PHARMACY PROVIDER MANUAL

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- Special Health Services https://www.hhs.nd.gov/health/children/special-health-services

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Pharmacy Claims Inquiries
Phone: 1-701-328-4086
Fax: 1-701-328-1544 Attn: Pharmacy
medicaidpharmacy@nd.gov

Medical Claims – Traditional Medicaid Eligibility Inquiries
Phone: 1-701-328-7098
Phone: 1-877-328-7098
mmisinfo@nd.gov

Medical Claims - Medicaid Expansion (BCBS ND)
Phone: 1-833-777-5779

Medicaid Fraud Inquiries
Phone: 1-701-328-4024
Phone: 1-800-755-2604
medicaidfraud@nd.gov

Coordinated Services Program
Phone: 1-701-328-2346
Phone: 1-800-755-2604
MedicaidCSP@nd.gov

Eligibility Verification Line
Phone: 1-877-328-7098
Phone: 701-328-7098

POS State Network Communications
ITD Support Center
Phone: 1-701-328-4470
Phone: 1-877-328-4470

POS Switch Companies Network
(See Page 20)
RelayHealth Help Desk 1-800-401-5973
eRx Network Help Desk 1-866-379-6389

Third Party Liability (Private Insurance/Medicare)
Phone: 1-701-328-2347
Phone: 1-800-755-2604
medicaidtpl@nd.gov

Provider Enrollment
Phone: 1-701-277-6999
Fax: 701-433-5956
NDMedicaidEnrollment@noridian.com

Special Health Services (SHS)
Phone: 1-701-328-2436
Fax: 701-328-1645
dohcshsadm@nd.gov

AIDS Drugs Assistance Program (ADAP)
Ryan White Part B Coordinator
Phone: 1-701-328-2379
Fax: 1-701-328-0338
gmathern@nd.gov

Durable Medical Equipment
Phone: 1-701-328-2764

State Address
Department of Health and Human Services
600 E Boulevard Ave, Dept 325
Bismarck ND 58505-0250

INTRODUCTION

All Medicaid (traditional and expansion) pharmacy claims as well as Special Health Services (SHS), AIDS Drug Assistance Program (ADAP), Russell Silver Program, and some county jail claims are processed by the ND Medicaid pharmacy system.

A variety of federal laws outline program requirements with the most significant being:

1. Social Security Act §1927 (ssa.gov)
2. Federal Register: Medicaid Program; Covered Outpatient Drugs

PHARMACY SERVICES PROGRAM REQUIREMENTS

1. Reimbursement of Drugs (Page 18):
    1. Federal Upper Limit (FUL): Federal Upper Limit | Medicaid
    2. NADAC: Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs
    3. Maximum Allowable Cost (MAC) program

2. Covered Outpatient Drug (COD) Status (Page 12)

3. Manufacturer/Labeler Drug Rebate Program (Page 13)

4. Prospective/Retrospective Drug Utilization Review (Page 14)

5. Professional Dispensing Fee (Page 18)

6. The quantity of medication dispensed shall not exceed a 34-day supply unless:
    1. Member has primary insurance
    2. The medication is packaged as a unit of use which lasts beyond 34 days
    3. The medication is low-cost maintenance medication where 90 days is allowed.

7. Provider numbers (pharmacy and prescriber) must be NPIs

UNIQUE CHARACTERISTICS TO POS SYSTEM

1. All claims submitted are processed in real time and will be either paid or denied. Paid claims may also be reversed by the submitting pharmacy.

2. Eligibility - POS billing confirms the member's Medicaid eligibility on the date the prescription is dispensed. It is not required to make a separate call to the member eligibility verification system (VERIFY – Page 30) because the POS system uses the same source of information as VERIFY. If the member is ineligible on the dispensing date, the claim will be denied.

3. Recipient Liability (Page 20)

4. Third party Liability (Page 21)

5. Prospective Drug Utilization Review (Page 15)

6. POS System Availability - The North Dakota Medicaid POS system is scheduled to be available 24 hours a day, seven days a week except for maintenance.

7. Network Processing Difficulties - The POS system is accessed via one of the pharmacy claims networks connected with North Dakota Medicaid. At times, the switch network system may be out of service or unable to exchange information with the state's system. If the condition persists, please contact the network's help desk directly for assistance.

RelayHealth Help Desk	1-800-401-5973
eRx Help Desk	1-866-379-6389

   If one of these conditions persists more than 20 minutes, record the message you received and contact:

   ITD Support Center
   1-701-328-4470
   1-877-328-4470

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INSTRUCTIONS FOR POINT-OF-SALE (POS) BILLING

North Dakota Medicaid only accepts electronic claims submitted via POS or claims entered by providers through our web portal at mmis.nd.gov. Pharmacies submitting via POS must submit claims in the National Council for Prescription Drug Programs (NCPDP) version D.0 format.

GENERAL TIPS FOR BILLING

1. Always bill your usual and customary charge to the general public for each prescription.
   a. All discounts the member would be eligible to receive (e.g., discounts for age, occupation, or received by payment of a nominal membership fee) are to be reduced from the usual and customary charges before billing Medicaid.
   b. Providers are required to use their acquisition cost plus the professional dispensing fee as their usual and customary for Federal Supply Schedule and 340b purchased drugs:

2. Metric decimal quantities should be used per NCPDP guidelines.

3. The NDC dispensed must be the NDC billed to ND Medicaid.

4. All services require a prescription order from a licensed prescriber, including over the counter products.

5. Timely Filing: All initial claims must be submitted within 365 days from the date of dispensing of the prescription. All adjustments must be submitted within 365 days of the remittance advice date of the paid prescription.

6. Use ND Medicaid's websites to find information regarding payment rules:
   https://ndmedicaid.acentra.com/
   www.hhs.nd.gov/medicaid-pharmacy-providers
   www.hhs.nd.gov

7. North Dakota Medicaid uses a variety of payment parameters that may result in a rejected claim. Please use the Guidance for Point-of-Sale Rejections to navigate these rejection messages

PROVIDER REQUIREMENTS

To prescribe or dispense drugs for coverage by the Medicaid program, a provider must have a valid state license and be an enrolled provider with the state Medicaid program. The provider must also have a valid DEA license to prescribe or dispense controlled substances.

These requirements are verified during claims processing. If the required licenses and enrollment are not on file for both the prescriber and pharmacy, the claim will not be covered. Valid DEA and state licenses can be provided by fax to the pharmacy claims team at 701-328-1544 to update the state license file for drug coverage.

PROVIDER ENROLLMENT

Please reference the following for detailed information:

Provider Guidelines, Manuals, and Policies
Medicaid Provider Enrollment Information

For provider enrollment inquiries:

Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

Email: NDMedicaidEnrollment@noridian.com

Phone: (701) 277-6999
Fax: (701) 433-5956

OUT OF STATE PHARMACIES

Pharmacies that are out of state (defined as physically located outside of North Dakota and the three bordering states - MT, SD, MN) must fill out a prior authorization to justify the reason that the service is not available in-state. Drugs that have limited distribution and are known to only be available out of state do not require prior authorization.

Please notify pharmacy claims if a drug only available out of state is rejecting for prior authorization so the system can be updated.

DRUG COVERAGE

COVERAGE REQUIREMENTS

Federal law requires that ND Medicaid cover all FDA approved drug products made by manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS), except as indicated in the non-covered services, limited coverage, and covered outpatient drug status categories described below.

NON-COVERED SERVICES

The following are not covered by the Medicaid program:

1. Drugs determined to be less-than-effective (COD status of 5 or 6)

2. Drugs made by manufacturers which have a labeler code not included in a rebate agreement with CMS.

3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered unless the contract pharmacy is only considered a contract pharmacy due to the ND pharmacy ownership law and an agreement has been reached between the provider and ND Medicaid.

4. Cost of shipping or delivering a drug

5. Drugs which coverage is limited or excluded by the state or federal law:

    - Agents when used to promote fertility
    - Agents when used for cosmetic purposes or hair growth/removal
    - Drugs dispensed after their expiration date
    - Drugs which are experimental or investigational
    - Drugs used for erectile dysfunction

6. The following products, when provided for Medicaid members in nursing facilities, are part of the per diem and therefore cannot be billed through a pharmacy claim.

    - OTC drugs, even if prescribed
    - Nursing stock drugs and durable medical equipment (e.g., saline, sodium chloride for inhalation and trach therapy)
    - Vitamin and mineral products

7. Drugs when used outside of FDA recommended or compendia supported indications or dosages per the Social Security Act Section 1927.

LIMITED COVERAGE CATEGORIES

Non-Prescription /Over the Counter (OTC) Drugs:

- Aspirin, acetaminophen, NSAIDs, antacids, histamine-2 antagonists, iron supplements, non-sedating antihistamines, MiraLAX (and the generics), artificial tears, emergency and maintenance contraception, keratolytics, lice treatments, sodium chloride tablets, opioid antagonists, and nicotine replacement products
- These products must have valid NDC numbers, be included in a CMS rebate agreement, and prescribed by an authorized prescriber.
- A recent list of OTCs NDCs that have been paid can be found at www.hidesigns.com/ndmedicaid.

Dietary Supplements:

- Renal failure multivitamins, fat soluble vitamin combinations commonly used for cystic fibrosis, prenatal vitamins, folic acid, iron supplements, vitamins D, E, and injectable vitamin B_{12}
- The following metabolic supplements are covered for certain conditions: riboflavin, hydroxocobalamin, thiamine, biotin, niacinamide, pyridoxine and sodium and potassium citrate-citric acid

Anorexia, weight loss, and weight gain:

- Agents covered for anorexia/weight gain are megestrol, dronabinol, Serostim
- Agents covered for weight loss are phentermine, bupropion, naltrexone, and topiramate.
- Agents covered for antipsychotic induced weight gain include Victoza and metformin.

Medicare Part D Full Benefit Dual Eligibles if Part D plan does not cover:

- Prescription agents for symptomatic relief of cough and colds
- Non-Prescription/OTC: aspirin, acetaminophen, sodium bicarbonate tablets, MiraLAX (and the generics), artificial tears, sodium chloride tablets, fluoride dental gel, iron supplements
- Dietary Supplements as listed above

Hospice:

- Coverage of drugs not covered by hospice requires prior authorization for clinical review of medical necessity
- Reimbursement for drugs related to the member's terminal illness (i.e., hospice formulary) is included in the per diem rate for hospice covered services and will not be reimbursed separately through the Medicaid Pharmacy Program

Compounds:

- A payable ingredient must be included in the compound
- All NDC's submitted must be valid and not discontinued.
- ND Medicaid must calculate the reimbursement amount total for all ingredients:
  - 448-ED values must be the quantity dispensed for each individual ingredient of the compound.
  - 442-E7 is the sum of quantities submitted for 448-ED, irrespective of final volume or weight.
- Submission Clarification Code 08 can be billed to exclude non-payable ingredients from payment methodology, or the ingredient can be removed if an ingredient submitted is not included in the First Data Bank file or does not have a price.

COVERED OUTPATIENT DRUG (COD) STATUS

Per 42 CFR 441.25, federal financial participation (FFP) is not available for drugs that are subject to a notice of opportunity for hearing issued by the Food and Drug Administration (FDA) and published in the Federal Register on a proposed order of FDA to withdraw the drug's approval because it has determined that the drug is less than effective for all its labeled indications. FFP is also not available for drugs that are identical, related, or similar to such drugs, as defined in 21 CFR 310.6.

In addition to the prohibition on FFP for such drugs, these drugs are not eligible for manufacturer rebates under the MDRP, and therefore are non-covered by ND Medicaid.

For purposes of the Medicaid Drug Rebate Program (MDRP), labelers report these drugs quarterly to Medicaid Drug Programs (MDP) system with a covered outpatient drug (COD) status of 05 (DESI-5) or 06 (DESI-6):

- COD status 05 = DESI 5 - LTE/IRS drug for all indications
- COD status 06 = DESI 6 - LTE/IRS drug withdrawn from market

See the following links for information –

- www.fda.gov/drugs/enforcement-activities-fda/drug-efficacy-study-implementation-desi
- eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/Pharmacy/DESIDrugList.aspx
- www.medicaid.gov/medicaid/prescription-drugs/downloads/mdp-cms-qtrly-rebate-file-format-11.pdf

MANUFACTURER/LABELER DRUG REBATE AGREEMENT PROGRAM

Medicaid Drug Rebate Program | Medicaid

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that pharmaceutical manufacturers have a rebate agreement in effect with CMS for their pharmaceuticals to be reimbursed by Medicaid programs.

Only pharmaceuticals with a labeler code (first 5 digits of an NDC in the 5-4-2 NDC format) included in a rebate agreement are covered by Medicaid. Some pharmaceutical manufacturers have more than one labeler code. Therefore, if a manufacturer wants all products to be reimbursable, all labeler codes must be included in their rebate agreement with CMS.

Manufacturer rebate payments to the state are based on prescription claims payment data identified by NDC number. The actual NDC number on the package from which the medication is dispensed must be utilized on all pharmacy claims submitted for payment.

Failure to correctly reflect the actual NDC number dispensed may negatively impact revenues generated for the state. Therefore, it is imperative that pharmacists take care to correctly identify the specific NDC number of the pharmaceutical dispensed.

Inaccurate records may result in:

- The Medicaid agency billing the wrong manufacturer
- Disputes between the state and the manufacturer in the amount of rebate due
- An audit of the records of pharmacy providers which may result in false claims charges and reversals of payments

DRUG UTILIZATION REVIEW (DUR) REQUIREMENTS

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that all state Medicaid programs include a retrospective and prospective drug utilization review (DUR) program, including patient counseling, for all covered outpatient pharmaceuticals. The primary goal of drug utilization review is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use. The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The Medicaid DUR program includes retrospective DUR, prospective DUR, and the DUR Board.

PATIENT COUNSELING REQUIREMENTS

State law NDCC 61-04-13-01 outlines counseling requirements that apply to all ND licensed pharmacies and is enforced by the North Dakota Board of Pharmacy. ND Medicaid does not have additional requirements.

- Requirement for counseling for new and refill prescriptions
- Requirement for pharmacist or auxiliary personal authorized to make offer
- Requirement of whether counseling is required in situation where patient's representative is not readily available to receive a counseling offer or the counseling itself
- Requirement for mail order pharmacies

Counseling must include, in the exercise of professional judgement for the pharmacist considers significant, the following:

- The name and description of the medication
- The dosage form, dosage, route of administration, and duration of drug therapy
- Special directions and precautions for preparation, administration, and use by the patient
- Common severe side or adverse effects or interactions and therapeutic considerations that may be encountered, including their avoidance, and the action required if they occur
- Techniques for self-monitoring drug therapy
- Proper Storage
- Prescription refill information
- Action to be taken in the event of a missed dose

Per consultation with the ND Board of Pharmacy, ND Medicaid does not have requirements for documentation for offers of counseling, refusals of counseling, or actual counseling. Since there is no requirement for said documentation, there is no retention requirement.

All of the above patient counseling requirements apply to any pharmacy dispensing medications to ND Medicaid members.

PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)

In compliance with OBRA 90 DUR requirements, pharmacy providers must screen each prescription for certain therapeutic problems using the OBRA 90 defined standards at point of sale before each prescription is dispensed.

Pharmacies must use a prospective DUR software database which screens for the therapeutic problems listed in paragraph 1. a - g, below. The pharmacy provider's prospective DUR program must be based upon predetermined standards, consistent with subsection 1927 of the Social Security Act. OBRA requires:

1. A pharmacist using his/her professional judgment shall review the patient record and each prescription drug order presented for therapeutic appropriateness by identifying the following, when possible:

    a. Overutilization or underutilization
    b. Therapeutic duplication
    c. Drug-disease contraindications, where diagnosis is provided by the prescriber
    d. Drug-drug contraindications
    e. Incorrect drug dosage or duration of drug treatment
    f. Drug allergies
    g. Clinical abuse/misuse

2. Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the prescriber.

ND MEDICAID PRODUR AUDITS

ProDUR audits are performed on all drug claims submitted through the POS system in the response transaction. These are supplemental to, not in lieu of, those required by law to be performed by the pharmacy provider. The ProDUR information provided to pharmacists by North Dakota Medicaid ProDUR audits are based on information from the current claim, from claim history for the same and different pharmacies, and from the member's diagnostic history on medical claims. The medical, clinical, and pharmaceutical information used in POS ProDUR audits are supplied by First Databank.

The following audits are performed:

	Audit	NCPDP Code
a.	Early Refill (Same drug, same pharmacy)	ER
b.	Drug Drug Interactions	DD
c.	Duplicate Therapy Same Drug (Same drug, same or different pharmacy)	ID

d.	Therapeutic Duplication	TD
e.	Medical Disease Diagnosed Contraindicated	MC
f.	Drug Disease Contraindicated	DC
g.	Adult High Dose	HD
h.	Geriatric High Dose	HD
i.	Pediatric High Dose	HD
j.	Adult Low Dose	LD
k.	Geriatric Low Dose	LD
l.	Pediatric Low Dose	LD
m.	Additive Toxicity	AT
n.	Iatrogenic Side Effect (Inferred)	IC

DUR OVERRIDE CODES

Pharmacists billing via POS are required to evaluate any ProDUR Information that is returned with a claim and intervene appropriately. One from each column are needed to override an alert.

CONFLICT CODES

DC	Drug-Disease (Inferred) precaution
ER	Early refill
MC	Drug-Disease (Reported) precaution

INTERVENTION CODES

M0	Prescriber consulted
P0	Patient consulted
R0	Pharmacist consulted other source

OUTCOME CODES

1B	Filled Rx as is
1C	Filled with different dose
1D	Filled with different directions
1F	Filled with different quantity
1G	Filled with prescriber approval

RETROSPECTIVE DUR

The retrospective DUR program involves reviews of patient drug history profiles generated from Medicaid paid claims data. The reviews are based upon predetermined standards consistent with subsection 1927 of the Social Security Act.

The retrospective review of the patient drug history profiles includes evaluation for:

1. Therapeutic appropriateness
2. Overutilization and underutilization
3. Appropriate use of generic products
4. Therapeutic duplication
5. Drug-disease contraindications
6. Drug-drug interactions
7. Incorrect dosage or duration of therapy
8. Clinical abuse/misuse

REIMBURSEMENT OF DRUGS

FEDERAL UPPER LIMITS (FULS)

In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.

PROFESSIONAL DISPENSING FEE

In all instances, the professional dispensing fee will be $12.46 (does not apply to Physician Administered Drugs):

- For claims with days supply 28+ days: one dispensing fee is paid every claim
- For claims with days supply < 28 days: one dispensing fee will be paid per 28 days
  - May override with NCPDP D.0 Submission Clarification Code of 5 as appropriate (unit of use products, liquids, creams, antibiotics, etc.)

PAYMENT METHODOLOGY

1. For prescribed drugs that are covered by North Dakota Medicaid, including covered OTC drugs, North Dakota Medicaid will reimburse at the following lesser of methodology effective 10/1/2016 (Lesser of a, b, or c).

   a. The usual and customary charge to the public*

   b. North Dakota Medicaid's established Maximum Allowable Cost (MAC)** for that drug plus the professional dispensing fee

   c. Current National Average Drug Acquisition Cost (NADAC)** for that drug plus the professional dispensing fee
   OR
   If there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee.

   * Federal Supply Schedule purchased drugs: Providers are required to use their acquisition cost plus the professional dispensing fee as their usual & customary (Refer to 1a of this section).

   ** MAC and NADAC are based on provider supplied acquisition cost surveys. For reimbursement lower than cost, dispute forms are available to submit for each: NADAC and SMAC Dispute Forms

2. 340B drugs are reimbursed with the following lesser of methodology (less of a or b):
   a. The 340B MAC pricing (ceiling price) plus the professional dispensing fee, OR
   b. Actual acquisition cost plus the professional dispensing fee

   For more information regarding 340b, including how to indicate drug is 340b:
   - See Page 24 of this manual
   - See payer sheet

3. Indian Health Service, Tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing (one pharmacy encounter payment per person per facility per date of service). As these claims are paid through an encounter rate, they are not included in the invoicing process for the Medicaid Drug Rebate Program.

The reimbursement methodologies above also apply to:
1. Drugs not distributed by retail community pharmacies (e.g., long-term care facilities and specialty mail order drugs)
2. Clotting factors from specialty pharmacies, Hemophilia Treatment Centers (HTC), and Centers of Excellence
3. Drugs acquired at Nominal Price (outside of 340b or FSS)
4. Physician Administered Drugs (no professional dispensing fee will be paid for Physician Administered Drugs)

Brand Name Drugs – Generic Equivalent Exists
ND Medicaid prefers brand name:
ND Medicaid may require brand name when the brand is less expensive net of rebates than available generics. Pharmacies must bill with a DAW 9 to be paid properly.

Generic not available:
Temporary market shortages, or isolated geographic shortages may cause a pharmacy to bill a brand because they do not have access to a generic. In this case, pharmacies must call ND Medicaid to get an override and the pharmacies will have to then bill with a DAW 1 and enter a note on the prescription file explaining the situation and the discussion with ND Medicaid. ND Medicaid will not allow DAW 9 to be used due to a shortage that is temporary or isolated.

COPAYS

There is no copay for any service for North Dakota Medicaid

RECIPIENT LIABILITY

Recipient liability is also known as “excess income” or “spend down.”

Recipient liability is the monthly amount a member must pay toward the cost of medical and/or pharmacy services before they become eligible for Medicaid benefits. Recipient Liability is applied to the first claims* billed each month (whether medical or pharmacy). It cannot be waived.

Recipient liability is not drug specific and is not a copay. Recipient Liability is most comparable to a deductible.

For POS claims, at the time a prescription is billed to the state via the Point-of-Sale (POS) System, any recipient liability remaining is applied immediately to that claim and is due and payable at that time. Recipient liability is immediately updated by each claim (whether medical or pharmacy). The weekly remittance advice will reflect that transaction.

If a member does not pick up an ordered prescription that has recipient liability by the end of the next business day, you must reverse the claim to ensure that the recipient liability is applied to other services received by the member. If the member comes to pick up the prescription later, simply rebill and any remaining recipient liability will be applied.

*For persons residing in long term care facilities, recipient liability is not applied to pharmacy claims. The member’s recipient liability is applied against the facility charge, which is received at the end of in the month. In rare cases, the facility charge will be insufficient to satisfy recipient liability. When this happens, the state will recoup payments from the pharmacy which will then have to bill the member or family for any previously paid claims. Payment recoupment will be by claim adjustment by state staff and will be reflected on a remittance advice.

THIRD PARTY LIABILITY

For questions regarding Third Party Liability (e.g., private insurance, Medicare), please call our TPL help desk at 701-328-2347 or e-mail at medicaidtpl@nd.gov.

If other insurance or other responsible party (third party liability, including court ordered insurance) has been identified through the member, the human service zone, the member eligibility verification system (VERIFY), or the Point-of-Sale (POS) system, the pharmacy must collect payment from the other source prior to billing Medicaid.

Claims Processing Rules

A claim will deny for the following instances:

1. If there is no insurance payment indicated on the claim and there is TPL indicated on the state MMIS system.

2. The number of other payers on the claim must match the number of other payers in the MMIS system.

3. The other payer amount paid (431-DV) field is a negative value.

A claim will continue processing for the following instances:

1. If there is an insurance payment indicated on the claim and there is no TPL in the state MMIS system. State staff will review these claims, contact the member, and enter the insurance into the system.

2. If there is worker's comp or an accident policy in the state system. State staff will review these claims, contact the pharmacy, and ask them to rebill as appropriate.

Formulary and Service Authorization Rules

ND Medicaid cannot be billed as the primary payor in the following cases:

- Primary insurance denies service authorization due to medical necessity
- Primary insurance processes non-formulary medication but not does pay because a formulary medication option exists

If the primary insurance denies a prescription, all options with the primary insurance must be exhausted (appeal for formulary coverage, prior authorization, changing medications to a formulary medication, etc.). Medications that are fully excluded where no alternative exists for coverage by primary insurance may be reviewed for coverage by providing proof of exclusion and inability to obtain prior authorization.

Medicare Coverage

ND Medicaid does not provide outpatient prescription medication coverage (e.g., retail pharmacy) for individuals who are eligible for Medicare, even when the member is not enrolled in a Medicare Part D plan. Members cannot simply choose to have medication coverage through Medicaid by choosing to not enroll in or disenrolling from a Medicare Part D plan.

If a member is eligible for Medicare, but not currently enrolled in a Medicare Part D plan, Humana LiNET may be billed for drug coverage until the member can enroll into a Medicare Part D plan. ND Medicaid does not administer this program. Please direct inquiries to Humana LiNET.

Website: Medicare's LINET Pharmacy Resources - Humana
Phone: 1-800-783-1307

340B PROGRAM

Covered Entities

Covered entities must indicate they wish to be 340b providers in their provider enrollment paperwork. Only those providers who have enrolled as 340b providers will be allowed to bill for 340b products.

Contract Pharmacies

Contract pharmacies are not allowed to bill for 340b product and must carve out ND Medicaid unless the contract pharmacy is only considered a contract pharmacy due to the ND pharmacy ownership law and an agreement has been reached between the provider and ND Medicaid.

Fee-for-Service

For pharmacy and physician administered drug claims for traditional Medicaid and pharmacy drug claims for Medicaid expansion, 340b product billing is allowed. However, ND Medicaid pays a calculated ceiling price, and most pharmacies choose to not use 340B supply.

Managed Care

For physician administered drug claims for Medicaid expansion, providers are not allowed to use 340b product.

Billing Instructions:

Pharmacy Dispensed Drugs

Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee with a clarification code of 20 (when using 340b product for traditional or expansion Medicaid prescriptions).

Drugs billed to ND Medicaid with a clarification code of 20 are excluded from the Medicaid drug rebate invoicing process to avoid duplicate discounts.

Physician Administered Drugs

Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost and utilize the 340b specific modifiers (JG, TB, or UD) on the claim line for the drug when billing 340b product to traditional ND Medicaid.

Drugs billed on a claim line with a JG, TB, or UD modifier are excluded from the Medicaid drug rebate invoicing process to avoid duplicate discounts.

Excluded Products:

Some products are required to be excluded from 340b billing. Excluded NDCs for 340b

Out of State Pharmacies

All information in this 340b section also applies to out of state pharmacies

ADJUSTMENTS TO PAYMENTS

REVERSALS

Pharmacists may retract any claim that has been paid by submitting an NCPDP reversal transaction. Reversals may be used in many circumstances. Following are some examples:

a. A prescription is not picked up by the member. Pharmacies are expected to reverse claims not picked up within 15 days to ensure accurate dispense dates and drug utilization review edits.

    i. Pharmacies must reverse a claim that has recipient liability by the end of the next business day to ensure that the recipient liability is applied to other services received by the member.

b. Prospective Drug Utilization Review (ProDUR) information provided by the system as a claim was paid results in a prescription not being dispensed or being modified. If modified, the new claim may be submitted at any time after the reversal.

c. An error was made when submitting the claim. A corrected claim may be submitted and processed at any time after the reversal. If you feel an error has been made in payment as shown on your remittance advice, you may correct the error by reversing and re-billing with the necessary corrections

d. A claim with inaccurate information was submitted resulting in a paid claim. The claim can be reversed and resubmitted with corrected information.

REFUNDS

If you discover that you have been overpaid, please contact the appropriate benefit team:

Medicaid Expansion or Traditional Medicaid Programs:
Phone: 701-328-4086
Fax: 701-328-1544
Email: medicaidpharmacy@nd.gov.

Special Health Services (SHS) Program
Phone: 1-701-328-2436
Fax: 701-328-1645
dohcshsadm@nd.gov

AIDS Drugs Assistance Program (ADAP)
Phone: 1-701-328-2379
Fax: 1-701-328-0338
gmathern@nd.gov

DENIED POS CLAIM

If a claim has been DENIED for any reason and you think it is payable, you may REBILL via POS, making any needed claim corrections. Examples include:

a. A claim is denied because the Medicaid ID number is invalid. Correct the number and resubmit.

b. A claim is denied because the member is not eligible. If the member later establishes eligibility for the dispensing date, resubmit the claim via POS within the one-year filing limit.

LONG TERM CARE CREDIT

Pursuant to State Medicaid Director Letter #06-005, any drug products that are unused due to a discontinued prescription or to the discharge or death of the member must be restocked by the dispensing pharmacy and credited to the Medicaid program (returns must comply with the North Dakota State Board of Pharmacy rules).

The credit may be made by reversing the original transaction and then re-submitting with the adjusted actual units utilized.

AUTOMATIC REFILL AND FILL SYNC PROGRAMS

Medicaid does not pay for any prescription (original or refill) based on a provider's auto-refill policy. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program.

Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. A prescription with remaining refills authorized does not in itself constitute a request for the provider to refill the prescription.

MEDICATION BUBBLE PACKAGING

Medicaid does allow bubble packaging for compliance. Medicaid does not cover additional supply based on discontinued or modified prescriptions included in bubble packaging programs. The bubble packaging must be repackaged to utilize medications that have already been paid and are to be continued.

Medicaid does allow bubble packaging for use in living arrangement where medications are administered by direct care personnel. Any medication that is already paid for by ND Medicaid must be utilized and repackaged for administration by direct care personnel.

Medicaid does not pay for additional medication based on a facility's admission and bubble packaging policies.

Laws governing freedom of choice of pharmacy and long-term care credits must be followed.

SUPPLEMENTAL COMPOUND PAYMENT

The supplemental compound payment is not intended to provide additional payment for ingredients that were reimbursed through the compound claim or for ingredients that are not payable (e.g., obsolete NDC). Bulk compounds and Expansion claims are not eligible for the supplemental payment.

Medicaid may allow a supplemental compound payment for an individual compound if:

- Ingredient waste is not wholly reimbursed through the compound claim. The smallest available package size should be used to minimize waste.
- Hazardous compound precautions are required.
- Higher level of compound complexity is required with no available alternatives.
- Compound ingredients require prior authorization (not reimbursed through the compound claim), and there are no suitable alternatives:
    - Unable to use alternatives due to allergy or clinical contraindication
    - Shorter beyond-use-date (BUD) or storage conditions leading to substantial extra compounding/dispensing

Supplemental compound payment may be requested through prior authorization (SFN 511 form) for HCPCS code S9430.

- Submit the SFN 511 form once for each individual compound (specific to the member and the compound)
- S9430 must be billed on a medical claim:
    - 1 unit may be billed per dispensing.
    - The authorization number must be included on the claim.
- Claim status for the supplemental payment can be viewed in the online portal, and payment can be viewed on the pharmacy's remittance advice.

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COORDINATED SERVICES PROGRAM (CSP)

When a member is placed on the Coordinated Services Program (CSP), that member is limited to services provided by the CSP providers (pharmacy, dentist, and primary CSP prescriber), or a provider with a referral in place by their primary CSP prescriber and the referral is on file with Medicaid. Providers are made aware they are a CSP provider by a mailed notice.

Claims prescribed by or billed by non-CSP providers will be rejected with a detailed message. Therefore, the only claims payable for a CSP member are those prescribed by the primary CSP prescriber and billed by the primary CSP pharmacy, or providers with referrals on file with ND Medicaid. An exception can be requested by contacting medicaidcsp@nd.gov or 701-328-2346.

PLACING A REFERRAL

If the prescription is not from the primary CSP prescriber or a referred prescriber, the primary CSP prescriber must send the referral information to medicaidcsp@nd.gov. The pharmacy can inform the member and the prescriber that the primary CSP prescriber must send a copy of the CSP referral information to the state office. When a referral is verified, the pharmacy will be able to bill for prescriptions written by the referred prescriber. It is inappropriate to simply change the prescriber to the primary CSP prescriber if there is no referral.

FRAUDULENT CLAIM SUBMISSION

ND Medicaid utilizes a Program Integrity Unit to carry out the surveillance and review process to protect the integrity of the Medicaid program, which is federally mandated.

For detailed information and procedures of the program:
Compliance, Reporting, Fraud & Abuse

For information how to report suspected Medicaid fraud:
Medical Services Fraud and Abuse

Fraud, Waste, and Abuse Inquiries
Phone: 1-800-755-2604
Email: medicaidfraud@nd.gov
Form: Suspected Fraud Referral form

Claims submitted in error or with false information must be reversed or may be recouped on audit. The following are examples of activity that may be considered fraudulent.

MODIFIED PRESCRIPTIONS
Claims must be submitted to ND Medicaid as true and accurate based on the prescription issued by a valid prescriber. The claim information cannot be modified from the prescription to produce a paid claim, including days of supply and diagnosis unless the prescription is modified in accordance with rules governed by the North Dakota State Board of Pharmacy.

NON-MEMBER UTILIZATION OF SERVICES
A prescription filled for a Medicaid member must be for use for the indicated eligible member. The dispensed medication may not be transferred for use by a non-ND Medicaid eligible individual, including family members or friends without payer coverage.

SERVICES NOT REQUESTED
A paid claim must be the result of a valid prescription requested to be filled by and subsequently picked up by a member. Per § 456.705 Prospective Drug Review (c) and 1927 (g)(2)(A)(ii), signature or other documentation of counseling is not required by ND Medicaid as counseling is simply part of the scope of practice for pharmacists under state law (NDCC 61-04-13-01). ND Medicaid does have requirements for paid claims that are not picked up from the pharmacy in a timely fashion. Please refer to “Reversals” section (page 26) of this manual for more information.

Any prescriptions filled without a request from a member, or their responsible party may be subject to recovery. Any pharmacy provider who pursues a policy that includes filling

prescriptions on a regular date or any type of cyclical procedure may be subject to audit, claim recovery or possible suspension or termination of their provider agreement.

SERVICES FOR DECEASED INDIVIDUALS

The date of service for a claim cannot be after the date of death. The claim may process and pay if the date of death has not yet been updated in the state eligibility system. Paid claims with a date of service after the date of death will be recouped on audit. For situations with nursing home or other similar end of month billing, the pharmacy may resubmit the end of month claims with the date of death as the date of service once they receive the accurate date of death information.

THIRD PARTY LIABILITY

If a pharmacy submits a claim (with false information populated in 431-DV or 352-NQ) that was denied by the primary insurance to Medicaid for payment, that will be considered fraud. Field 352-NQ cannot be populated unless the primary insurance actually processed the claim as a paid claim.

ELIGIBILITY AND CLAIM INQUIRY

For traditional Medicaid, the Automated Voice Response System (AVRS) and the MMIS portal will return results. Neither of these will return results for Medicaid expansion members. Eligibility must be verified for Medicaid Expansion member by calling ND DHHS Eligibility at 1-844-854-4825 or Blue Cross Blue Shield at 1-833-777-5779

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)
Enrolled providers may readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- Member Inquiry
- Payment Inquiry
- Service Authorization Inquiry
- Claims Status

AVRS Access Telephone Numbers (available 24/7)
Phone: 1-877-328-7098
Phone: 1-701-328-7098

For detailed instructions on how to use AVRS, please reference Provider Requirements located at Provider Guidelines, Manuals and Policies. AVRS does not contain information for all programs administered by the Department of Health and Human Services.

Please reference the following for more information:

Traditional Medicaid

Eligibility information can be obtained by using AVRS.

Special Health Services (SHS):

SHS eligibility information is not available on AVRS. Eligibility for SHS members must be determined by contacting the state SHS office.

Breast and Cervical Cancer Detection (Women's Way)

Eligibility information can be obtained by using AVRS. The Centers for Disease Control and Prevention funds this breast and cervical cancer early detection program, known as *Women's Way*.

Children's Health Insurance Program (CHIP)

Eligibility information can be obtained by using AVRS.

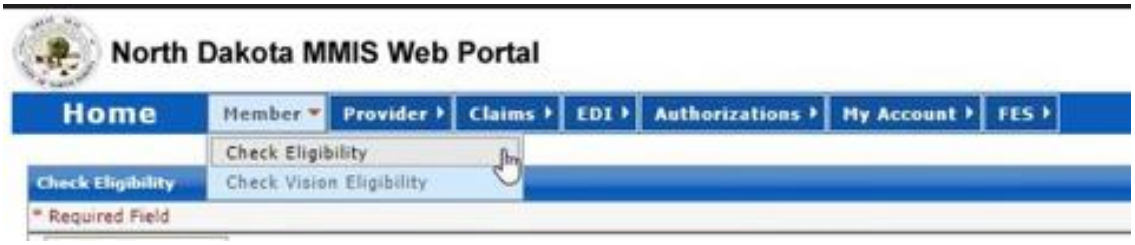
Medicaid Expansion

Medicaid Expansion eligibility information is not available on the AVRS system. Eligibility information can be obtained by calling 1-844-854-4825.

Medicaid Expansion pharmacy benefits are administered by North Dakota Medical Services. Please visit the ND DHHS Medicaid Expansion Website for information on medical benefit claim processing.

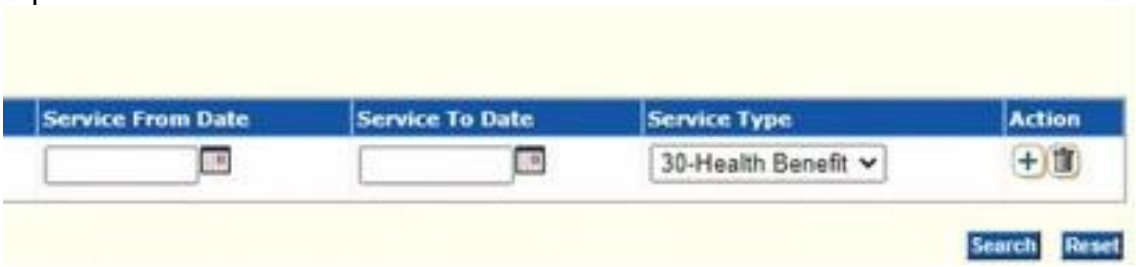
MMIS WEB PORTAL ELIGIBILITY VERIFICATION

Enrolled providers can access eligibility information through the MMIS web portal at https://mmis.nd.gov/portals/wps/portal/EnterpriseHome

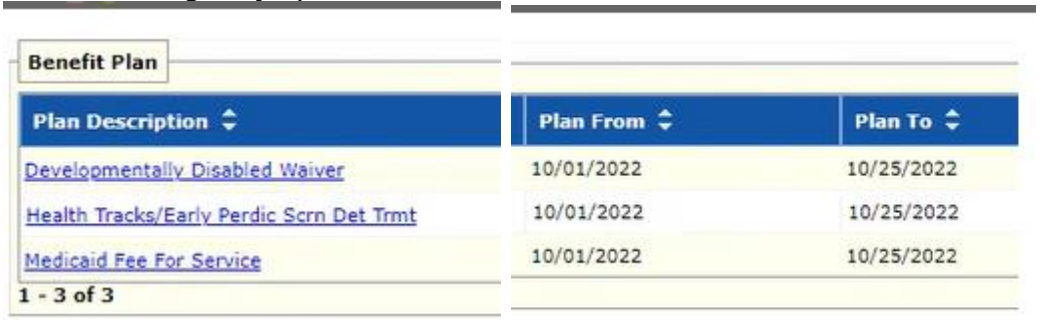


2 of these 3 fields must be filled out to produce results:

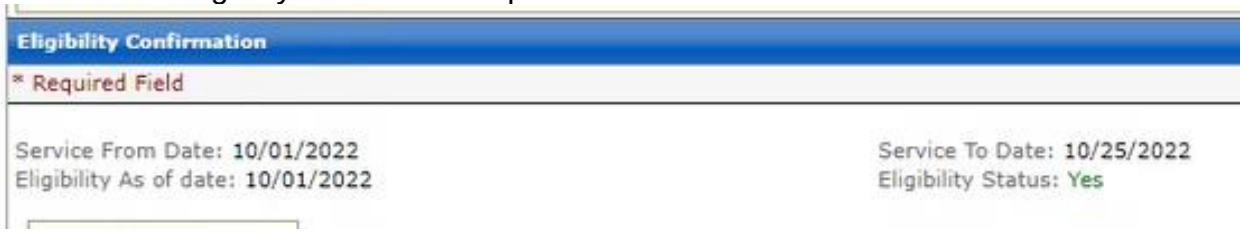
The Service From Date and Service To Date must be filled out, and Service Type must equal 30-Health Benefit:



The plans that the member is enrolled in will appear under the Benefit plan section. Please note that the Plan From and Plan To will reflect the dates that were used in the Service From Date and Service To Date fields under the Eligibility Inquiry section, not the actual eligibility span.



The confirmation of active eligibility can be found under the Eligibility Confirmation section. The Eligibilty Status must equal Yes.



Other fields of interest include TPL Spans, Lock-In Status, and Other General Information (which includes recipient liability information)

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MEDICARE PART B COVERED ITEMS

Certain items of durable medical equipment, supplies and drugs are payable by MEDICARE on behalf of members who are eligible for both Medicare and Medicaid. These items include:

- Ostomy & Urologic Supplies
- Wheelchairs
- Crutches
- Canes
- Oxygen Equipment
- Braces (Orthopedic)
- Lumbosacral Supports
- Corsets (Orthopedic)
- Prostheses
- Medically necessary Durable Medical Equipment from a licensed prescriber for use in the home (Purchase & Rental)
- Diabetic supplies, including blood glucose pumps, monitor, strips, and lancets
- Medicare Part B covered drugs

Billing is accomplished in two steps:

1. First, bill Medicare on CMS 1500 forms or electronically Electronic Health Care Claims | CMS

2. When the claim has been processed by Medicare, it should automatically cross over to Medicaid for consideration of payment of any deductible and coinsurance amounts that are due.

3. Medicaid will then reimburse for any deductible amount due from the member plus any coinsurance amount due, if any, up to the Medicaid allowable payment, for each item.

4. If you have not received payment within 60 days of billing Medicare, bill electronically or through the web portal. Be sure to include the Medicare payment on the submission. Instructions for billing electronically or through the web portal are available under Billing/Claims at: https://www.hhs.nd.gov/healthcare/medicaid/provider/education-and-training.

   Please also see:
   MMIS - ND Health Enterprise Medicaid Management Information System | Health and Human Services North Dakota

DURABLE MEDICAL EQUIPMENT (DME)

For those pharmacies dispensing Durable Medical Equipment (DME), you are required to comply with everything in the DHHS DME Manual.

Covered diabetic supplies (strips, lancets, machines, syringes, pen needles, tubeless insulin pumps, smart insulin pen, continuous glucose monitors) and inhaler spacers are reimbursable using NDC numbers billed as a POS claims, provided the primary insurance also allows POS billing. Medicare Part B claims are not payable through POS.

ROUTINE DRUGS, SUPPLIES & DME FOR LONG TERM CARE FACILITIES

Some items are reflected on facilities cost statement as part of their per diem rate and in not payable to pharmacy or other suppliers. Please see the following policies for more information:

Health Facilities

Pharmacy POS items that are allowed for separate payment

1. Insulin Vials, Pens and Syringes
2. IV and SQ Medications
3. IV Solutions (if medication admixed)
4. Prescription Drugs, except Vaccines as covered under this manual

VACCINE AND MEDICAL BILLING

For detailed information on vaccine coverage and billing, please reference the Immunizations policy located at Provider Guidelines, Manuals and Policies.

TRADITIONAL MEDICAID BILLING INQUIRIES

Please contact the medical call center rather than the pharmacy call center:

Phone: 701-328-7098
Email: mmisinfo@nd.gov.

MEDICAID EXPANSION BILLING INQUIRIES

Vaccines must be billed to Blue Cross Blue Shield if the recipient is enrolled with Medicaid Expansion. For more information, please contact Blue Cross Blue Shield.

Phone: 1-833-777-5779
Website: https://www.hhs.nd.gov/human-services/medicaid/expansion
https://medicaid.bcbsnd.com/