Nevada Medicaid and Nevada Check Up

Provider Manual

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1.0 Introduction

Effective July 1, 2022, Magellan Medicaid Administration, Inc. (MMA), a division of Magellan Rx Management, is the Pharmacy Benefits Management (PBM) for the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) Fee-For-Service (FFS) Medicaid program. As the PBM, MMA will administer the point-of-sale (POS) system to process pharmacy claim transactions. The POS system will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted.

After submission, MMA will respond to the pharmacy provider with information about client eligibility, the plan-allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable rejection messages. ProDUR messages will be returned in the DUR response fields. Other important related information will appear in the free-form message area.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

1.1 Nevada Medicaid Pharmacy Program

This manual provides claims submission guidelines for the Nevada FFS Medicaid and Nevada Check Up pharmacy program administered by MMA.

Important plan coverage and reimbursement policies are available in this *Nevada FFS Medicaid Provider Manual*. The MMA website contains a link to this document. Subsequent revisions to this document are available on the Nevada state web portal at https://nevadamedicaid.magellanrx.com

Nevada Medicaid state policy is in Chapter 1200 of the *Medicaid Services Manual* (MSM). The MSM is on the DHCFP website at http://dhcfp.nv.gov

2.0 Magellan Services Call Center

MMA has a pharmacy support center (PSC), clinical support center (CSC), and web support center to assist pharmacies, prescribers, and members.

Table 2.0.1 – MMA Services Call Center

Provider Services	Phone Number/Email	Availability/Comments
MMA Pharmacy Call Center (will connect callers to both the PSC & CSC)	1-800-695-5526	Monday–Friday 8:00am to 8:00pm ET After-hour support is available 24 hours a day, 7 days a week
MMA Pharmacy Call Center Fax Line	1-844-347-3202	Monday–Friday 8:00am to 8:00pm ET After-hour support is available 24 hours a day, 7 days a week
MMA Provider Portal	1-800-424-5878 https://nevadamedicaid.magellanrx.com	Monday–Friday 8:00am to 8:00pm ET
Check Write and Remittance Advice (RA) to pharmacies	NevadaFFSfinance@magellanealth.com	
Nevada Department of Health and Human Services Provider Enrollment.	1-877-638-3472 https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx	Monday–Friday 8:00 a.m. to 5:00 p.m. PT

2.1 Pharmacy and Clinical Support Centers

MMA provides a toll-free number for pharmacies available 7 days a week, 24 hours a day, and 365 days a year responding to questions on coverage, claims processing, and plan eligibility. Examples of concerns/issues addressed by the PSC staff include:

- **Questions on Claims Processing Messages** – It is important to contact the PSC at the time of dispensing if a pharmacy needs assistance with alert or denial messages. MMA's staff are able to provide claim information on all error messages, including ProDUR messaging.
- **Clinical Issues** – To address these situations, the CSC will provide assistance with initiating clinical prior authorizations (PAs). A second level of assistance is available if a pharmacist's question requires a clinical response. The PSC is not intended to be a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist.

2.2 Magellan Website Pharmacy Portal

Announcements, provider forms, drug information, *Nevada FFS Medicaid Provider Manual*, policies, and bulletins will be posted on the MMA website, https://nevadamedicaid.magellanrx.com.

3.0 Program Setup

3.1 Client Identification Card

An ID card will show coverage for the eligible plan member only. Per the standard NCPDP, the ID card will contain the following:

- RxBIN
- RxPCN
- RxGRP
- Issuer (80840)
- Member ID
- Member Name
- Issue Date
- Other required information and instructions a pharmacy needs to accurately submit claims, including the Pharmacy Call Center phone numbers, etc.

Figures 3.1.1 and *3.1.2* show an example of the *NV Medicaid ID card proof.*

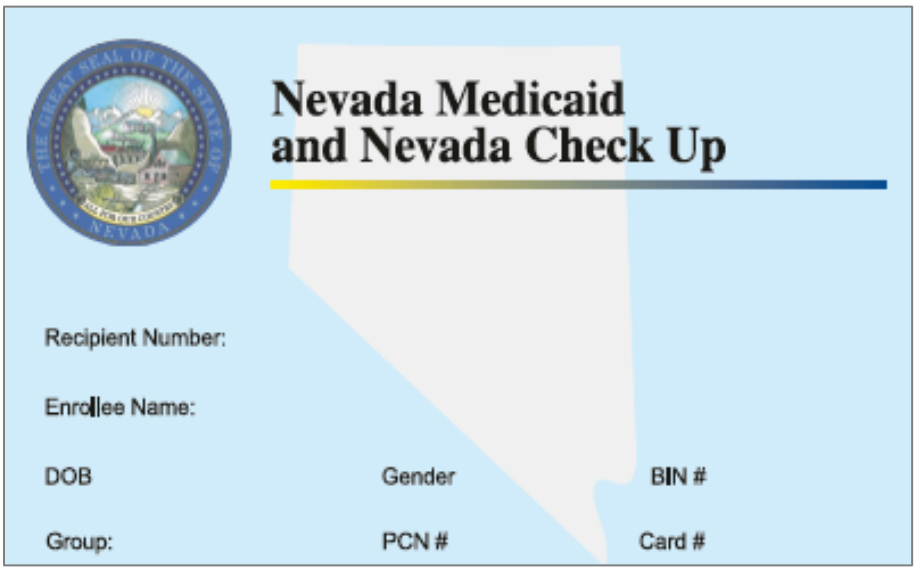

Figure 3.1.1 – Client ID Card (Front)

Figure 3.1.2 – Client ID Card (Back)

3.2 Claim Formats

MMA will accept claim submission by POS for the Nevada FFS Medicaid program. A paper claim may only be accepted with approval by DHCFP. Batch and web claim submission are allowed. The following standard formats are accepted:

Table 3.2.1 – Claim Formats Accepted by MMA

Billing Media	NCPDP Version	Accepted - Yes/No Comments
POS	NCPDP D.0	Accepted • Four claims per transmission where each claim has Coordination of Benefits (COB) segments (one or many) or PA supporting information (such as codes submitted on the claim that are used for PA processing). Information included on the first claim of the transmission will not affect processing of subsequent claims.
Batch	NCPDP Batch 1.2	Accepted
Web Claims Submission	NCPDP D.0	Accepted

3.3 Point of Sale – NCPDP Version D.0

As part of claims processing, MMA uses an online POS system to provide submitters with real-time online information on the following:

- Plan eligibility
- Claim status
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the MMA online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure that their system is able to process in accordance with the payer specifications sheet.

3.3.1 Supported POS Transaction Types

A pharmacy's ability to use these transaction types depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1), reversals (B2), and re-bills (B3). Other transactions listed in the table below are also supported.

- **Original Claims Adjudication (B1)** – This transaction type captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
- **Claims Reversal (B2)** – This transaction type is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- **Claims Re-Bill (B3)** – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 103) is equal to B3.
- The following fields must match the original paid claim for a successful transmission of a B2 (Reversal) or B3 (Re-bill):
  - Service provider ID – National Provider Identifier (NPI) number

- Prescription number
- Date of service (date filled)
- National Drug Code (NDC)

NCPDP Version D.0 Transaction Types Supported	
NCPDP D.0 Transaction Code	**Transaction Name**
B1	Billing
B2	Reversal
B3	Re-bill
E1	Eligibility Inquiry

3.3.2 Required Data Elements

A software vendor needs MMA's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The MMA claims processing system has program-specific field requirements (e.g., Mandatory, Situational, and Not Required). The table below lists abbreviations that are used throughout the payer specifications to depict field requirements. For additional information, refer to the *Payer Specification* document on the Plan Portal.

Definitions of Field Requirements Indicators Used in Payer Specifications	
Code	**Description**
M	MANDATORY Designated as MANDATORY in accordance with the *NCPDP Telecommunication Implementation Guide Version D.0.* The fields must be sent if the segment is required for the transaction.
R	REQUIRED Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	QUALIFIED REQUIREMENT "Required when" the situations designated have qualifications for usage ("Required if x," "Not required if y").

Claims are not processed without all the required (or mandatory) data elements.

Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Claims are edited for valid format and valid values on fields that are not required.

If data are sent in fields not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks result in claim denials.

- **Required Segments** – The transaction types implemented by MMA have NCPDP-defined request formats or segments.
- **Payer Specifications** – A list of transaction types and their field requirements are available online at https://nevadamedicaid.magellanrx.com. These specifications list B1 and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by MMA.
- **Program Setup** – The table below lists required values unique to plan programs.

Important Required Values for Program Set Up		
Fields	**Description**	**Comments**
BIN#	024888	
Processor Control #	683377	
Group	NVMEDICAID	
Provider ID #	NPI	10 bytes (numeric)
Cardholder ID #	Cardholder ID	Up to 20 bytes (numeric)
Prescriber ID #	NPI number	10 bytes (numeric)
Product Code	National Drug Code (NDC)	11 digits

3.4 Paper Claims

POS is mandated; paper claims are not accepted.

4.0 Program Specifications

4.1 Plan Co-Pays

Client Standard Co-pay	
Generic	$0.00
Brand	$0.00

4.2 Timely Filing Limits

Nevada Medicaid pharmacy providers are to submit all claims electronically at the time of dispensing prescriptions.

- POS Original Claims (NCPDP transaction 01-04/B1) 180 days
- POS Reversals (NCPDP transactions B2) 180 days
- POS Re-bills (NCPDP transactions B3) 365 days

Claims that exceed the prescribed timely filing limit will deny and return NCPDP error code – 81 *"Timely Filing Exceeded".*

4.3 Dispensing Limits/Claim Restrictions

The Nevada PBM FFS Medicaid plan may have dispensing limits/claim restrictions. Refer to the formulary listed on https://nevadamedicaid.magellanrx.com. Please review the reject responses on the claim and contact the PSC if further information is needed.

4.3.1 Days' Supply/Quantity Limits

Products allowed to process differently from the standard plan days' supply limit will be listed on the formulary.

Drugs	Days' Supply
• Standard (All, unless noted as exception)	34
• Anticonvulsants • Thyroid Preparations	Up to 100
• Estrogens • Antihypertensives • Antianginals • Antiarrhythmics • Progesterone • Antidiabetics • Cardiac Glycosides • Diuretics	Require 84–100 days after one-time initial fill
• Contraceptives, Topical • Contraceptives, Oral	Up to 365 days after one-time initial fill of maximum 90 days

Exceptions to the 34-day supply of medications are allowed for maintenance medications.

- Maintenance medications are required to be filled in three-month (100-day) supplies.
- A one-time initial fill of less than three months will be allowed for the first fill to assure tolerability and compliance.
- Prescription quantities may be reviewed; in cases for which less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

Medications administered in a skilled nursing facility or physician's office are exempt from the three-month (100-day) supply requirement.

- In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.
- Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement).

4.3.2 Dollar Limit

Nevada PBM FFS Medicaid will continue to edit using a cost ceiling of $10,000 for all drugs. All dollar limits are established by the plan. Please refer to the specific reject response or contact the PSC for assistance.

4.3.3 Minimum/Maximum Age Limits

All age limits are established by the plan and will be listed on the formulary. Please refer to the specific reject response or contact the PSC for assistance.

4.3.4 Refills

- Refills may be obtained after 80 percent of the previously dispensed days' supply has been used.
- **DEA = 0**: original plus 365 days from original Date Rx Written.
- **DEA = 2**: No refills
- **DEA = 3–5**: original plus 180 days from original Date Rx Written.

4.4 Partial Fills

For cases in which a pharmacy provider does not dispense the full amount per the prescriber's directions, the pharmacy provider should submit the claim as a partial fill and indicate such on the claim transaction.

- Partial fills must be billed via the POS system
- Standard NCPDP fields required for partial fills will be supported and required.
- The dispense fee will be paid on the initial fill.
- The co-payment, if applicable, will be collected on the initial fill.
- Partial fills cannot be use with multi-ingredient compound claims.
- Partial fills may not be transferred from one pharmacy to another.
- Two partial fill transactions may not be submitted on the same day; the service date must be different for each of the partial transactions and the completion transaction.

4.5 Incremental Fills

Incremental fills are the dispensing of incremental quantities of the total amount ordered specifically for Schedule II medications, as allowed under federal and state regulations. A single prescription for CII drug may be filled in multiple increments on separate claims only if **ALL** of the following conditions are met:

- All incremental claims are processed by the same pharmacy.
- Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed.
- Any quantity remaining on the prescription after 30 days from the date prescribed cannot be filled.
- Reimbursement for incremental fills of CII drugs will not be processed differently and will use established reimbursement policy.
- A full dispensing fee is included in the calculation of allowed amount for each incremental fill.

4.6 Vacation Fills

To override an early refill denial message for a non-controlled substance (Reject Code 88) for which the prescriber has authorized a vacation fill, enter "03" as the Submission Clarification Code (Field 420-DK). A member may request an early refill on a controlled substance by contacting the appropriate district office. The state will evaluate whether an early refill is justified and medically necessary.

4.7 Lost/Stolen/Damaged Medication

The member is responsible for payment to replace lost, stolen, or otherwise destroyed medication, even if a physician writes a new prescription for the drug (refer to MSM Chapter 1200). In a life-threatening situation, a member may request maintenance medication by contacting the appropriate district office. The state will evaluate based on medical necessity.

4.8 Mandatory Generic Requirements

Per Nevada Revised Statute (NRS) 639.2583, if the practitioner has not indicated that generic substitution is prohibited, then the pharmacy provider must dispense, in substitution, another drug that, compared to the brand name:

- Is less expensive
- Is biologically equivalent
- Has the same active ingredient or ingredient of the same strength, quantity, and form of dosage
- Is of the same generic type and is the least expensive of the drugs that are available for substitution.

All dispense-as-written (DAW) codes are allowed for submission but will not override any claim edits (such as pricing or PA requirement). PA may still be required when a brand name drug is prescribed. If the code is DAW 3, DAW4, or DAW 5 and the claim is submitted for a generic product, then the claim will deny for *NCPDP 8K- DAW Code Value Not Supported*.

DAW Code Examples	
DAW Code	**DAW Description**
DAW 0	No Product Selection Indicated
DAW 1	Substitution Not Allowed by Prescriber
DAW 2	Substitution Allowed-Patient Requested Product Dispensed
DAW 3	Substitution Allowed- Pharmacist Selected Product Dispensed
DAW 4	Substitution Allowed- Generic Drug Not in Stock
DAW 5	Substitution Allowed-Brand Drug Dispensed as a Generic
DAW 6	Override
DAW 7	Substitution Not Allowed-Brand Drug Mandated by Law
DAW 8	Substitution Allowed-Generic Drug Not Available in Marketplace
DAW 9	Substitution Allowed by Prescriber but Plan Requests Brand

4.9 Tamper Resistant Pads

CMS requires that tamper resistant prescription pads be used for all written claims in order to be eligible for reimbursement. The definition of tamper resistant is defined on the CMS website and includes meeting all of the following industry recognized requirements:

- Using one or more features to prevent copying / replication
- Using one or more features to prevent erasure or modification
- Having features to prevent the usage of counterfeit prescription forms.

4.10 E-Prescribing

Prescribers are encouraged to utilize e-prescribing whenever possible. Prescribers using e-prescribing will have a client's claims history, eligibility, drug coverage data, as well PA needs available.

For more information and to see whether your practice meets the requirements for a direct electronic connection, please visit https://www.medicaid.nv.gov/providers/eprescribing.aspx.

4.11 Dispensing Practitioners

The Nevada PBM FFS Medicaid program reimburses practitioners to dispense medications from a remote site or satellite consultation site when the following criteria are met:

- Must have a current Certificate of Registration through the Nevada State Board of Pharmacy. Refer to NRS 639.070 and NAC 639.390.
- Must be enrolled with Nevada PBM FFS Medicaid provider enrollment as a provider type 28.
- The dispensing practitioner's site must be located in the state of Nevada.
- All clinical criteria and dispensing limits apply.
- Claims must be submitted using Provider Type 28.
- Claims must be submitted in the NCPDP format through Medicaid's POS system.

4.12 Pharmacy Lock-In

Recipients may be locked into a designated pharmacy if meeting certain criteria designated by the Nevada PBM FFS Medicaid program. Pharmacies will receive an *NCPDP-50 – Non matched pharmacy number* rejection if they try to fill a prescription at an unauthorized pharmacy.

For additional information, please refer to MSM Chapter 1200:
https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/

5.0 Drug Information and Edits

5.1 Covered and Non-Covered Drugs

Nevada PBM FFS Medicaid program will cover medications as outlined in Chapter 1200 of the most up to date *Medicaid Services Manual*.

- Covered medications are subject to any applicable PA, quantity, and age limits.
- Medications must be manufactured by a company engaged in the Federal Medicaid Rebate Drug Program.
- All written (non-electronic) prescriptions for outpatient clients must be written on a tamper-resistant prescription pad.
- Covered medications are currently included on the Preferred Drug List (PDL) as established by the Silver State Scripts Board. Refer to Chapter 200 of the *Medicaid Operations Manual* for the Silver State Scripts Board bylaws.

Excluded medications:

- Agents used for weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes for hair growth
- Yohimbine
- DESI medications designated "ineffective" or "less than effective" by the FDA with regard to the substance or diagnosis for which the medication is prescribed.
- Medications considered "experimental" with regard to the substance or diagnosis for which the medication is prescribed.
- Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program, unless rated "1-A" by the FDA.
- Agents used for impotence/erectile dysfunction

5.2 Covered OTCs

The Nevada PBM FFS Medicaid program will cover over the counter (OTC) drugs and supplies with the following limitations:

- OTC drugs and supplies will be subject to any applicable PA, quantity, and age limits. Approvals will be for a one-month limit.
- Any more than two prescription requests for medications within the same therapeutic class will require PA.
- Insulin will be exempt from any clinical PA requirements.

OTC drugs and supplies are subject to OTC Maximum Allowable Cost (MAC) program benefit limits.

OTC Therapeutic Class	MAC
Irritants/Counterirritants	$50
Topical local anesthetics	$50
Antidiarrheal	$25
All other OTC drugs/supplies (excluding insulins and diabetic supplies)*	$500

***Note:** for *All other OTC drugs/supplies (excluding insulins and diabetic supplies)*, a cost ceiling edit of $500 will be applied. Please refer to the specific reject response or contact the PSC for assistance.

5.3 Diabetic Supply

Blood glucose testing equipment and supplies, as well as injection devices, are a Part B-covered benefit. These items are not considered Part D drugs and therefore are not a Part D benefit. After billing Medicare Part B for these items, Medicaid can be billed as the secondary payer using standard COB billing practices.

5.4 Vaccines

Nevada Medicaid FFS reimburses pharmacies for administered adult and childhood vaccines. All vaccinations are covered per the latest recommendations of the Advisory Committee on Immunization Practices (ACIP) without PA.

Pharmacies are reimbursed $7.80 administration fee if administered in the pharmacy. For vaccines that are dispensed and administered off site, the pharmacy will be reimbursed the standard dispensing fee, except for COVID-19 vaccines. COVID-19 vaccines are reimbursed $40.11 administration fee if administered in the pharmacy or $76.06 if

administered at home. The administration fee will be returned in the *Incentive Fee* field (521-FL) for all claims for vaccinations.

5.4.1 Pharmacist Administered Vaccinations

Pharmacists administering vaccinations must adhere to the requirements specified in MSM Chapter 1200:

- The administering pharmacist must be appropriately certified by the Nevada State Board of Pharmacy.
- Records must be kept on file for auditing.
- Pharmacies are responsible for physician oversight of the program and other state licensing requirements per the Nevada Board of Pharmacy Regulations.
- Pharmacies must enter vaccinations given on the Nevada WebIZ website at https://webiz.nv.gov/webiznet_nv/Login.aspx.
- Pharmacies must enroll in the Vaccines for Children (VFC) Program. VFC vaccines are provided at no cost to the provider by the Nevada State Health Division for recipients who are under 19 years of age.

If the recipient is under 19 years of age, a zero-ingredient cost (506-F6) will be returned and the claim will only pay the $7.80 administration fee.

If the recipient is 19 years of age or over, the ingredient cost will be reimbursed based on the "lesser of" logic included in the Provider Reimbursement Rates section.

All claims should be submitted through the pharmacy point of sale system.

5.4.2 COVID-19 Vaccines

All doses of approved COVID-19 vaccines are a covered benefit with the following age limits:

COVID-19 Vaccine Age and Quantity Limits		
Product	**Age**	**Quantity Limits**
J&J	Min age 18 years	1.0 mL per lifetime
Pfizer	12 years and above	1.5 mL lifetime
Pfizer	5–11 years	0.8 mL lifetime
Pfizer	6 months – 4 years	0.6 mL lifetime
Moderna	Min age 6 years	2 mL lifetime
Moderna	6–11 years	1.5 mL lifetime
Moderna	6 months – 5 years	0.75 mL lifetime

An administration fee will be paid for covered COVID-19 vaccines. Providers will need to submit claims in the following manner:

COVID-19 Vaccine Administration Fee					
NCPDP Field Name	**NCPDP Field #**	**First Dose**	**Second Dose (If Applicable)**	**Third Dose (If Applicable)**	**Booster Dose(s) (If Applicable)**
Professional Service Code (DUR-PPS)	440-E5	MA = Medication Administration	MA = Medication Administration	MA = Medication Administration	MA = Medication Administration
Day Supply	405-D5	1-Day	1-Day	1-Day	1-Day
Submission Clarification Code (SCC)	420-DK	2 = Other Override	6 = Starter Dose	7 = Medically Necessary	10 = Meets Plan Limitations
Ingredient Cost Submitted	409-D9	$0.01	$0.01	$0.01	$0.01
Dispensing Fee Submitted	412-DC	$0.00	$0.00	$0.00	$0.00
Basis of Cost Determination	423-DN	15 = Free Product	15 = Free Product	15 = Free Product	15 = Free Product
Incentive Amount Submitted	438-E3	$40.11	$40.11	$40.11	$40.11

COVID-19 Vaccine Administration Fee					
NCPDP Field Name	NCPDP Field #	First Dose	Second Dose (If Applicable)	Third Dose (If Applicable)	Booster Dose(s) (If Applicable)
Product / Service ID / NDC	407-D7	EUA Approved NDC	EUA Approved NDC	EUA Approved NDC	EUA Approved NDC
Fill Number	403-D3	00	01	02	03, 04

5.5 Oral Treatments for COVID-19

Nevada Medicaid reimburses for Paxlovid™ and Lageviro™. Pharmacies are advised to bill an incentive of $10.17 when dispensing oral treatments for COVID-19. Plan coverage is for a maximum of one treatment course per 90 days.

5.6 Claim Submission for Synagis®

Providers must submit requests for PA for the number of required whole vials. Requests for partial vials will be rejected with messaging from the pharmacy system indicating missing or invalid quantity. Please refer to the following table for dosing allowance for calculating dosage and number of required vials.

Dosing Allowance: Synagis® is available only in 50 mg and 100 mg vials. Due to the potential for significant waste, the following table should be utilized to determine permitted dose (within 10% of calculated dose due to vial overfill) and vials to dispense.

Dosing Allowance	
Weight-based Dose	Range Vial Quantity Recommendation
≤ 52.49 mg	1 vial of 50 mg/0.5 mL
52.5 mg – 104.99 mg	1 vial of 100 mg/1 mL
105 mg – 157.49 mg	1 vial of 50 mg/0.5 mL and 1 vial of 100 mg/1 mL
157.5 mg – 209.99 mg	2 vials of 100 mg/1 mL
210 mg – 262.49 mg	1 vial of 50 mg/0.5 mL and 2 vials of 100 mg/1 mL
262.5 mg – 314.99 mg	3 vials of 100 mg/1 mL

5.7 Injectable Drugs

Covered injectable drugs will be identified on the formulary found on the MMA website at https://nevadamedicaid.magellanrx.com/home.

Intravenous (IV) therapy drug claims must be submitted through the pharmacy POS system using the multi-ingredient functionality.

Dispensing Fees:

- For outpatient antibiotic therapy, a daily dispensing fee of $10.17 will be applied to the claim.
- For recipients in long-term care, a daily dispensing fee of $10.17 will be applied to the claim. This fee will be multiplied by the number of days for which the therapy was provided.

Supplies:

- IV therapy supplies, enteral nutrition/supplies, standard total parenteral nutrition (TPN) solution and supplies are billed on the CMS-1500 claim form or through the 837P electronic transaction. Medications added to TPN Solution immediately prior to administration are billed through the pharmacy POS system.
- For coverage and limitations, see the Billing Guidelines for Provider Type 33, MSM Chapter 1200, Section 1203.2 and MSM Chapter 1300.

5.8 Gender Dysphoria Hormones

When the beneficiary gender does not match the restricted gender code on the formulary file, the claim will reject with NCPDP Reject Code *61 – Product/Service Not Covered for Patient Gender* with supplemental message "Gender requirement not met. Prior Authorization Required."

Gender Dysphoria treatment hormones are a covered benefit for Nevada Medicaid recipients. Documentation of the proper diagnosis of F64.1 through F64.9 (gender dysphoria) must be included. The gender restriction will be bypassed when the pharmacy transmits this diagnosis on an electronic claim.

5.9 Family Planning Drugs

You may submit claims for family planning drugs directly to Medicaid without billing a primary insurance carrier first.

5.10 Managed Care Organization

MMA will load pharmacy encounters for Nevada's Managed Care Organizations (MCOs). Historical encounter data loaded to MMA's system will become part of that member's medication history and will be considered in the claims adjudication process, such as ProDUR or Automated Prior Authorization (AutoPA) determinations if the drug is covered under FFS Medicaid.

5.11 Long-Term Care Claims

- Long term care (LTC) recipients will be identified via the incoming claim NCPDP field *384-4X Patient Residence* when one of the following values are submitted:
  - 02 = Skilled Nursing Facility
  - 03 = Nursing Facility
- Non-billable for recipients in an LTC:
  - Dental supplies
  - Disposable supplies
  - Emollient supplies
  - Endocrine supplies
  - Fluid and electrolyte supplies
  - Metabolic, nutritional, and temperature supplies
  - Respiratory supplies
  - Supplements (see MSM Chapter 1300)
  - Urological supplies
  - Wound care supplies
- Billable items include:
  - IV drugs/TPN may be billed as a separate charge for recipients in LTC facilities
  - Drugs indicated as unit dose, as indicated by First Data Bank (FDB)
- Unit dose repackaging incentive
  - Enrolled pharmacies are entitled to a per claim incentive fee of $0.43. Submit this fee in the **Incentive Amount Submitted**. Additionally, submit a value of "3" (Pharmacy Unit Dose) in the **Unit Dose Indicator** field.

5.12 Hospice Drugs

Per MSM Chapter 3200, drugs, supplies, and durable medical equipment (DME) prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada PBM FFS Medicaid hospice program and are to be billed in accordance with the appropriate *Medicaid Services Manual* chapter for those services.

Hospice recipients can be identified by:

- Information on the recipient's Medicaid enrollment file, or
- If the **Patient Location** code on the inbound claim contains a code "11" (Hospice)

Recipients under the age of 21 are entitled to concurrent care under the Affordable Care Act (ACA); that is, curative care and palliative care at the same time while an eligible recipient of the Medicaid Hospice Program.

PA is required to bill Medicaid for a drug that is unrelated to the terminal illness.

Refer to MSM Chapter 1200 https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/ for additional information about PA criteria.

6.0 Prior Authorizations

6.1 Clinical Prior Authorizations

The MMA clinical call center will receive PA requests for products that have clinical edits. PA requests are made by the prescribing physician or the prescribing physician's agent (must be a documented agent). Requests may be initiated by telephone, fax, mail, or WebPA. PA requests should not be completed by the pharmacy. PA requests submitted by the pharmacy and not the prescribing physician or prescribing physician's agent will be denied or will be subject to overpayment recovery.

The requirement of PA may be waived when medical conditions or a time factor relating to treatment makes it inappropriate. Approval for payment of services provided in such circumstances rests with DHCFP, based on submitted documentation justifying failure to obtain PA.

6.1.1 Fair Hearing Requests

A fair hearing request can be submitted by a recipient (member) or the recipient's authorized representative in person, in writing, or via the internet, telephone, or other available electronic means (e.g., fax) if the recipient experienced the following:

- A denial, reduction, suspension, or termination of requested services
- Delays in requested service that don't meet regulated turnaround times
- Errors made by DHCFP or contracted partners (e.g., MMA)
- The recipient has been locked into one pharmacy for all controlled substances

Requests should be submitted using the *Hearing Request Form* (attached to the *Notice of Decision*) from the member or the recipient's authorized representative. The request must be received by the DHCFP office within 90 calendar days of the notice date unless the recipient can provide a valid reason for the delay. If the time permitted for a standard fair hearing could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function, an expedited fair hearing can be requested. Expedited requests carry a turnaround time of three days.

6.2 Emergency Protocols

The Nevada PBM FFS Medicaid program pays for an emergency supply of medications that require a clinical PA if a PA request has not been processed and it is after hours, a weekend, or a designated holiday. An example of when this may occur is when the prescriber is unavailable to provide sufficient information required to complete the PA.

The appropriate PA process must be utilized during regular business hours. All of the following conditions must be met for an emergency supply:

- The recipient is eligible on the date of service.
- The medication requires clinical PA (formulary edits do not qualify).
- The medication is not an excluded product.
- The days' supply for the emergency period does not exceed days' supply parameters.

6.2.1 Emergency Supply Override Process

NOTE: *An emergency situation is a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the recipient, or the continuation of immediate and severe adverse consequences to the recipient, if an outpatient drug is not dispensed when a prescription is submitted.*

If the prescriber is not available and the dispensing pharmacist determines that the recipient needs to receive the prescribed drug, then the dispensing pharmacist should enter the **Level of Service (NCPDP field 418-DI) '3 – Emergency"** to identify this as an emergency claim. This will allow bypassing PA requirements and provide up to a maximum of a 96-hour supply when utilized.

Members will be allowed one use of the **Level of Service** for POS Emergency claims to the same drug/strength/dosage form, per member, per 180 days.

If this limit is exceeded, the claim will deny *NCPDP 76 – Plan Limitations Exceeded* and the pharmacy must contact the call center for further assistance.

6.3 Preferred Drug List/PA/Quantity/Duration Lists

- All claims are checked against the PDL, benefit requirements, and DUR criteria. A complete listing of PA criteria, quantity limits, and duration of therapy edits may be found on the MMA website at https://nevadamedicaid.magellanrx.com/home.
- All claims are checked for compliance with state and federal requirements.
- Prescriptions must be dispensed pursuant to the orders of a physician or legally authorized prescriber. Any subsequent refills may be dispensed not more than one year from the date the prescription was written (or earlier whenever legally dictated).
- Schedule 2 drugs (CIIs) may not be refilled; a new prescription is required for each fill.
- Controlled drugs other than CIIs may be refilled, pursuant to the order of a physician or legally authorized prescriber, for up to five refills or six months, whichever comes first.
- Non-controlled drugs may be refilled, pursuant to the order of a physician or legally authorized prescriber, for up to one year.

6.4 ProDUR Drug Utilization Review

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of MMA assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the MMA ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Pharmacists use their education and professional judgments in all aspects of dispensing.

6.4.1 Drug Utilization Review Edits

ProDUR edits involving narcotic analgesics, sedative hypnotics, benzodiazepines, or skeletal muscle relaxants require a telephone call to the PSC to obtain an override.

The following ProDUR edits will deny for the plan:

- **Early Refill (ER)**
  - Non-controlled products early refill tolerance: 80 percent
    - For non-controlled products, the system will automatically check for an increase in dose, and when an increase in dosage is detected, the system will not deny the current claim for early refill.
  - Controlled products early refill tolerance: 90 percent
    - The call center may assist in overriding this reject if one of the following circumstances exists:
      - A change in dosage/therapy has occurred.
      - Patient is no longer taking the original dosage.
      - A change in dosage time/frequency has occurred.
      - Two strengths of the same drug are used to make a strength of that medication that is not currently manufactured.
- **Drug to Drug (DD)**
- **Therapeutic Duplication (TD)**
- **Minimum/Maximum Daily Dosing (LD, HD)**
- **Drug to Geriatric Precautions (PA)**
- **Drug to Pediatric Precautions (PA)**

6.4.2 ProDUR Overrides

The following are the NCPDP interactive **Professional Service**, **Result of Service**, **Reason for Service**, and **Submission Clarification** codes. These codes may be used to override ProDUR denials at the POS. Override codes must be entered each time error occurs.

Problem/Conflict Type: The following override codes may be used by providers for any situation in which a provider-level override is allowed for ProDUR denials.

ProDUR Overrides		
Reason for Service Codes	• **ER** • **TD** • **DD**	• **HD** • **LD** • **PA**
Professional Service Code/Description allowed for Submission	• **AS**/Patient Assessment • **CC**/Coordination of Care • **DE**/Dosing Evaluation/ Determination • **FE**/Formulary Enforcement • **GP**/Generic Product Selection • **M0**/Prescriber Consulted • **MA**/Medication Administration • **MR**/Medication Review • **PH**/Patient Medication History • **PM**/Patient Monitoring	• **P0**/Patient Consulted • **PE**/Patient Education/Instruction • **PT**/Perform Laboratory Test • **RO**/Physician Consulted Other Source • **RT**/Recommended Laboratory Tests • **SC**/Self Care Consultation • **SW**/Literature Search/Review • **TC**/Payer/Processor Consulted • **TH**/Therapeutic Product Interchange
Result of Service Code/Description	• **1A**/filled as is, false positive • **1B**/filled prescription as is • **1C**/filled, with different dose • **1D**/filled, different direction • **1E**/filled, with different drug • **1F**/filled, different quantity • **1G**/filled, Prescriber approved • **1H**/brand-to-generic change • **1J**/Rx-to OTC change • **1K**/filled, different dosage form • **2A**/prescription not filled • **2B**/not filled – direction clarified	• **3A**/recommendation accepted • **3B**/recommendation not accepted • **3C**/discontinued drug • **3D**/regimen changed • **3E**/therapy changed • **3F**/therapy chg – cost inc accepted • **3G**/drug therapy unchanged • **3H**/follow-up report • **3J**/Patient referral • **3K**/instructions understood • **3M**/compliance aid provided • **3N**/medication administered
Submission Clarification Code/Description (Listed as reference only, not required on claims)	• **01**/No Override • **02**/Other Override • **03**/Vacation supply • **04**/Lost prescription	• **05**/Therapy change • **06**/Starter Dose • **07**/Medically necessary

All ProDUR alert messages appear at the end of the claim's adjudication transmission. Alerts appear in the following format:

Alerts	
Format	**Field Definitions**
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates whether the dispensing provider also dispensed the first drug in question. • 1 = Your Pharmacy • 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters. Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. • 1 = First Databank • 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. • 0 = No Value • 1 = Same Prescriber • 2 = Other Prescriber

7.0 Coordination of Benefits (COB)

Nevada PBM FFS Medicaid is always the payer of last resort unless a recipient also has Nevada Medication Assistance Program (NMAP).

COB edits will be applied when third-party liability (TPL) exists for the beneficiary and claim DOS.

TPL refers to:

- An insurance plan or carrier
- A program
- A commercial carrier

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured; and a self-funded plan

The terms *third-party liability* and *other insurance* are used interchangeably to mean any source other than the plan that has a financial obligation for health care coverage.

7.1 COB General Instructions

7.1.1 COB Process – General

- COB edits will be applied when TPL exists for the enrollee and claim DOS.
- The Nevada PBM FFS Medicaid is always the payer of last resort. Providers must bill all other payers first before billing Nevada PBM FFS Medicaid. This requirement also applies to compounds.
- COB processing requires that the **Other Payer Amount Paid**, **Other Payer ID**, **Other Payer Date**, and **Other Payer Patient Responsibility** be submitted on the claim to the plan. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.
  - System returns **Other Payer** details in the "COB Response Segment" (items returned are subject to information received on the recipient's COB records):
    - Other Payer Coverage Type
    - Other Payer ID Qualifier
    - Other Payer ID
    - Other Payer Processor Control Number (PCN)
    - Other Payer Cardholder ID
    - Other Payer Group ID
    - Other Payer Person Code
    - Other Payer Help Desk Phone Number
    - Other Payer Patient Relationship Code
    - Other Payer Benefit Effective Date
    - Other Payer Benefit Termination Date
- Co-pay-only claims and Other Coverage Code = 8 are not allowed.

The following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes. Where applicable, it has been noted which **Other Coverage Code** (NCPDP Field # 308-C8) should be used based on the error codes received from the primary.

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
0 – Not Specified	OCC 0 is allowed; submit when recipient does not have TPL.	Claim will reject with a 41 error if recipient record has TPL. Claim should be submitted to the primary payer for payment.
1 – No Other Coverage	OCC 1 is allowed; submit when recipient does not have TPL.	When the recipient has TPL on file and the OCC 1 is submitted, the claim will continue to reject for NCPDP 41. Claim should be submitted to primary payer for payment.
2 – Exists Payment Collected	OCC 2 is accepted	Clam will process at reduced rate and pay
3 – Exists Claim Not Covered	OCC 3 is accepted	Claim will process but must be submitted with one of the reject codes listed in the Approved Other Payer Reject Code list.
4 – Exists Payment Not Collected	OCC 4 is accepted	Claim will process
8 – Claim Billing for a Co-pay	OCC 8 is not accepted	Claim will reject

7.2 Medicare Part B Crossover Claims

To promote accuracy, efficiency, and timeliness of claim completion through final claim payment, MMA recommends the utilization of a POS claim for crossover situations, but MMA will support paper claims to ensure that Medicare is responsible for their portion of the claim payment.

Medicare Part B Eligible Drugs:

- Full charges for a Medicare Part B-eligible drug are applied when the Medicare Part B annual deductible has NOT been met.
- If Medicare Part B denied payment on the claim and the charge was applied to the beneficiary's Medicare Part B annual deductible, then **the pharmacy MUST submit:**
  - Specific Medicare Part B Other Payer ID
  - Other Coverage Code = 4
  - Other Payer Amount Paid = $0.00
  - Other Payer Patient Responsibility Amount = Medicare Co-pay Amount
- Co-pay charges for a Medicare Part B eligible drug are applied when the Medicare Part B annual deductible has been met, and **the pharmacy MUST submit:**
  - Specific Medicare Part B Other Payer ID
  - Other Coverage Code = 2
  - Other Payer Amount Paid = Amount Paid by Medicare Part B
  - Other Payer Patient Responsibility Amount = Medicare Part B Co-pay Amount

MMA will reimburse the claim at the lesser of the member's co-pay amount from Medicare or the Nevada Medicaid allowed amount. Medicaid will cover Part B co-pays for recipients with an eligibility code of A, B, 5, or S.

7.3 Medicare Part D COB

MMA will allow COB claims for which the pharmacy indicates by submission of

- OCC code = 2 **(Other Coverage Exists Payment Collected)** to indicate that a payment has been received from Medicare Part D, or
- OCC code = 4 **(Other Coverage Exists Payment Not Collected)** to indicate that Medicare Part D did not deny the claim, but there was no payment received from Medicare Part D.

If the appropriate COB fields are not submitted, the claim will deny for *NCPDP – 13 M/Is Other Coverage Code.* Products that are excluded from coverage by Part D may pay if covered under the Nevada PBM FFS Medicaid plan. These products can be billed directly to MMA without COB information. Claims will deny *NCPDP 620 – This Product/Service may be covered under Medicare Part D* if a drug is not designated as a Medicare Part D excluded drug.

If the claim is submitted with the NCPDP field *384-4X Patient Residence of 02 = Skilled Nursing Facility* or *03 = Nursing Facility* and is therefore identified as an LTC recipient, then the claim will deny *NCPDP error code 70 Product/Service Not Covered*.

Note: Medicaid will not reimburse Part D co-pays for recipients in LTC facilities, as these are waived in accordance with federal Medicare regulations. DHCFP will pay co-pay charges for a Medicare Part D drug paid by the member's Part D plan. In order for the claim to be paid, the pharmacy must submit:

- Specific Medicare Part D Other Payer ID
- Other coverage Code = 2
- Other Payer Amount Paid = Amount Paid by Medicare Part D
- Other Payer Patient Responsibility Amount = Medicare Part D Plan co-pay Amount

DHCFP will also pay the Medicare Part D co-pay for any medication covered by Part D, up to a maximum amount of $4.30.

8.0 Compound Claims

All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be submitted on the claim. At least one item in the compound must be a covered drug. **If an excluded or non-PDL agent is included in the compound, the claim will reject for NCPDP 70-Product/Service Not Covered.** The pharmacy may place an "**8**" in the submission clarification code field and resubmit the claim; however, be advised that any component of a compound requiring PA will necessitate an approval prior to receiving payment.

Important Notes:

- The **Claim Segment Product ID** (i.e., National Drug Code [NDC]) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
- A non-blank space value is expected in the **Claim Segment Product ID** field for field validation. The pharmacy submits a single zero in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected if a single zero is not submitted as the Product ID.
- A **Submission Clarification Code** value of "**8**" only allows a claim to continue processing if at least one ingredient is covered. Non-rebateable ingredients will process with the submission clarification code, but only rebateable ingredients are eligible for reimbursement.
- The **Compound Type**, NCPDP Field # 996-G1, is required to be submitted on all compound claims. If this field is not submitted, the claim will reject.
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- If total cost is not equal to the sum of the ingredients' cost, the claim will deny.
- Multiple instances of an NDC within a compound will not be allowed.
- Duplicate edits are applied regardless of the compound status of the claim.

8.1 Fields Required for Submitting Multi-Ingredient Compounds

On the **Claim** Segment:

- Enter **Compound Code** (NCPDP Field # 406-D6) of "2."
- Enter **Product Code/NDC** (NCPDP Field # 407-D7) as "0" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter **Product/Service ID Qualifier** (NCPDP Field # 436-E1) as "00" to identify the product as a multi-ingredient compound.
- Enter **Quantity Dispensed** (NCPDP Field # 442-E7) of entire product.
- Enter **Gross Amount Due** (NCPDP Field # 430-DU) for entire product.
- **Submission Clarification Code** (NCPDP Field # 420-DK) = Value "8" will only be permitted for POS (not valid for paper claims) and should be used only for compounds.

On the **Compound** Segment:

- **Compound Dosage Form Description Code** (NCPDP Field # 450-EF)
- **Compound Dispensing Unit Form Indicator** (NCPCP Field # 451-EG)
- **Compound Route of Administration** (NCPCP Field # 452-EH)
- **Compound Ingredient Component Count** (NCPCP Field # 447-EC) (Maximum of 25)

For **each line item**:

- **Compound Product ID Qualifier** (NCPCP Field # 488-RE) of "00"
- **Compound Product ID** (NCPDP Field # 489-TE)
- **Compound Ingredient Quantity** (NCPDP Field # 448-ED)
- **Compound Ingredient Cost** (NCPDP Field # 449-EE)

9.0 340B Drug Discount Program

The **340B Drug Discount Program** is a federal program that requires drug manufacturers to provide covered outpatient drugs to certain eligible 340B-enrolled entities at significantly reduced prices. Please see Appendix A for 340B requirements.

10.0 Provider Reimbursement

10.1 Provider Reimbursement Rates

For all drugs and supplies (other than vaccinations), the following reimbursement logic is always used. The lesser of:

- National Average Drug Acquisition Cost (NADAC) and Dispensing Fee
- Wholesale Acquisition Cost (WAC) and Dispensing Fee
- Federal Upper Limit (FUL) and Dispensing Fee
- Maximum Allowable Cost (MAC) and Dispensing Fee
- Gross Amount Due (NCPDP field 430-DU)
- Usual and Customary (NCPDP field 425-DQ)

For products that do not have the WAC, FUL, MAC, or NADAC, the pharmacy must bill the AAC as the amount in the **Gross Amount Due** (NCPDP field 430-DU).

10.1.1 Dispense Fees

All claim dispense fees are $10.17.

Exception: IV therapy multi-ingredient compounds. Dispense Fee is $10.17 multiplied by the number of days of therapy.

10.1.2 Vaccines

Refer to *Vaccines* for dispense fee information.

10.1.3 At-Home OTC COVID-19 Tests

Nevada Medicaid reimburses for at-home over-the-counter COVID-19 tests that have been authorized by the U.S. Food and Drug Administration (FDA). Nevada Medicaid will reimburse a pharmacy at a rate of up to $12 per individual test (or the cost of the test, if less than $12) with a quantity limit of 8 tests per month. Providers must bill on a per-unit basis. For example, if a package includes two tests, the provider should bill for two units, which would equate to up to a $24 reimbursement.

10.2 Maximum Allowable Cost

10.2.1 MAC List Disputes (Appeal Process)

To comply with applicable state laws, Magellan has implemented an appeal process that allows a participating network pharmacy to dispute Maximum Allowable Cost (MAC) pricing of a covered prescription drug product by filing an appeal. This process also includes a timely review and investigation to resolve MAC disputes.

For a MAC appeal, the pharmacy must obtain, fully complete, and submit a *MAC Appeal Form* to MMA within 30 calendar days of the date of service submitted on the claim (unless otherwise specified by law) and adhere to state-specific requirements.

Participating pharmacies may be required to submit their actual acquisition cost (including any rebates) for each NDC being reviewed. Failure to submit the actual acquisition cost will not result in Magellan rejecting claims for review but could diminish the accuracy of review and, therefore, the likelihood of a successful and complete review. Known manufacturer shortages, multiple appeals for the same product, and reduced generic availability also play roles in the decision to increase a MAC price.

Appeals are investigated, resolved, and responded to within 10 calendar days (unless otherwise specified by law). Providers will be notified electronically of the MAC appeal decision. This notification includes the reason for denial, a minimum of one alternate NDC for the product when applicable, and the source (if requested or required by law) where the alternate NDC may be purchased from a licensed wholesaler at or below the MAC.

- For additional questions regarding our MAC appeal process or for general information, please visit https://nevadamedicaidqa.magellanrx.com/provider/documents.
- Appeal forms can be found at https://nevadamedicaid.magellanrx.com/provider/documents and submitted via email or sent **ATTN: MAC Department** to fax number (888) 656-1951. Please note that processing may be delayed if information is illegible or incomplete.

11.0 Pharmacy Relations

The Nevada Provider Network consists of contracted providers. To enroll, please contact the Nevada Division of Health Care Financing and Policy Provider Enrollment.

- https://medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx
- Phone: (877) 638-3472 and then select the option for "Provider Enrollment"
- Hours: Monday–Friday 8:00 a.m.–5:00 p.m. PT

12.0 Provider Responsibilities

Pharmacy providers must maintain records for all prescriptions dispensed to eligible Medicaid recipients. Please refer to *Medicaid Services Manual* (MSM) Chapter 1200, Section 1203.1A, for specific requirements.

13.0 Definitions, Abbreviations, and Acronyms

Term	Definition
AAC	Actual Acquisition Cost
ACEI	Angiotensin Converting Enzyme Inhibitor
AMPs	Average Manufacturer Prices
AutoPA	Automated Prior Authorization
CAP	Corrective Action Plan
CIIs	Schedule II Controlled Substances
CMS	Center for Medicare & Medicaid Services
COB	Coordination of Benefits
CSC	Clinical Support Center
DAW	Dispense as Written
DEA	Drug Enforcement Administration
DHCFP	Division of Health Care Financing and Policy
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
EIN	Employee ID Number
ESRD	End Stage Renal Disease
FDB	First Data Bank
FFS	Fee-For-Service
FWA	Fraud, Waste, and Abuse
GPO	Group Purchasing Organization
GSA	General Services Administration
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
HRSA	Health Resources and Services Administration
I.V.	Intravenous
LEIE	List of Excluded Individuals and Entities
LTC	Long-Term Care
MAC	Maximum Allowable Cost
MCOs	Managed Care Organizations
MEF	Medicaid Exclusion File
MFCU	Medicaid Fraud Control Units

Term	Definition
MMA	Magellan Medicaid Administration, Inc.
MSM	*Medicaid Services Manual*
NADAC	National Average Drug Acquisition Cost
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OCC	Other Coverage Code
OIG	Office of Inspector General
PAD	Physician Administered Drugs
PAs	Prior Authorizations
PDL	Preferred Drug List
PHI	Protected Health Information
POS	Point-of-Sale
ProDUR	Prospective Drug Utilization Review
PSAO	Pharmacy Services Administration Organization
PSC	Pharmacy Support Center
RetroDUR	Retrospective Drug Utilization Review
SAM	System for Award Management
SCHIP	State Children's Health Insurance Program
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
UAC	User Administration Console
URAs	Unit Rebate Amounts
VFC	Vaccines for Children
WAC	Wholesale Acquisition Cost

14.0 Appendix A – 340B Drug Pricing Program

The 340B Drug Pricing Program is a federal program that requires drug manufacturers to provide covered outpatient drugs to certain eligible 340B-enrolled entities at significantly reduced prices.

This section contains the DHCFP policies and procedures for FFS providers who participate in the 340B Drug Pricing Program. This guidance applies to prescription drugs dispensed in an outpatient setting (i.e., pharmacy) and drugs administered in a physician's office or clinic. **This guidance does not apply to prescription drugs provided in an inpatient hospital setting.**

14.1 Definitions

- **Duplicate discount –** When a manufacturer provides a drug to a covered entity with the 340B discount, in addition to the manufacturer paying a rebate to the DHCFP on the same drug (42 USC 256b(a)(5)(A)(i) (2010)).
- **Contract pharmacy –** An arrangement under which the 340B covered entity signs a contract with a pharmacy to provide pharmacy services. Contract pharmacies can be made available to covered entities that do not have access to available or appropriate "in-house" pharmacy services.
- **Covered entity –** An entity that is enrolled with the federal 340B Drug Pricing Program and is required to adhere to all state, federal, and 340B regulations pursuant to the 340B Public Health Service Act (42CFR1.A 10.3 and 42CFR1.A 10.10 (2018)).

14.2 Covered Entities & The DHCFP

Covered entities choose whether to dispense 340B-purchased drugs to Nevada Medicaid recipients, and this decision affects how providers bill the DHCFP.

- The DHCFP requires covered entities to determine whether they will dispense only 340B drugs to Nevada Medicaid recipients (carve-in) or whether they will dispense no 340B drugs to Nevada Medicaid recipients (carve-out). **Covered entities cannot bill both 340B-purchased drugs and non-340B drugs to the DHCFP.**
- Covered entities that choose to carve in must bill the DHCFP for 340B drugs at their actual acquisition cost (AAC).
- Covered entities must ensure that there is a mechanism in place that does not allow for duplicate discounts (i.e., the covered entity cannot receive a drug at a 340B discounted price in addition to the DHCFP receiving a rebate from the drug manufacturer).

14.3 Covered Entities & 340B

When an eligible entity enrolls in the 340B Drug Pricing Program, it accepts the responsibility of complying with all the provisions listed below.

- Covered entities that carve in must list all National Provider Identifier (NPI) numbers used to submit claims on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF).
- Covered entities must comply with the "no diversion" stipulation, which mandates that 340B drugs may not be resold or transferred to a person who is not a patient of the entity.
- Covered entities are responsible for repayment to the manufacturer if a duplicate discount occurs because of a billing error.
- Non-compliance of the DHCFP 340B policy could result in the repayment of discounts to the manufacturer for the duplicate discount, the repayment of discounts with interest, and/or the covered entity could be removed from the 340B Drug Pricing Program entirely.

14.4 The DHCFP & 340B

The DHCFP has the responsibility of accurately reimbursing covered entities and appropriately collecting rebates from drug manufactures.

- The DHCFP identifies and excludes all 340B drug claims from the utilization data submitted to drug manufacturers to ensure that covered entities are not getting discounted drugs in addition to Nevada Medicaid receiving rebates from the drug manufacturers.

14.5 340B Policy Statements

1. The DHCFP allows covered entities to dispense 340B drugs at the provider level (i.e., carve-in).
   - Any covered entity that is billing 340B drugs to the DHCPF must register with the HRSA.
   - The covered entity must list all NPI numbers used to submit claims on the MEF.
2. Duplicate discounts are prohibited in the 340B Drug Pricing Program.
   - It is the covered entity's responsibility to ensure that duplicate discounts do not occur.
   - To prevent duplicate discounts from taking place:

- The covered entity is required to follow HRSA's rules and provide HRSA with their NPI at the time of enrollment.
- The covered entity is required to ensure that HRSA has their NPI on the MEF, which lets states and manufacturers know that drugs billed under those NPI numbers are not eligible for rebate.

3. The submitted ingredient cost on a claim must be the 340B AAC.
4. Manufacturers are permitted to audit covered entities' records if they suspect product diversion or that multiple discounts are taking place.
   - To ensure compliance, covered entities are responsible for creating and maintaining a system that inhibits this.
5. Contract pharmacies are **NOT** permitted to bill 340B drugs to the DHCFP.
   - ***The use of contract pharmacy services is voluntary,*** and covered entities are not required to use multiple contract pharmacies or even any contract pharmacy at all. Covered entities should conduct their own business review and patient assessment to determine what level of pharmacy services are needed, as well as the appropriate delivery mechanism for those services.
6. Covered entities are responsible for repayment to manufacturers of duplicate discounts due to the covered entity failing to follow the DHCFP's billing policy.

14.6 DHCFP Fee-for-Service (FFS) NCPDP D.0 Billing Changes for 340B Outpatient Drug Claims

1. Effective July 1, 2022, FFS 340B claims submitted via the National Council for Prescription Drug Programs (NCPDP) D.0 format **must include** the following:
   - A value of "20" in field 420-DK, Submission Clarification Code; and
   - A value of "08" in field 423-DN, Basis of Cost Determination.

The above guidance supersedes all previous billing guidance for FFS 340B claims submitted via the NCPDP D.0 format.

2. Effective July 1, 2022, claims will reject with an error message if:
   - The *Submission Clarification* and *Basis of Cost Determination* fields indicate that the drug was purchased through the 340B Drug Pricing Program but the pharmacy NPI number is not listed on the HRSA 340B MEF.
   - The pharmacy NPI number is listed on the HRSA 340B MEF but the *Submission Clarification* and *Basis of Cost Determination* fields did not include the correct values.

14.7 DHCFP Billing Instructions for 340B Physician Administered Drugs (PAD)

The DHCFP uses HRSA's MEF to identify all 340B drug claims. This process allows for claims to be excluded from the rebate stream, thereby avoiding duplicate discounts. However, an additional identifier is required at the claim submission level for all 340B PAD claims.

1. Effective July 1, 2022, all claims and encounters for PAD purchased through the 340B program **must include**:
   - One of the following:
     - "UD," "JG," or "TB" in the *Procedure Code Modifier* field on the 837P and 837I.
       - UD: Medicaid level of care 13, as defined by each state (Short Description – Medicaid care level 13 state).
       - JG: Drug or biological acquired with 340B drug pricing program discount (Short Description – 340B acquired drug).
       - TB: Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes (Short Description – Tracking 340B acquired drug).
   - A valid NDC number on all PAD claims and encounters. Additional billing information and guides can be found under the DHCFP Provider Portal at https://nevadamedicaid.magellanrx.com/home.
2. Effective July 1, 2022, claims will reject if:
   - The *Procedure Code Modifier* field on the 837P and 837I claims indicates that the drug was purchased through the 340B Drug Pricing Program, but the physician's NPI number is not listed on the HRSA 340B MEF.
   - The provider NPI number is listed on the HRSA 340B MEF, but the procedure code fields did not include the correct values.

14.8 Ceiling Price Calculation for Outpatient Drugs

Effective July 1, 2022, if the submitted ingredient cost for a 340B-purchased drug exceeds the 340B ceiling price, claims will trigger a notification. Ceiling prices are determined by the Average Manufacturer Prices (AMP) and unit rebate amounts (URA). Covered entities must submit their 340B AAC to the DHCFP.

AAC for covered outpatient drug is the unit cost that the facility pays for a drug after subtracting all discounts. A facility may establish written protocols for establishing or calculating the facility's AAC based on a monthly, quarterly, or other average of the facility's AAC. A written protocol may not include an inflation markup, spread, or margin to be added to the facility's actual purchase price after subtracting all discounts.

For more information, please visit HRSA's website: 340B Ceiling Price Calculation.

14.9 Additional Guidance

For additional information, including FAQs on the 340B program, as well as information on how to ask additional questions, please visit the HRSA website at https://www.hrsa.gov/.

Policy and billing questions for the DHCFP can be directed to: rxinfo@dhcfp.nv.gov.