necessary if the drug is not excluded from the generic mandate.
  - **DAW 2 DAW 5 and DAW 7**
    - These DAW codes should never be used. The Department has discontinued the use of all of these.



# Drugs Restricted from Coverage

- The Department does not cover certain drugs as pharmacy benefits. These include:
  - 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
  - See Bulletin B0500202 - Causes Reject 70 in POS Terminals

**Certain non-covered drugs may be covered through the medical benefit.**



# Billing Supplies

- **Submit a supply claim on the Colorado 1500 for the following:**
  - Syringes
  - Test Strips
  - Nutritional Supplements (Ensure)
  - Injectable drugs (including Synagis®) dispensed in a Physician's Office
  - Medical Supplies (Oxygen, gauze, bandages)
- Bill paper supply claims on the Colorado 1500, not the CMS 1500. Bill paper claims for drugs on the PCF.



# Physician Administered Drugs

- Drugs administered in a practitioner's office or clinic must be billed by the practitioner using HCPCS codes on the CO-1500 claim form. (Injectable drugs, diaphragms)
- According to State policy (Volume 8, 8.831), pharmacies cannot bill for drugs administered in a practitioner's office.
- By State policy, practitioners may not send members to pharmacies to get injectable drugs for use in the practitioner's office.



# Physician Administered Drugs

- Injectable drugs may be billed by a pharmacy through PDCS only under the following conditions:
  - The drug is self-administered by the member at their home
  - The drug is administered by a home health nurse in the member's home
  - The drug is administered in a long-term care facility where the member resides

**Note:** See Bulletins **B1100292** (01/11), **B1100307** (10/11), and **B1100308** (11/11)



# Thank You!

