North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Please visit our website at www.dhhs.state.nc.us/dma

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Attention:

Outpatient Pharmacy Program

TABLE OF CONTENTS

PRESCRIPTION LIMITATIONS

On June 1, 2006, the N.C. Division of Medical Assistance (DMA) will implement a new prescription limit of **eight** prescriptions per recipient per month for recipients age 21 and older.

Exemptions from the Monthly Prescription Limitations
A pharmacist may override the monthly prescription limit with three additional prescriptions per recipient per month. Overrides are available at the discretion of the pharmacist after consultation with the recipient's primary care physician based on the assessment of the recipient's need for additional medications during the month of service.

Recipients under 21 years of age are exempt from the prescription limitation under guidelines established through Medicaid for Children (Health Check). Recipients who reside in nursing facilities and intermediate care facilities/mental retardation centers are also exempt from the prescription limitation. Exemption from the monthly prescription limitation for these recipients is incorporated into the recipient eligibility file. Community Alternatives Program recipients are **not** exempt from the limit.

Indicating Exemption from the Prescription Limitation
An override for exemption from the prescription limitation is indicated by entering a "5" in the PA/MC field or by entering an "E" in the block on the paper claim form used to designate patient location (LOC). An override for exemption from both the prescription limit and the copayment is indicated by entering an "8" in the PA/MC field or by entering a "B" in the block on the paper claim form used to designate LOC. Refer to Attachment A for additional information on exemptions to copayments and prescription limits.

The Six Prescription Limit Override form will not be needed once the new prescription limit goes into effect on June 1, 2006. However, forms used prior to June 1, 2006 should be retained on file for five years in case of an audit.

MEDICATION THERAPY MANAGEMENT PROGRAM

Some recipients have clinical indications that warrant more prescriptions than are allowed under the monthly prescription limit and are, therefore, exempt from the monthly limitation. DMA requires that recipients receiving more than 11 prescriptions per month be evaluated as part of a medication therapy management program. To exempt such recipients from the monthly limitations, DMA requires that they be enrolled in the Medication Therapy Management Program. The recipient's pharmacist and primary care physician must review the recipient's medication profile every three months to ensure clinically appropriate and cost-effective use of drug therapy. If needed, the pharmacist should obtain consultation for specific patient therapy questions from clinical pharmacy experts (e.g., AHEC pharmacists, CCNC pharmacists, drug information centers and academic pharmacists, etc).

The first review by the recipient's pharmacist and primary care physician must be completed within two months of the recipient's identification for the program and at a minimum of every three months thereafter. Pharmacies participating in this program are eligible for a monthly medication therapy management fee for each Medicaid recipient being managed.

Documentation of the review of the recipient's medical profile can use the pharmacy's standard software, which incorporates professional standards of clinical appropriateness. The appropriate signatures by the recipient's primary care physician and pharmacist are required on the Medication Therapy Management Form to assure compliance with the frequency of review and agreement on actions undertaken. If the primary care physician refuses to sign the Medication Therapy Management Form then the pharmacist must document this on the form. The name of the primary care physician who refused to sign and the reason for the refusal must be stated.

Monitoring by Program Integrity

It is the pharmacy provider's responsibility to document the review of the recipient's medication profile and to retain copies of the signed documentation and Medication Therapy Management Form on file in the pharmacy for five years. The documentation must be readily retrievable for review by DMA's Program Integrity staff, who will routinely monitor pharmacies receiving medication therapy management fees. Pharmacy providers will be subject to recoupment of the monthly medication therapy management fee if documentation does not show that reviews actually occurred.

Criteria for Medication Therapy Management (MTM) Form

Medication therapy management allows a licensed pharmacist to provide the following pharmaceutical care services to optimize patient specific therapeutic outcomes**:**

- Each pharmacy must develop their own MTM form.
- List all current dispensed medications from the patient's active drug profile inclusive of OTC medications.
- Obtain necessary assessments of patient's health information.
- Perform a comprehensive medication review to identify medication-related problems, such as adverse drug events, therapeutic duplication, discontinued medications, drug-drug-interactions, food-drug interactions.
- Check when appropriate for dose consolidation and dose optimization.
- Provide patient specific education designed to enhance patient understanding and appropriate use of the patient's medications.
- Monitor patient medication regimen adherence.
- Document care delivered and communicate essential information to the patient's primary care provider.

Medication Therapy Management Fee

A monthly medication management fee of $10.00 per recipient will be paid to each pharmacy that participates in the Medication Therapy Management Program. Payments are made the on the 1st checkwrite of the following month. Reimbursement is based on the number of recipients locked-in to that pharmacy on the last day of the month.

RECIPIENT LOCK-IN (RESTRICTED PHARMACY SERVICES) PROGRAM

Beginning June 1, 2006, only recipients obtaining more than 11 prescriptions per month will be restricted to a single pharmacy, and pharmacists will no longer need to remove and retain the pharmacy stub from the recipient's Medicaid identification card.

DMA will continue to utilize a Recipient Lock-In (Restricted Pharmacy Services) Program for recipients identified for the medication therapy management program who require more than 11 prescriptions each month. Restricting these recipients to a single pharmacy will ensure that medications are evaluated on a consistent basis by both the pharmacist and the recipient's primary care physician. Every six months recipients will be systematically removed from the Lock-In Program when fewer than 12 prescriptions were filled each month. The recipient's primary care physician or pharmacy provider can contact EDS at 1-800-688-6696 or 919-851-8888 to request changes to the pharmacy lock-in provider.

When the new prescription limit is implemented, recipients who are currently obtaining more than 11 prescriptions per month will be systematically locked into the pharmacy that filled the majority of their prescription during the month of April 2006. After June 1, either the pharmacy or the primary care physician will need to call EDS at 1-800-688-6696 or 919-851-8888 to identify new recipients who are to be restricted to a single pharmacy and managed through the Medication Therapy Management Program. The following recipients are exempt from mandatory pharmacy lock-in:

- Recipients who are less than 21 years of age.
- Recipients residing in intermediate care facilities/mental retardation centers.
- Recipients residing in a skilled level of care nursing facility.

Refer to ***Attachment A*** for additional information on Exemptions to Copayment and Prescription Limit Override Information.

Emergency Supplies for the Recipient Lock-In Program
Emergency fills will be allowed for recipients who are locked into a pharmacy for situations where the recipient may not be able to get to their pharmacy. The emergency supply is limited to a 4-day supply. The provider will be paid for the drug cost only and the recipient will be responsible for the appropriate copayment.

Records of dispensing of emergency supply medications are subject to review by Program Integrity. Paid quantities for greater than a 4-day supply are subject to recoupment.

Lock-In Exemption for Recipients Residing in Long-Term Care Facilities
Recipients residing in nursing facilities and intermediate care facilities/mental retardation centers are exempt from mandatory pharmacy lock-in and medication therapy management program because medication reviews are required by OBRA 1990 guidelines and by facilities' contracts with pharmacy providers.

Recipients Lock-In and Living Arrangement Changes
Recipients who are restricted to one pharmacy can have their primary care physician or pharmacy provider contact DMA to request changes to the pharmacy lock-in provider. Changes in a recipient's living arrangement may require a change to the pharmacy lock-in provider and it would be expected that the recipient's current pharmacy lock-in provider contact DMA to facilitate this change.

Recipient Lock-In and Addition of Specialty Pharmacy Provider

Recipients may be assigned a specialty pharmacy provider in addition to the pharmacy provider the recipient is locked into when necessary to receive medications only available through a specialty pharmacy provider. Specialty pharmacies are pharmacies that provide compounded drugs, and high-cost injectables and infusion therapies used to treat chronic diseases with low prevalence, which are routinely administered in the outpatient setting and require special handling and distribution. Examples of drugs provided by specialty pharmacies include drugs that require compounding and drugs used in diseases such as hemophilia, growth retardation, RSV, and hepatitis C.

Specialty pharmacies will have to register with EDS (1-800-688-6696 or 919-851-8888) and be added to the recipient's lock-in file before they can provide services to that recipient. Claims submitted by a specialty pharmacy that has not registered to provide services to a recipient who is locked in to a pharmacy will be denied.

QUANTITY LIMITATIONS ON EPISODIC DRUGS

On May 1, 2006, DMA implemented quantity limitations for episodic drugs based on advice from the N.C. Physicians Advisory Group. These new service requirements allow DMA to impose quantity limitations for drugs used episodically and in quantities that support less than daily use. Quantity limitations are based on FDA labeling and evidence-based guidelines that are in line with best practice standards. DMA will monitor utilization of designated episodic drugs on an annual basis or more frequently if necessary in order to assess the need for changes in the limits.

The first drug classes that quantity limitations have been placed are the sedative hypnotic drug classes H2E and H8B. Recipients will be able to obtain 15 units of these drugs each month with additional quantities requiring prior authorization. Prior authorization for quantities in excess of 15 units each month must be requested through ACS at (866) 246-8505. Prior authorization criteria and forms for the sedative hypnotics are available on the DMA ACS Prior Authorization website at http://www.ncmedicaidpbm.com. Recipients receiving a skilled level of care are exempt from this policy, but this living arrangement must be indicated on the Medicaid eligibility file.

Episodic Drugs Quantity Dispensing Limits

Drug	GCN	Quantity Limit per Month	Maximum Days Supply	Prior Authorization Allowed for Excess Quantities
Ambien, Ambien CR	00870, 00871, 25456, 25457	15	34	Yes
Sonata	92723	15	34	Yes
Prosom, Estazolam	19181, 19182	15	34	Yes
Dalmane, Flurazepam	14250, 14251	15	34	Yes
Restoril, Temazepam	13840, 13841, 13845, 24036	15	34	Yes
Halcion, Triazolam	14280, 14281, 14282	15	34	Yes
Doral	40870, 40871	15	34	Yes
Lunesta	23925, 23926, 23927	15	34	Yes
Rozerem	25202	15	34	Yes

Attachment A: Table of Exemptions to Copayment and Prescription Limit Specific Edit Override Information

	Exemption			NCPDP			Manual
Condition	**Copay**	**Rx Limit**	**Both**	**Location**	**PA Code**	**Rx Clarification Field**	**Claim**
Eight Rx Limit Exemption (effective 6/1/06)							
Notation of Rx limit override dependent on pharmacy review (9th, 10th & 11th)	N	Y			5		Loc=E
Six Rx Limit Exemption (end date 5/31/06)							
Notation of diagnosis for 6 Rx exemption	N	Y			5		Loc=E
Copay Exemption							
Family Planning	Y	N			Drug File		Drug File
Intermediate Care Facility	Y	N		2			7
Skilled Nursing	Y	N		7			8
Pregnancy	Y	N			4 or Eligibility File		Eligibility File
Exempt from copay only	Y	N			4		Not Existing
Eight Rx Limit and Copay Exemption (effective 6/1/06)							
Health Check < 21 years old	Y	Y			Eligibility File		Eligibility File

	Exemption			NCPDP			Manual
Condition	**Copay**	**Rx Limit**	**Both**	**Location**	**PA Code**	**Rx Clarification Field**	**Claim**
Eight Rx Limit and Copay Exemption cont. (eff. 6/1/06)							
CAP	Y	N			Eligibility File		Eligibility File
Exempt from copay and 8 Rx limit	Y	Y	Y		8		B
Six Rx Limit and Copay Exemption (end date 5/31/06)							
Health Check < 21 years old	Y	Y			Eligibility File		Eligibility File
CAP	Y	Y	Y		Eligibility File		Eligibility File
Exempt from copay and 6 Rx limit	Y	Y	Y		8		B
Locations with No Automatic exemptions							
Hospice	N	N		11			
Rest Home	N	N		5			6
Specific Edit Overrides							
Edit 907 (Dosage over FDA guidelines)	N	N				2	
Edit 946 (Medicare Part B Edit) for recipients incorrectly identified as having part B	N	N			1		

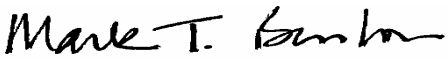
Condition	Copay	Rx Limit	Both	Location	PA Code	Rx Clarification Field	
Early Refill Override – Vacation (in addition to DUR override)	N	N				3	
Early Refill Override – Lost prescription (in addition to DUR override)	N	N				4	
Early Refill Override – Change in Therapy (in addition to DUR override)	N	N				5	

Attachment B: Summary of Medicaid Billing Requirements

- The subscriber ID is the recipient's MID number consisting of nine (9) digits plus one (1) alpha character in the tenth position.
- Currently, the prescriber's DEA number is the number used to identify the prescriber of the prescription.
- Eight prescriptions per month limit.
- Copayments are $3.00 for generic drugs, selected OTC products that are covered, and brand name drugs.
- The maximum days supply for all drugs, except birth control medications and prepackaged hormone replacement therapies, is a 34-day supply unless the medication meets the criteria described in **Clinical Coverage Policy #9, Section 5.2, Dispensing Limitations**, to obtain a 90-days supply.
- The dispensing fee is deducted for additional prescriptions dispensed within the same month.
- Compounds – Refer to **Clinical Coverage Policy #9, Section 3.2, Coverage of Compounded Drugs**.
- Nursing home providers may combine all of the prescriptions dispensed during a month as one prescription and submit it at the end of month as long as the **first** date of service a claim is dispensed during the month is indicated as the date of service and the days supply is accurate.
- The Amount Billed should be the lower of usual and customary charge or the calculated Medicaid price. The calculated Medicaid price is the **MAC price or the AWP - 10% + the dispensing fee**. Federal or state MAC prices are used unless it is overridden with auditable required documentation.
- MAC overrides are allowed if the prescriber hand writes brand "Medically Necessary" on the face of the prescription. MAC overrides are billed with DAW 1.
- Other Payor amounts must be included when applicable for Medicaid, as the payor of last resort, to pay the calculated Medicaid price minus the copay and the Other Payor Amount field.

Exclusions from Payment

- OTCs (except Insulin and selected OTC products per **General Medical Policy No. A-2**)
- Devices
- Diaphragms
- DESI drugs
- Compounds equivalent to DESI drugs
- Fertility medications
- Medications for cosmetic purposes
- Medications for non-FDA approved uses
- Drugs from manufacturers who have not signed Drug Rebate agreements
- Inpatient hospital prescriptions
- Drugs administered in the prescriber's offices, which should be submitted by the prescriber using J codes
- Routine immunizations
- Durable medical equipment
- Prescriptions dispensed by providers who are not enrolled with Medicaid
- IV fluids (Dextrose 500 ml or greater) and irrigation fluids used by Medicaid recipients in an inpatient facility are not billed through the N.C. Medicaid Outpatient Pharmacy Program; they are billed by the facility as ancillary services



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