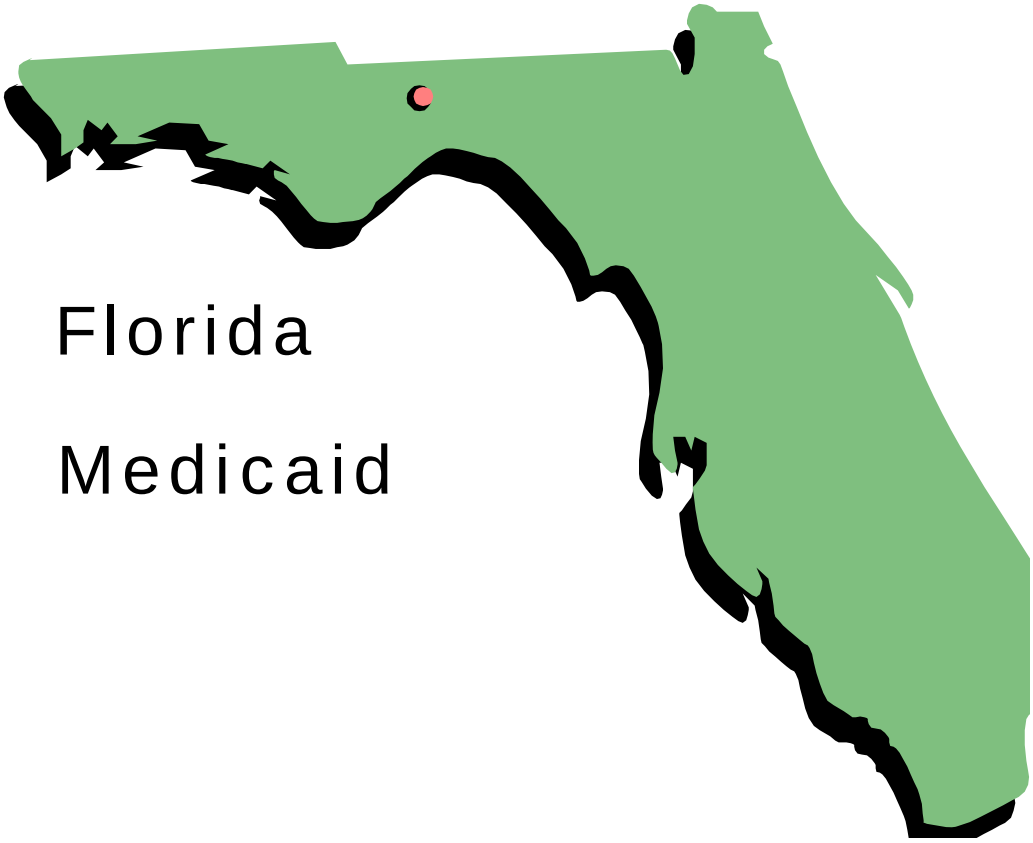


PRESCRIBED DRUGS COVERAGE, LIMITATIONS AND REIMBURSEMENT HANDBOOK

Agency for Health Care Administration

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

June 2012

INTRODUCTION TO THE HANDBOOK

Florida Medicaid Provider General Handbook	General information regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy and important resources for providers are included in the Florida Medicaid Provider General Handbook. The general handbook is updated as needed, and may be accessed at www.mymedicaid-florida.com. Pharmacy providers must comply with all applicable policies in the General Handbook as well as the Prescribed Drug Coverage, Limitations, and Reimbursement Handbook, which is incorporated by Rule 59G-4.250. Reimbursement rates are in Rule 59G-4.251, F.A.C., Florida Medicaid Prescribed Drugs Reimbursement Methodology.

Handbook Use and Definitions

Purpose	The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
"Provider"	The term "provider" is used to describe any entity, facility, person, or group enrolled in the Medicaid program that renders services to Medicaid recipients and bills Medicaid for those services. They are identified with a unique provider number for each location. Each unit of a chain or group is a separate provider with their own unique number.
"Recipient"	The term "recipient" is used to describe an individual who is eligible for Medicaid.

Handbook Updates

How Changes Are Updated	The Medicaid provider handbooks are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com . Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Prescribed Drugs Coverage, Limitations and Reimbursement Handbook is incorporated by reference in rule 59G-4.250, F.A.C. The Medicaid handbooks will be updated as needed.
Identifying New Information	New or changed material since last publication will be indicated by yellow highlighting. The effective date of these revisions shall be the effective date of the revised handbook.

CHAPTER 1
THE FLORIDA MEDICAID PRESCRIBED DRUG PROGRAM

Overview

Introduction

This chapter describes Medicaid prescribed drug services policies related to organization and administration, provider qualifications, provider enrollment, payment for services, prescription drug services for health maintenance organizations, record-keeping requirements, point-of-service enrollment, Medicaid computer system, diverted pharmaceuticals, and recipient over-utilization or fraud.

Legal Authority

The Medicaid program is authorized by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code.

The Florida Medicaid prescribed drug services program is authorized through Chapter 409.906(20), F.S., 409.908, F.S., and 409.912, F.S. These statutes allow the Agency for Health Care Administration to pay for and control spending for prescribed drugs. Chapter 59G-4.250, F.A.C., implements policies for the prescribed drug services program. Chapter 59G-4.251, F.A.C., implements the reimbursement methodology for prescribed drug services.

The regulation of the practice of pharmacy and the state authority for the licensing of pharmacists and pharmacies are found in Chapter 465, F.S. and Chapter 64B, F.A.C

In This Chapter

This chapter contains:

Organization and Administration

Who Pays Medicaid Claims

Medicaid contracts with a private company to pay claims. This company is referred to as the Medicaid fiscal agent. The fiscal agent also performs a variety of other functions for Medicaid including enrollment of providers and management of the recipient eligibility system. In addition, it provides management of pharmacy benefits through the Pharmacy Benefits Management (PBM) vendor.

Who Can Provide Services

Health care practitioners and health care facilities that meet the conditions of participation and eligibility requirements, and are enrolled in Medicaid, will provide services and be reimbursed for rendering Medicaid-covered services.

The State of Florida Legislature, in 409.912(37)(a) 4, F.S., has authorized Medicaid to limit its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or other similar criteria. If the Agency for Health Care Administration (AHCA or the Agency), Medicaid Division, has a sufficient number of Medicaid providers, AHCA is allowed to impose a moratorium on Medicaid pharmacy enrollment. AHCA can terminate any Medicaid contract with 30 days notice without cause. All terms of the contract will remain in force for the full 30 days.

Payment for Services

Provider's Charges for Services

The provider's charges for services billed to Medicaid must not exceed the provider's usual and customary charge.

The providers must ensure that the average charge to Medicaid does not exceed the average charge to all other customers in any quarter for the same drug, quantity, and strength. This is known as the usual and customary charge for the provider.

Reimbursement for Services

Medicaid reimbursement for prescribed drug services is on a fee-for-service basis. Medicaid reimbursement methodology for prescribed drugs in detailed in Rule 59G-4.251, F.A.C., and submission of pharmacy claims for reimbursement is discussed in detail in Chapter 3 of this handbook.

Payment For Services, *continued*

Billing the Recipient	Prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid and must document this in writing in the recipient's medical record. Other than copayments and coinsurance, a provider cannot bill the recipient except under any of the following circumstances: 1. The provider chooses not to bill Medicaid for any part of that service and the recipient has been informed prior to the service being provided. 2. The service is not covered by Medicaid. 3. There is a balance due on an Enhanced Benefits Account (EBA) claim (i.e., there was insufficient credit balance to fully pay for the item).

Medicaid Computer System

Introduction	The Florida Point of Sale (POS) System™ is the system that processes drug claims, and the Florida Medicaid Management Information System (FMMIS) is the system that processes all other claims, makes payments to Medicaid providers, and issues Medicaid identification cards. Medicaid will not reimburse a provider for a claim unless FMMIS shows that a recipient is eligible on the date of service.
Time Required	There could be a delay between the time an individual recipient is notified that he is eligible for Medicaid and the appearance of the information on the FMMIS and POS systems.
Claims Pended for Eligibility	As of January, 2012, if a claim is filed before eligibility data appears on FMMIS and POS System™, the claim will no longer pend for up to 14 days for a previously eligible recipient. The claim will deny immediately. Note: See Chapter 5 in this handbook for information about resubmitting denied claims.
MediPass	Prescribed drug services do not require authorization by the MediPass Gatekeeper provider.

Health Maintenance Organizations (HMO)

Prescribed Drug Services

HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.

A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.

Provider Qualifications

Introduction

To receive Medicaid reimbursement, a provider must be enrolled in Medicaid, meet the provider qualifications at the time the service is rendered, and be in compliance with all licensure, local, state, and federal laws, rules, regulations, Medicaid bulletins, manuals, handbooks, and statements of policy as amended.

Pharmacy Definition

A pharmacy is a facility licensed in accordance with Chapter 465, F.S. and Chapter 64B, F.A.C. to dispense legend drugs.

Provider Qualifications

To enroll in Medicaid, the pharmacy must have one of the following permits issued by the Department of Health, Division of Medical Quality Assurance, Board of Pharmacy as defined by Chapter 465, F.S.:

- Community Pharmacy
- Institutional Class 1 Pharmacy
- Nuclear Pharmacy
- Special Pharmacy categories:
  - Assisted Living Facility (ALF)
  - Parenteral
  - Closed System
  - End Stage Renal Disease (ESRD)

The pharmacy must be physically located in Florida or within the 50 mile border limitation for Georgia and Alabama providers unless services are provided that cannot be otherwise obtained within these geographic limitations, and a specific exemption is granted by the Deputy Secretary for Medicaid.

Provider Qualifications, *continued*

Dispensing Practitioners

The Medicaid prescribed drug program may reimburse physicians and other practitioners for dispensing drugs to Medicaid recipients if the practitioner meets all of the following conditions:

1. Is registered with his or her professional licensing board as a dispensing practitioner.
2. Enrolls in the Medicaid program as a pharmacy provider and complies with all other requirements of the prescribed drug services program.
3. Maintains a current Florida Medicaid Medical Provider agreement.

Provider Enrollment

Introduction

Every pharmacy and each of its branch locations must submit a provider enrollment application and sign a Florida Medicaid non-institutional Medicaid provider agreement in order to provide Medicaid services. The Agency may enroll a provider located outside the State of Florida if the provider's location is no more than 50 miles from the Florida state line, or the Agency determines a need for that provider type to ensure adequate access to care.

Qualified at the Time of Enrollment

Applicants must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Multiple Categories of Service

A provider with more than one category of service, such as a pharmacy that is also enrolled as a durable medical equipment and medical supplies provider, can be assigned one provider number with different two-digit suffixes to use for billing different categories of service. The suffixes are called "location codes."

340B Providers

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Qualified entities purchasing at public health pricing under these provisions must register with the Health Resources and Services Administration (HRSA). See www.hrsa.gov/opa . Claims for outpatient prescription claims must be billed to Medicaid at actual acquisition cost for the drug. The 340B provider must report its Medicaid Identification/National Provider Identifier (NPI) to HRSA in order for such claims to be excluded from manufacturer rebate invoicing. The HRSA website provides a tutorial of billing details at www.hrsa.gov/opa . The provider must notify the Medicaid Bureau of Pharmacy Services of its 340B status in writing. See Chapter 3 of this handbook for instructions for how to bill Medicaid for drugs purchased at 340B pricing.

Enrollment Process

The applicant must submit a Medicaid enrollment package to the Medicaid fiscal agent. See the fiscal agent website at www.mymedicaid-florida.com for information and instructions about enrollment. The fiscal agent will notify the applicant in writing that he or she has been enrolled or denied enrollment.

Provider Enrollment, *continued*

Closures

The provider must report any closure of a location to the fiscal agent on official letterhead stationery. The letter must contain the provider's number and the effective date of the closure.

Enrollment Forms

New applicants must submit a completed application including all required items to the fiscal agent.

New Provider Enrollment

Required documents include:

- Enrollment application (current version available at www.mymedicaid-florida.com)
- Non-Institutional Medicaid Provider Agreement ((current version available at www.mymedicaid-florida.com)
- Bank Letter verifying bank transit/ABA routing number, account name and account number or voided copy of check or deposit slip verifying account information
- W-9 or Proof of FEIN (IRS tax ID)
- Fingerprint card(s) and check payable to Medicaid Fiscal Agent for $43.25 for each card submitted. If eligible, in lieu of this requirement the entity may submit an "FDLE Criminal History Check and Fingerprinting Exemption" form.
- Copy of DEA license
- Copy of Department of Health (DOH) Board of Pharmacy permits (PH prefix) and any other DOH permits associated with that pharmacy.
- Copy of Pharmacy Prescription Department Managers permit (PS prefix)
- Copy of Remittance Advice (RA) form, if the applicant wishes to receive Remittance Advice information electronically rather than paper notice
- Report of beginning inventory

Enrollment forms can be obtained on the fiscal agent's website at www.mymedicaid-florida.com. Click Provider Support, then click Forms. Provider enrollment forms may also be obtained from The Medicaid Pharmacy Benefit Manager (PBM). To obtain enrollment forms, the provider must write or call:

Florida Medicaid Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7082
800-289-7799 (Option 4)

Provider Enrollment, *continued*

Effective Date of Enrollment

Per section 409.907(9), F.S., upon approval of a fully completed application, Medicaid will enroll the applicant as a Medicaid provider. The enrollment effective date for a new provider shall be the date that AHCA or the Medicaid fiscal agent received the provider application except for the following situations:

- With respect to providers who must be licensed, upon approval of the provider application, the enrollment effective date shall be the date the agency receives the complete provider application.
- With respect to a provider that completes a change of ownership, the effective date is the date the Agency received the application, the date the change of ownership was complete, or the date the applicant became licensed, whichever date is later.

- Payment for any claims for services provided to Medicaid recipients between the date of receipt of the application and the date of approval is contingent upon any and all applicable audits and edits contained in Medicaid's claims adjudication and payment processing systems.

An applicant should not bill Medicaid until the applicant receives confirmation from Medicaid that it is enrolled in Medicaid and has received its Medicaid provider ID number and confirmation of the effective date of the enrollment.

Approved Application

An approved application is an accurately and fully completed application that meets all the enrollment requirements, including criminal history checks and onsite inspections, and is approved by Medicaid.

Provider Enrollment, *continued*

Change of Ownership Enrollment

If the applicant is submitting a **change of ownership** application, to enroll in the Medicaid program the applicant must submit the application **at least 60 days prior to the date of change of ownership**.

To enroll in the Medicaid program the new applicant must submit the following additional documents to the Medicaid Contract Management (MCM) Provider Enrollment Unit prior to the date of sale or stock transfer agreement:

- New Florida DOH Board of Pharmacy permit
- DEA license
- Florida Medicaid non-institutional provider agreement
- Actual copy of the “Bill of Sale” or “Purchase Agreement”

Enrollment forms and documents should be submitted to:

For Regular Mail:
Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

For Overnight of Express Mail Delivery:
Florida Medicaid Provider Enrollment
2671 Executive Center Circle, Suite 100
Tallahassee, FL 32301

All new applicants, including change of ownership applicants, are also required to maintain on file a descriptive prescription department inventory that has occurred within 30 days of the date of Medicaid Provider approval. The inventory may consist of invoices or shipping documents that at a minimum show the date of receipt, name of drug, the supplier, quantity and package size. Inventory is to be kept separate from other inventory records and must be on site for five years.

Accuracy of Information

All statements and documents submitted to AHCA or the Medicaid fiscal agent by the applicant must be true and accurate. Filing of false information is sufficient cause for termination from participation or denial of an application for enrollment.

Provider Enrollment, *continued*

Mail Order Pharmacies

Mail order pharmacies physically located in the State of Florida may be enrolled as Medicaid providers. A mail order pharmacy not located within the state of Florida, but licensed in Florida in accordance with Section 465.0156, Florida Statutes, may be enrolled when product distribution restrictions make a specific drug product covered by Medicaid available only from that provider and when approved by the Agency.

Provider Enrollment Application

The provider enrollment application asks the applicant to provide certain information including: provider name, telephone number(s), address, applicable license number(s), tax ID number, category of service, specialty, all group affiliations, a list of all owners with five percent or more interest, and alternate addresses, if applicable. Information is required for each partner, subcontractor, all individual officers, directors, managers, financial custodian of records, and persons authorized to make Electronic Funds Transfers (EFT).

Non-Institutional Provider Agreement

All owners having five percent or greater ownership , principals, partners and financial custodians must sign the Medicaid provider agreement affirming that the uniquely numbered provider will comply with all laws and rules governing the delivery and reimbursement of services or goods to Medicaid recipients. A Chief Executive Officer (CEO) or President of an organization may sign the agreement in lieu of the above. The provider is responsible for compliance with the terms of the agreement by his employees and subcontractors.

Authorized agents who are not designated as “registered” agents in the Articles of Incorporation may sign the Enrollment Application but not the Provider Agreement. Authorized agents must be designated in writing by the organization to transact business on its behalf.

Point-of-Sale Enrollment

Introduction

Point-of-Sale claims processing is available to pharmacies that are Florida Medicaid providers. Point-of-Sale provides on-line adjudication of Medicaid claims. With Point-of-Sale, a claim is electronically processed through the claims-processing cycle in real-time; and a response indicating that the recipient is eligible or ineligible and that the claim is payable or rejected is returned to the pharmacy within seconds of submission. See Chapter 3 in this handbook for information on Point-of-Sale claims processing.

***Point-of-Sale Enrollment**, continued*

Point-of-Sale Agreements	To obtain authorization to submit claims via point of sale, the provider must complete, sign and send a Medicaid Pharmacy Point-of-Sale Provider Certification Agreement and a Medicaid Point-of-Sale Claim Submission Authorization Form to the Medicaid fiscal agent.
Obtaining Point-of-Sale Agreements	The Medicaid Pharmacy Point-of-Sale Provider Certification Agreement and the Medicaid Point-of-Sale Claim Submission Authorization Form are included in the Medicaid Provider Enrollment Application. Additional copies of the Medicaid Pharmacy Point-of-Sale Provider Certification Agreement and of the Medicaid Point-of-Sale Claim Submission Authorization Forms can be obtained by calling the Medicaid fiscal agent, Provider Enrollment, at 800-289-7799. Forms may also be obtained on the Medicaid fiscal agent's web portal at www.mymedicaid-florida.com. Click Provider Support, then click Forms.
Submitting Point-of-Sale Agreements	The originals of the completed and signed Medicaid Pharmacy Point-of-Sale Provider Certification Agreement and a Medicaid Point-of-Sale Claim Submission Authorization Form must be mailed to: Florida Medicaid Provider Enrollment P. O. Box 7070 Tallahassee, Florida 32314-7070
Relevant Web Sites for Information	Providers, prescribers, and vendors can find relevant information at web sites for the following entities: Florida Department of Health at http://www.doh.state.fl.us; Agency for Health Care Administration at www.ahca.myflorida.com; or Bureau of Medicaid Pharmacy Services at www.ahca.myflorida.com/Medicaid/Prescribed_Drug . Florida Medicaid Fiscal Agent Web Portal at www.mymedicaid-florida.com .

***Point-of-Sale Enrollment**, continued*

FDLE and FBI Background Check and Fingerprint Card

Each uniquely numbered provider and each principle of its controlling corporation, partnership, association, or other entity must be fingerprinted for a state and national criminal background check.

Principals are defined as an officer, director, billing agent, managing employee, affiliated person, or any partner or share holder having an ownership interest of five percent or greater. Pharmacy department managers are required to submit background checks.

The background check is accomplished by completing and submitting to the fiscal agent a fingerprint card for each individual for whom a criminal background check is required, and a check for the total amount due payable to the fiscal agent.

Note: For information on exceptions to the requirement for a criminal background check, please contact the area Medicaid office. The telephone numbers and addresses for the area Medicaid offices may be found on the AHCA website at www.ahca.myflorida.com .

Reasons for Denial

Applicants must comply with all requirements of 409.907, Florida Statutes, which specifies reasons for denial of any Medicaid provider applicant. See the Florida Medicaid Provider General Handbook at www.mymedicaid-florida.com for additional information regarding reasons for denial for any provider applicant.

In addition, an application to be a Medicaid pharmacy provider shall be denied when AHCA determines that:

1. The applicant pharmacy is not fully operational, as determined solely by the Agency. A fully operational applicant pharmacy must meet the following conditions:

   a) The applicant pharmacy must be a financially viable concern, that is properly licensed and in compliance with all current laws;
   b) The pharmacy department must be open during established business hours, according to license;
   c) A licensed pharmacist must be present and on duty, and sufficient pharmacy department inventory must be obtained in accordance with Florida law; and
   d) The pharmacy must be receiving prescriptions and dispensing medications, have established accounts with licensed pharmaceutical wholesalers, and must be accepting payment from multiple third party payers.
2. A pharmacist is not on duty when visited at site or available on location by telephone contact during normal business hours;
3. Applicant has no pharmacist or pharmacy manager on duty prior to issuance of Medicaid provider number;

***Point-of-Sale Enrollment**, continued*

Reasons for Denial (continued)

4. Applicant has no established pharmacy inventory prior to acceptance into the Medicaid program unless the ownership has an established relationship in good standing with the Agency (a report of beginning inventory must be provided in the enrollment package);
5. Applicant has a limited or restricted inventory for service in a single area (e.g., inhalation medications) to an extent that the applicant could not serve the average number of recipients for the area;
6. Physical site is inaccessible to patients, either able or disabled, or the size and facilities do not meet the legal requirements of space available for the average number of patients attending pharmacies in the area;
7. Geographical location is in an area that has sufficient pharmacies to serve the number of recipients in the area (s. 409.912 (37)(a) 4, F.S.);
8. Pharmacy is not providing patient counseling;
9. Applicant is not able to demonstrate ownership of the real estate or have a valid lease with a security deposit for their business venue;
10. Applicant is unable to demonstrate that its computer system can accept the required recording of data or provide the required reports;
11. The pharmacy's hours listed with the Board of Pharmacy (or in the appropriate place as designated by the Board) are proven not to be the actual hours of operation;
12. Applicant has failed to respond to the requests by AHCA or the fiscal agent for information.
13. Applicant is making acquisitions from persons or entities not appropriately licensed in accordance with Chapter 499 F.S.;
14. Applicant has an existing Medicaid provider number for the applicant's pharmacy license number unless exempted by Medicaid for 340B billing purposes;
15. Applicant billed for services through a Medicaid provider prior to approval or denial of enrollment of the applicant;
16. Applicant has the same or similar pharmacy license type and same business address as an existing Medicaid provider that is actively enrolled;
17. A change of ownership or change in control was not in compliance with state law or rule; or
18. Applicant failed to submit a report of beginning inventory with the enrollment package.

Durable Medical Equipment and Medical Supply Services

Pharmacy providers automatically receive a Durable Medical Equipment (DME) location code when enrolled. To be reimbursed for DME and medical supplies, the pharmacy provider must request activation of the location code by sending a letter to the Medicaid fiscal agent to request activation of the DME locator code. The DME locator code attached to the pharmacy must be at the same location as the pharmacy. The letter must contain an original signature. Faxed letters will not be accepted. Mail the letter to:

Florida Medicaid Provider Enrollment DME
P.O. 7082
Tallahassee, Florida 32314-7082

All DME billing must be on the CMS-1500 claim form using the pharmacy's provider number with the unique DME locator code.

***Point-of-Sale Enrollment**, continued*

Handbooks	When the DME location code is activated, the fiscal agent will send the pharmacy provider a DME and Medical Supply Services Coverage and Limitations Handbook and the Medicaid Provider Reimbursement Handbook, CMS-1500. Handbooks may also be obtained on the fiscal agent's web portal at www.mymedicaid-florida.com. Click Public Information for Providers, then click Provider Support, then click Handbooks.
Reporting Changes	Refer to the Medicaid Provider General Handbook for requirements and time constraints for reporting issues such as change of address, change of pharmacy manager, discontinuance of Medicaid services, and change of ownership.
Provider Re-enrollment	A provider agreement is valid for the period stated in the agreement. The provider must renew the agreement by completing a new provider agreement and other required forms, and submitting them to the Medicaid fiscal agent at least 30 days prior to the expiration date of the existing agreement.

Recording Keeping Requirements

Records That Must be Retained

Records related to the provision of services to a Medicaid recipient appropriate for the type of service provided, must be retained for five (5) years and must include the following:

- Medicaid claim forms and any documents that are attached;
- Professional records, such as patient treatment plans and patient records;
- Prior and post authorization, and service authorization information;
- Prescription records, physician orders, medication administration records;
- Business records, such as accounting ledgers, financial statements, itemized purchase/acquisition records, itemized invoices, credit returns, itemized inventory records, check registers, canceled checks, sales records, etc.;
- Tax records, including purchase documentation;
- Drug dispensing reports by drug NDC which state for any time period the total number of units dispensed by provider across all lines of business (e.g., cash customers, third party payers) including credit returns;
- Patient counseling documentation; and
- Provider enrollment documentation.

Incomplete records not in compliance with the Medicaid documentation and record retention policies will be subject to administrative sanctions and recoupment of Medicaid payments.

***Record Keeping Requirements**, continued*

Requirements for Prescription Records

For other information concerning prescription records, see Chapters 465 and 893, F.S., and rule division 64B-16, not incorporated herein.

Documentation Required for Additional Refills

The authorization of additional refills on an existing prescription must be noted by either creating a new original prescription, by adding the additional authorized refills to the original prescription or prescriber's order by noting at least the date of authorization, number of additional refills, and the prescriber or prescriber's agent authorizing the refills, pursuant to Chapters 465 and 893, F.S. and Chapter 64B-16, Florida Administrative Code. This notation must be retained on the original prescription hard copy (paper form) or prescriber's order (paper form), or in the computer database and readily retrievable. Adding additional refills without documenting the above information is not sufficient for compliance.

Requirements for Patient Records

The pharmacy must maintain a patient record for each Medicaid recipient for whom new or refill prescriptions are dispensed. The record can be electronic or hard copy. The pharmacy's patient record system must provide for the immediate retrieval of the information necessary for the pharmacist to identify previously dispensed drugs when dispensing a new or refill prescription.

The patient record must contain the following information:

The recipient's first and last name, address, date of birth, gender, and Medicaid identification number.

A list of all prescriptions that were obtained by the recipient at the pharmacy during the 12 months immediately preceding the most recent service that includes the name, the quantity, date received, the prescriber's full name and address, and state license number.

Any known allergies, drug reactions, idiosyncrasies, chronic conditions or disease states of the patient, and the identity of any over the counter drugs or devices currently being used by the patient that would relate to any prospective drug use review.

Any related health information indicated by a licensed health care practitioner.

The pharmacist's comments, if any, relevant to the patient's drug therapy.

***Recording Keeping Requirements**, continued*

Overpayments

Pursuant to section 409.913, F.S., AHCA shall recover overpayments to any Medicaid provider that has received any benefits or payments under the Medicaid program that are not reimbursement of valid claims for services. The provider should be able to document reimbursement of an overpayment.

Determination of Overpayments:

(a) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

(b) Providers may be overpaid because of, but not limited to, being paid for services or goods that were:

1. Not furnished to the recipient by the provider; or
2. Not Medicaid covered goods or services that are medically necessary; or
3. Not of quality comparable to those furnished to the general public by the provider's peers; or
4. Billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by AHCA; or
5. Not provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; or
6. Not documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

In addition to all other documentation required under state and federal law, the provider must maintain invoices, manufacturer and/or wholesaler sales records, distributor delivery records to the provider, and provider payment records to support the size and quantity of the goods paid for by Medicaid during the audit period. If inventory data pertaining to any such product for the beginning and end of the audit period are not furnished by the provider, it will be taken that the beginning and ending inventory quantities are the same for that product.

***Recording Keeping Requirements**, continued*

Repayment of Overpayments

Pursuant to 409.913, F.S., when the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the Agency, after notice to the provider, shall:
(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to Chapter 120, F.S., any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:
1. Makes repayment in full; or
2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b)Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

Audits

To ensure compliance, the Agency shall conduct audits. For detailed information regarding audits and administrative sanctions, see 59G-9.070, F.A.C.

Diverted Pharmaceuticals Program

Requirements

All Medicaid pharmacy providers will be required to perform the following functions when dispensing prescription drugs (tablets and capsules, excluding nitroglycerin-containing products or medication that is required by the manufacturer to be dispensed in the manufacturer's original packaging) to a Medicaid patient:

- Remove from original container and place in pharmacy vial;
- Prescription drugs that are in the dosage form of any of the following: creams, ointments, ophthalmics, inhalers, topical patches, otics, reconstituted medications, and injectables: Inscribe an "M" on the outside of the original manufacturer's packaging by using an indelible marker and ensuring that the "M" is clearly visible or remove the manufacturer label.

Recipient Over-Utilization or Fraud

Definition of Lock-in	Lock-in means that a recipient must obtain Medicaid services from a provider or providers designated by AHCA, or chosen by the recipient and accepted by AHCA.
Recipient Lock-In	The following recipients will be considered for lock-in to a pharmacy provider: • Recipients who have utilized Medicaid prescribed drug services with a frequency or amount that is not medically necessary, as determined by AHCA; or • Recipients who have committed fraud through the unauthorized sale or transfer of a pharmaceutical product funded by Medicaid.
Legal Authority	AHCA Bureau of Medicaid Pharmacy Services is authorized to lock-in a Medicaid recipient to a designated pharmacy provider pursuant to a waiver granted to the state of Florida under Section 1915(a) of the Social Security Act, and Part 42 Code of Federal Regulations (C.F.R.) 431.54(e), for an exception to the requirements of Section 1902(a)(23) of the Social Security Act. Florida Statutes s. 409.912 (43) directs the Agency to implement a provider lock-in program for recipients found by the Agency to have used Medicaid goods or services at a frequency or amount not medically necessary. Recipients are to be assigned to specific providers of medically necessary goods or services for a period of not less than one year.
Choice of Pharmacy	After considering geographic location and access to pharmacy services, AHCA will determine the pharmacy to which the recipient will be assigned and will notify the recipient in advance by letter. If the recipient wishes to use another pharmacy provider, the recipient must complete and submit a request on the Request for Reconsideration form attached to the notification letter. (A copy of this form may also be found at the end of this chapter. The change of pharmacy request form may be accessed on the internet at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pdf/request_change_pharmacy_070611.pdf .) The request must be received within 21-days of the recipient's lock-in notification. AHCA will notify the recipient and the assigned pharmacy of its action by letter.
Lock-In Period	The initial lock-in period will not exceed one year. Six months following the end of the initial lock-in period, AHCA will review the recipient's recent drug utilization and determine whether the lock-in will be reinstated for another year.

***Recipient Over-Utilization or Fraud**, continued*

Exceptions	This limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department.
Fair Hearing	Upon determination by AHCA that a recipient will be assigned to a single pharmacy for services, the recipient will be notified by letter. The letter includes information about the recipient's opportunity for a fair hearing. The right of notice and the opportunity for a fair hearing applies to both the original lock-in and any lock-in occurring from future recipient actions. Note: Examples of the letters and the Request for Reconsideration used to communicate with the recipient concerning the pharmacy lock-in are found at the end of this chapter.
Recipient Change of Address	If a change of pharmacy is necessary due to the change of residence address of the recipient, the recipient can request a Request for a Change of Pharmacy Form found at the end of this chapter, or from the Bureau of Medicaid Pharmacy services website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/lockin.shtml . The form must be filed 30 days prior to the desired effective date. AHCA will process the change request immediately upon approval by the Bureau of Medicaid Pharmacy Services. The recipient and assigned pharmacy will receive notification by mail.
Lock-in Procedures	The procedures for imposing pharmacy lock-in restrictions are as follows: An individual recipient will be considered for lock-in upon receipt of information from within AHCA; from providers; or from other state or federal officials that a recipient has over-utilized or fraudulently obtained Medicaid prescribed drug services. Information for providers who wish to refer recipients to AHCA for consideration for lock-in may be found on the AHCA website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pdf/FL_lock_in_referral_form_110427.pdf . The Bureau of Medicaid Pharmacy Services will review the information and determine if the recipient and AHCA will be best served by a lock-in of pharmacy services. Upon the determination of the Bureau of Pharmacy Services to implement a lock-in, a letter will be sent to the recipient. The letter will include an explanation of the lock-in program, and advise the recipient of his/her right to (a) accept the decision; or (b) choose a different pharmacy subject to approval by AHCA; or (c) request a hearing. The letter will include a copy of the Request for Reconsideration form for use by the recipient in responding and providing additional information. (See the end of this chapter for a copy of the Request for Reconsideration form.) The letter to the recipient shall give notice that his/her response must be received by AHCA within 21 days of the date of the letter. If no response is received by AHCA, the lock-in to the pharmacy selected by AHCA will be implemented.

***Recipient Over-Utilization or Fraud**, continued*

Lock-in Procedures (continued)

If the recipient responds with additional information or a request for another pharmacy, AHCA will review the information and determine whether the pharmacy is appropriate for the recipient and can administer the lock-in program requirements to ensure medical necessity and prevent over-utilization of services. AHCA will notify the recipient of the approval or disapproval within five business days of receipt of the information.

If the recipient requests a hearing, AHCA will review the information and will either rescind the decision and notify the recipient by letter within five business days; or will refer the case to the Office of Appeal Hearings in the Department of Children and Families (DCF). After the hearing, a Final Order is issued by the DCF to the recipient with a copy to the Bureau of Medicaid Pharmacy Services notifying them of the decision. Upon receipt of the final order, AHCA will take appropriate action pursuant to the order.

0000000123

<RECIPIENT NAME>
<ADDR-LINE1>
<ADDR-LINE2 >
<CITY> <STATE> <ZIP CODE> *<LETTER DATE>*

Dear <RECIPIENT NAME>:

Our records show you are getting prescriptions for the same or similar controlled substance medicines from more than one doctor and filling those prescriptions at different stores. The medicines you have been receiving have a chance for overuse or abuse. Because of this, you will need to have all of your prescriptions filled by only one pharmacy for the next year.

We have selected the pharmacy location below for you, starting on <*Effective Date*>:
<Designated Pharmacy>
<Pharmacy Address Line 1>
<Pharmacy Address Line 2>
<City, State and Zip>

If you are happy with the pharmacy assignment, do nothing.

1. If you want a different pharmacy, fill out number 1 on the "Request for Reconsideration" form included with this letter and return it within 21 business days of the date of this letter. We will let you know by mail if your pharmacy request is approved, or
2. If you don't think you should have to get your medications from only one pharmacy, you may ask Medicaid to consider changing this decision. Give us your reasons under number 2 on the "Request for Reconsideration" form included with this letter and return it within 21 business days of the date of this letter. We will contact you to let you know the decision.

Your Right to a Fair Hearing

If you complete steps 1 or 2 and we deny your request, you can ask for a fair hearing by following the directions under the Your Right to a Fair Hearing section on the "Request for Reconsideration" form. You will continue to receive pharmacy services from the pharmacy assigned to you during the fair hearing process.

If you have questions, you can call Medicaid Pharmacy Services at (850) 412-4166.

Sincerely,

Bureau Chief
Medicaid Pharmacy Services

Enclosure
<Recipient Name >
<Recipient Address 1>
<Recipient Address 2>
<Recipient City, St. Zip>

REQUEST FOR RECONSIDERATION

Pick one of the two options below by writing your initials in the blank beside the number. Return this form within 21 days of the date of the cover letter.

If I move, I must notify Medicaid 30 days before getting my services at a different pharmacy by completing: the Request to Change form. To find the change form I can go to http://ahca.myflorida.com/Medicaid/Prescribed_Drug/lockin.shtml, call my local area office, or call the Medicaid Pharmacy Services at (850) 412-4166.

I also understand that I must use the assigned pharmacy location for one year. If I don't return this form, the pharmacy chosen for me by Medicaid will be my pharmacy.

1. [ ] _____ I accept the decision to use only one pharmacy location, but I wish to use the pharmacy(s) listed below (the second is for a home infusion pharmacy only):

Pharmacy Name _____

Address_____

City, State _____

Pharmacy Phone_____

Medicaid Provider or NPI Number (ask your pharmacist)_____

Use this second choice to choose a home infusion pharmacy only if you are on home infusion:

Pharmacy Name _____

Address_____

City, State _____

Pharmacy Phone_____

Medicaid Provider or NPI Number (ask your pharmacist)_____

2. [ ] _____I disagree with this decision for me to use only one pharmacy location and I would like Medicaid to review this decision based on the information below.

_____
_____
_____
_____
_____

More information may be submitted on another page and attached.

YOU MUST SIGN THIS FORM ON THE BACK

Your Right to a Fair Hearing

☐ Should my request be denied, I wish this to be considered a request for a fair hearing by the Office of Appeal Hearings, Department of Children and Families. At this Fair Hearing you may represent yourself, or use a lawyer, relative, friend or other spokesperson. You must request a fair hearing no later than 90 days from the receipt of this notice or you will waive your right to request a fair hearing, however if you check this box, Medicaid will forward this request to DCF Office of Appeals as your fair hearing request.

☐ I do not wish this to be considered a request for a fair hearing.

If I complete and return this form, I understand I will be contacted by Medicaid Pharmacy Services, Agency for Health Care Administration.

_____
Recipient (Print Here)

_____
Recipient (Sign Here)

_____
Address

_____
City, St. Zip

_____
Recipient ID # Recipient Phone #

NOTE: If you do not understand these options, please ask for help or contact Medicaid Pharmacy Services at (850) 412-4166 before signing this form. If you do not request reconsideration and you would like to have a fair hearing, send a request within 90 days of the date of this notice to the address below.

PLEASE MAIL COMPLETED FORM TO:
Medicaid Pharmacy Services
Agency for Health Care Administration
2727 Mahan Drive, MS 38
Tallahassee, FL 32308
Phone: (850) 412-4166
Fax: (850) 922-0685

Illustration 1.5 Request For A Change of Pharmacy

FLORIDA MEDICAID

REQUEST TO CHANGE LOCK-IN PHARMACY

One pharmacy change allowed in a six-month period

Recipient Name: _____

Recipient Medicaid Number: _____

Recipient Address: _____

Recipient City, State Zip:_____ Recipient Phone Number:_____

I want to change my "Lock-In" Pharmacy to the following:

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy City, State Zip:_____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy License Number:_____

Pharmacy Medicaid Provider Number:_____

Please make this change effective as of mm/dd/yyyy: _____/_____/_____

Recipient Signature _____ Medicaid ID: _____

Fax to: Medicaid Pharmacy Services 1-850-922-0685 or Mail to the address below

ENTIRE FORM MUST BE COMPLETED

FLORIDA MEDICAID

Better Health Care for all Floridians

Recipient Pharmacy Lock-In Referral Form

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Pursuant to Florida Statute 409.912(43), I am recommending that the above named recipient be placed in the Recipient Pharmacy Lock-in Program. I understand that this Program will require that this recipient to receive all their prescriptions from one pharmacy for a period of one year.

The above named recipient has utilized Medicaid prescribed drug services that may be considered duplicative and/or inappropriate with respect to the frequency and quantity for prescriptions filled. (Please provide details in the space provided below)

The recipient would prefer to use the pharmacy below (if known):

Pharmacy Name

Pharmacy Medicaid Provider #

NPI #

Pharmacy Phone Number -

Pharmacy Fax Number -

REFERRAL SOURCE: AHCA ☐ MCO ☐ MPI ☐ MFCU ☐ PHARMACY ☐ PHYSICIAN ☐

NAME: _____ DOH LICENSE #: _____

PHONE: _____ FAX: _____

Signature: _____ DATE: _____

When completed and signed by the referral source, please fax to Medicaid Pharmacy Services at (850) 922-0685. For questions concerning the Lock-in program, please call (850) 487-4441.

2727 Mahan Drive, MS #38
Tallahassee, FL 32308

Visit AHCA online at
http://ahca.myflorida.com

CHAPTER 2
PRESCRIBED DRUG SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered by the Medicaid prescribed drug services program. It designates limited and non-covered services and those requiring prior authorization. It also describes the coverage and limitations for prescribed drug services provided to recipients in nursing homes and other institutional care facilities. In addition, it explains how to bill for injectable drugs, compound drugs, and unit dose packaging; and how to determine units of measurement.

In This Chapter

This chapter contains:

Service Requirements

Medically Necessary

Per 59G-1.010 (166), F.A.C., medically necessary of medical necessity means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Medically Accepted Indications and Dosages

To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

Rebate Agreements

To be reimbursed by Medicaid, a legend drug must be included in a rebate agreement with the Secretary of the U.S. Department of Health and Human Services or otherwise approved for coverage by the Agency. A list of the participating manufacturers is available from the Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov . Click on "Medicaid Drug Rebate Program".

The Agency may also enter into agreements with the manufacturers to provide rebates of no less than the minimum percent established by the Florida Legislature in order for the products to be considered for inclusion on the preferred drug list. This percentage is subject to change and can be found on the Florida Medicaid Website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug . Click on "Current Information."

Service Requirements, *continued*

Dispensing Quantity Minimum	Medical and pharmacy boards agree that a prescription's authorization is for the total quantity and duration on the prescription unless specific restrictions on the quantity per dispensing are indicated on the prescription. Providers may not split a dispensed prescription into multiple claims to generate multiple dispensing fees. However, providers may bill for partial filling of a prescription.
Dispensing Quantity Maximum	Some drugs have maximum quantity limits to prevent billing errors and excessive utilization. Medicaid cannot reimburse for prescriptions when the dosage exceeds medically accepted standards. If necessary, the provider must consult the recipient's physician regarding the proper dosage. Medicaid will not reimburse for any prescription with more than a 34 day supply unless (a) the minimum marketed package size is greater than 34 days, or (b) the drug is designated as a maintenance drug for which a 100-day supply may be dispensed. Drugs approved for 100-day supply dispensing will be approved by the Medicaid Pharmaceutical & Therapeutics (P&T) Committee and posted on the AHCA website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug .

Covered Services

Preferred Drug List

The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.

Products in selected therapeutic classes will be presented to the P & T Committee with their relevant clinical efficacy and relative net cost positions. The P & T Committee will recommend the most cost effective drugs in each therapeutic category to AHCA for consideration for inclusion on the PDL. A minimum of two products per therapeutic class, if available, will be recommended. Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a non-PDL product. Please see the following section of this handbook for explanation of the prior authorization process for non-PDL products.

Non-PDL drugs may be approved for reimbursement upon prior authorization. A step-therapy process that requires initial use of PDL products before authorization of non-PDL products will then permit prior authorization (PA) for non-listed drugs. Oral contraceptives and HIV/AIDS-related anti-retroviral products are covered, and are exempt from PDL requirements. Mental health drugs are not exempt from PDL requirements. Nursing home residents and waiver program participants are not exempt from PDL requirements.

Per 465.025(6), F.S., and 64B16-27.500, F.A.C. drugs on the Florida Negative Formulary, as well as products from drug categories which are exempt from PDL requirements by statute, are included on the list to inform clinicians of cost effective choices. Most generic drugs with federal or state pricing limits are included on the PDL.

AHCA will publish and disseminate the additions and deletions to the PDL in a timely manner as they are adopted. The PDL and updates will be posted on the Agency website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/ .

Covered Services, *continued*

Prior Authorization for Non-PDL Drugs

Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

- There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
- The alternatives have been ineffective in the treatment of the beneficiary's disease; or
- Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
- The number of doses has been ineffective.

AHCA will publish and disseminate the additions and deletions to the PDL in a timely manner as they are adopted. The PDL and updates will be posted on the Agency website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml .

Legend Drugs (Prescription Drugs)

The Medicaid prescribed drug program reimburses for most legend drugs that are dispensed by community pharmacies or administered in outpatient settings. Legend drugs are drugs that require a prescription or that have the following statement on the label, "Caution: Federal law prohibits dispensing without a prescription."

Note: See Non-Covered Services in this chapter for the legend drugs that Medicaid does not reimburse.

Covered Services, *continued*

Counterfeit Proof Prescription Blanks

Chapter 409.912(37)(a)5., Florida Statutes, requires Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients to use a standardized counterfeit-proof prescription blank when writing prescriptions for Medicaid recipients. Medical practitioners (prescribers) must use a counterfeit-proof prescription blank produced by a vendor approved by AHCA when writing hard copy prescription(s) for Medicaid recipients for any covered service under the Florida Medicaid Prescribed Drug Services Program. Examples of covered services are drugs, syringes, nutritional supplements, and test strips. Prescriptions presented via other modes of transmission, e.g., facsimile, electronic, telephone, are exempt from this requirement.

Specifications and a list of approved vendors can be found on the fiscal agent's Web Portal at www.mymedicaid-florida.com . Click on Public Information for Providers, then on Pharmacy, and then on Counterfeit-proof Prescriptions.

Non-Legend Drugs and Supplies (Non-Prescription Drugs)

The following non-legend (over-the counter, or OTC) drugs and supplies can be reimbursed by the Medicaid Prescribed Drug Services Program. The drugs and supplies must be prescribed by licensed practitioners:

- Prescribed insulin;
- Prescribed OTC drugs that were previously legend drugs (at the Agency's discretion);
- Aspirin and selected package sizes of Tylenol when used as an anti-inflammatory agent;
- Sodium chloride solution for inhalation therapy;
- Guaifenesin as a single entity expectorant, in either a liquid or solid dosage form;
- Transdermal nicotine patches, gum, or lozenges containing nicotine when used in a smoking cessation program for no more than 24 weeks per 365 days or the manufacturer's recommendation, whichever is less.
- Vaginal antifungal creams.

The following non-drug DME items may be billed to Medicaid through the Florida MMIS DME claim system:

- Blood glucose monitors
- Blood glucose test strips
- Insulin needles and syringes

Reimbursement will be made according to the DME fee schedule on the AHCA website at http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx

Note: See Chapter 3 of this handbook for information on entering certification codes on the claim.

Covered Services, *continued*

Total Parenteral Nutrition	Medicaid reimburses for total parenteral nutrition (TPN) for recipients in their homes when supplied by pharmacies that are equipped and licensed to prepare sterile intravenous products. TPN must be billed as a compounded product; separate claims for the TPN components are not allowed. Interdialytic parenteral nutrition administered during a dialysis session is not covered.
Influenza, Pneumococcus and Shingles Vaccines	Medicaid reimburses for one vaccine per recipient per year for influenza for institutionalized recipients. Medicaid reimburses for pneumococcus vaccines for institutionalized recipients who do not have Medicare benefits. Pneumococcus vaccine is limited to once every five years per recipient. Medicaid reimburses for one dose of shingles vaccine (i.e., Zostavax) for institutionalized recipients age 60-64 years.
Intravenous immune globulin (IVIG)	All IVIG claims must be billed through the pharmacy service. Prior authorization is required for claims to be reimbursed for intravenous immune globulin. Please see the AHCA website for clinical criteria and prior authorization forms at www.ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/
Vitamin and Mineral Products	Only the following vitamin and mineral products can be reimbursed by the Medicaid prescribed drug services program: • Legend prenatal vitamins for pregnant or lactating recipients, and for recipients up to three months following birth, when certified on the claim for use in family planning (medical certification code 6); • Prescription strength folic acid as a single entity; • Prescription strength fluoride as a single entity; • Prescription strength pediatric multi-vitamins with fluoride for recipients under age 13, when medically necessary due to insufficient fluoride in household water supplies; • Aluminum and calcium products used as phosphate binders when prescribed for dialysis patients and certified on the claim for use by dialysis patients (medical certification code 8); • One vitamin or vitamin-mineral supplement per month, when prescribed for dialysis patients and certified on the claim (Med Cert 8) for use by dialysis patients; • Iron supplements (e.g., ferrous sulfate, gluconate, fumarate, and iron polysaccharide complexes) as single entity hematinics for non-institutionalized recipients; and • Fat soluble vitamin (vitamin A,D,E,K) products specifically formulated for cystic fibrosis patients. Utilizing certification codes for any other use than those listed is a false claim and constitutes Medicaid fraud. Note: See Chapter 3 for information on entering certification codes on the claim.

Covered Services, *continued*

Lice treatment

Medicaid reimburses for available generic over-the-counter (OTC) head/body lice treatment products. Kits as well as lotions/shampoos and mousse preparations will be covered. Covered prescription options for lice treatment are listed on the PDL at www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml .

Home Delivery or Mail Order Prescriptions

Medicaid enrolled pharmacies located in Florida may provide home delivery of covered items, at no additional cost to the recipient or Medicaid, consistent with all policies in this handbook (via mail order or other method) for recipients who desire this service.

1. All deliveries, including mailings to recipients will be at the provider's expense, including special shipping arrangements for insulin and other refrigerated medications.
2. Advertising or promotional materials must clearly state that recipient participation is voluntary and does not preclude services through other pharmacy providers. Further, materials may not claim that the entity is recommended or endorsed by any state or county agency, and may not state or imply that a Medicaid recipient will lose benefits if the recipient does not enroll with the entity.
3. Mail order providers are not exempt from the statutory 34-day supply limit for prescriptions, except for the specific maintenance medications approved for 100-day supply dispensing which are listed on the Medicaid website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug .
4. Reimbursement will be at the standard retail pharmacy rate as described in 59G-4.251, F.A.C.
5. As with community pharmacy providers, home delivery or mail order pharmacies may not "auto fill" prescriptions. Medications may be delivered or shipped to a recipient only upon specific request of the recipient. Mail order pharmacies must replace medication to the recipient at no cost to the recipient and may not bill Medicaid for the replacement prescription in the event of lost shipments. Recipients may not be denied medications due to lost shipment. The mail order pharmacy must attempt to find the shipment, but may not deny recipients a replacement shipment.
6. Direct home delivery within specified geographic areas is subject to provisions of 409.912, F.S.

Service Limitations

Introduction

Medicaid limits the quantity and number of refills that may be reimbursed for certain drug classes. Medicaid also limits reimbursement for certain drug classes to recipients based upon clinical considerations of the patient's age. A current list of drug limitations can be found on the Internet at: www.mymedicaid-florida.com . Click on Public Information for Providers, then Pharmacy, then Drug Limitations.

The following limitations apply to all drugs within a given therapeutic class.

Service Limitations, *continued*

	Limitations described below apply for specified drug classes:
Sedative Hypnotics	Reimbursement for oral dose forms of any sedative-hypnotic will be limited to no more than 45 units per 25 days.
Cough and Cold Medications	Single-entity guaifenesin, over-the-counter or legend, is covered for all recipients. All other legend cough and cold medications including antitussives, decongestants, expectorants other than guaifenesin, or any other legend antihistamine-decongestant combination that includes one or more of the above ingredients are limited to recipients under the age of 21.
Smoking Cessation Products	Reimbursement for nicotine patches, lozenges, gum and bupropion tablets (generic for Zyban®) is limited to 24 weeks duration per 365 days or the manufacturer's recommendation, whichever is less.
Amphetamines	Medicaid only reimburses for amphetamines when prescribed for an indication other than obesity, for example, narcolepsy or ADD/ADHD. The indication must be on the prescription.
Laxatives	Medicaid does not reimburse for laxatives with the exception of polyethylene glycol 3350 for children under the age of 21. Lactulose is covered only when used to treat hyperammonemia or bowel impaction secondary to a chronic condition such as quadriplegia. The indication must be on the prescription.
DESI Drugs	Medicaid does not cover drugs designated DESI ineffective by the Centers for Medicare and Medicaid Services (CMS).
Infertility Drugs	Drugs used to treat infertility are not covered.
Experimental Drugs	Experimental drugs are not covered.
Other Exclusions	Drugs prescribed for erectile dysfunction; hair growth restorers and other drugs for cosmetic use; and over-the-counter products not specified above are not covered.

Covered Services, *continued*

Outpatient Drugs Covered by Medicare Part B	Medicare Part B covers some oral anticancer drugs, certain respiratory drugs administered by nebulization, enteral nutritionals delivered by a pump, antihemophilic factors, oral immunosuppressive drugs, and certain home infusion drugs, such as TPN, if clinical criteria are met. Providers must be enrolled as Medicare suppliers through the Palmetto Government Benefits Administrators and must bill Medicare first. If the recipient receives Medicare benefits, Medicaid will pay any applicable deductibles and coinsurance up to the Medicaid allowable amount, based upon the recipient's eligibility category. See the Medicaid Provider General Handbook at www.mymedicaid-florida.com for additional information on Medicare crossover claims. Pharmacies must designate their DME Provider ID as the link for Medicare claims through the crossover claims system.
Recipient Information about Rejected or Denied Prescriptions	Medicaid provider pharmacies are required to exhaust all avenues available to them in order to fill a valid prescription. For other information regarding rejected or denied prescriptions, see 59G-4.255, F.A.C., not incorporated herein.
Preferred Drug List	The Preferred Drug List (PDL) is a listing of efficacious, safe, and cost effective choices for practitioners in all outpatient settings to reference when prescribing for Medicaid patients. Reimbursement for these products usually does not require prior authorization, and the PDL pertains to all provider locations where these drugs are prescribed, dispensed or administered. (Note: Prior authorization may be required to ascertain specific clinical factors related to the use of some drugs.) Drugs on the Florida Negative Formulary, as well as products from drug categories which are exempt by statute, are included on the list to inform clinicians of cost effective choices. Oral contraceptives and HIV/AIDS related antiretroviral agents are covered and are exempt from PDL restrictions. Most generic drugs with federal or state pricing limits are included on the PDL.

Covered Services, *continued*

Drug Prior Authorization

In order to be reimbursed by Medicaid, providers must obtain prior authorization before dispensing certain drugs.

Prior authorization from Medicaid is required prior to reimbursement in the following situations:

1. The drug is not on the Preferred Drug List.
2. Clinical Prior Authorization is required for specific drugs
   a) For an indication not approved in labeling;
   b) To comply with certain clinical guidelines; or
   c) If the product has the potential for overuse, misuse, or abuse. The Agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. A current list of drugs for which clinical prior authorization is required, and clinical prior authorization forms, may be found on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed_Drug .
3. If a prescriber hand writes "brand medically necessary" on the face of a prescription when a generic is available with a state or federal pricing limit.

Prior Authorization for Non-PDL Drugs

Prior authorization for drugs not on the PDL can be obtained by submitting a Prior Authorization form to the Therapeutic Consultation Call Center at fax number: (877) 614-1078. Prior authorization forms are on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed_Drug . For live response to questions, call toll-free (877) 553-7481. Live assistance is available from Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

72-Hour Emergency Supply

During hours that the prior authorization line is not available, dispensing pharmacies will be reimbursed for the ingredient cost plus a dispensing fee for a 72-hour emergency supply. Reimbursement for emergency supply is limited to twice per recipient for the same GSN within 30 consecutive days. The dispensing pharmacy cannot override claim system edits for drugs requiring a clinical prior authorization review, early refill rejections, high dose rejections, or for drugs restricted because of the patient's age or eligibility issues.

Information Required to Submit a Prior Authorization Request

When requesting prior authorization to obtain a non-PDL drug, the prescriber must provide the following information:

1. Recipient data – recipient's name, ten-digit Medicaid identification number, and date of birth;
2. Prescriber data – prescriber's name; mailing address; telephone and fax numbers and professional license number;
3. Drug data – drug name, strength, dosage form, and quantity needed;
4. Documentation of the reason for drug selection (i.e., physical or progress notes; hospital discharge summary; or other information pertinent pertaining to the specific need for the non-PDL drug); and
5. A copy of the prescription.

Covered Services, *continued*

How Non-PDL Requests are Processed	Medications on the Preferred Drug List must have been tried within the twelve months prior to the request for a non-PDL alternative product. Certain step-therapy prior authorization protocols require the prescriber to use medications in a similar drug class or for a similar medical indication unless contraindicated in the federal Food and Drug Administration labeling. Reimbursement for a drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides written medical or clinical documentation that the product is medically necessary because: • There is not an acceptable clinical alternative on the PDL to treat the disease or medical condition; or • The PDL alternatives have been ineffective in the treatment of the recipient; or • The number of doses has been ineffective, or based on historic evidence and known characteristics of the patient the PDL drug is likely to be ineffective.
Retroactive Approval	Generally, Medicaid cannot reimburse any prescription dispensed prior to obtaining the required prior authorization. Authorization requests will not be approved retroactively unless • the recipient's eligibility was determined retroactively, or • the recipient was discharged from a hospital to a nursing facility with prescription orders. Authorization request must be made within three days of hospital discharge. Retroactive approvals based on previous hospital orders are not guaranteed, and PDL requirements and clinical rules apply.
Early Refill Authorization	In the event of a change in therapy for a dosage increase, the pharmacy can submit a request for an early refill to begin on the date the previous quantity expires.
Drugs Requiring a Clinical Prior Authorization	A current list of drugs for which prior authorization is required and prior authorization forms is found on the Medicaid website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml . Follow the fax instructions at the bottom of the specific form for the drug requested.
Renewal Procedure	Prior authorization renewals are obtained by providing current recipient assessments, updated information (including dosage), and a new Prior Authorization Form and a copy of the written prescription from the physician.
Partial Fills/Dispensing Fee	In the event of partial fill of a prescription, only one dispensing fee per month per drug will be reimbursed.

Covered Services, *continued*

Brand Override for Generic with SMAC or FUL	If the prescriber writes a prescription for a brand name product that has an applicable state maximum allowable cost (SMAC) or federal upper limit price (FULP), the prescriber must complete a Request for Multi-Source Brand Drug form and either (a) Florida Medicaid Miscellaneous Prior Authorization form or (b) Clinical Prior Form, as appropriate for the specific drug. The completed forms and any available supporting documentation must describe the reason the generic product is not appropriate. Fax both forms and a copy of the prescription, with the "brand medically necessary" statement handwritten on the face of the prescription form, to: Medicaid Pharmacy Services at (850) 922-0685, or by mail to 2727 Mahan Drive, MS 38, Tallahassee, FL 32308. In addition, the prescriber is encouraged to submit the FDA MedWatch report form, which is available at: http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm The Request for Multi-Source Brand Drug and the Prior Authorization forms may be found at: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml.
Prior Authorization Number	The provider does not need to enter the number on the claim.
Timely Request for Renewal	Requests for renewal of prior authorization must be submitted before an existing prior authorization expires. Medicaid may not reimburse for prescriptions without an approved renewal.

Non-Covered Services

Introduction	The Medicaid prescribed drug services program does not reimburse for the items described in this section.
Medicare Part D	Prescriptions that are eligible for coverage through the Part D Medicare program for Medicare / Medicaid dual eligibles are not covered by Medicaid. Prescriptions for dual eligibles for drugs excluded by statute from the Part D program that are covered by Medicaid for other Medicaid recipients can be billed to Medicaid. Examples are benzodiazepines, barbiturates and some over the counter products. Medicaid does not reimburse for Medicare Part D drug copayment or for prescriptions not covered due to the Medicare Part D coverage gap. Medicaid will not pay any deductibles and coinsurance for drugs covered by Medicare Part D. Note: See the Florida Medicaid Provider General Handbook for additional information on Medicare crossover claims at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

Covered Services, *continued*

Over-the-Counter Drugs	Except for the drugs specified under the topic, "Covered Services, Non-legend Drugs and Supplies," in this chapter, over-the-counter (non-legend) drugs are not covered. For institutionalized recipients, all over-the-counter drugs, supplies, food supplements, and vitamins are considered nursing home floor stock and are reimbursed in the long-term care provider's per diem rate.
Vitamin and Mineral Products	Except those specified under the topic, "Covered Services, Vitamin and Mineral Products," in this chapter, Medicaid prescribed drug services does not reimburse for oral vitamins and minerals.
Immunizations and Vaccines	Immunizations are available from primary care providers and county health departments (federally qualified health centers and rural health departments). Medicaid prescribed drug services does not reimburse for immunizations and vaccines, except for influenza vaccine (limited to once per year for institutionalized Medicaid recipients who do not have Medicare benefits); pneumococcal vaccine (once per five years per institutionalized recipient who does not have Medicare benefits); shingles vaccine for institutionalized adults age 60-64 years (once per lifetime); and others specified under the topic, "Covered Services and Limitations for Institutionalized Recipients," in this chapter.
Hospice Drugs and Supplies	Medicaid prescribed drug services does not reimburse drugs for the treatment, relief of pain or symptom control related to a hospice recipient's terminal illness and related conditions. The cost of these drugs is included in the hospice provider's Medicaid per diem rate. The pharmacy must bill the hospice for all drugs related to the terminal illness and related conditions, including nutritional products, total parenteral nutrition, and analgesics. For Medicaid eligible individuals, other prescriptions not related to the patient's terminal illness will be reimbursed subject to other limitations in this handbook.
Cosmetic Agents	Medicaid does not reimburse for drugs and other agents used for cosmetic purposes or for hair growth.
Conditional Sale Drugs	A federal law prohibits Medicaid from reimbursing outpatient drugs when the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
Erythropoetin	Epoetin alpha and darbepoetin alfa are reimbursed through the Medicaid freestanding dialysis center program and must be billed by a dialysis center provider.

Covered Services, *continued*

Durable Medical Equipment (DME) and Supplies

The Medicaid prescribed drug services program does not reimburse for durable medical equipment and medical supplies, except for those items listed under the topic, "Covered Services, Non-Legend Drugs and Supplies," in this chapter. The following non-drug DME items may be billed to the Medicaid DME Program through the FLMMIS system:

- Blood glucose monitors
- Blood glucose test strips
- Insulin needles and syringes

Reimbursement will be made according to the DME fee schedule on the AHCA website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug . Click on Durable Medicaid Equipment reimbursed by Florida Managed Medicaid Services. For individuals dually eligible for Medicare and Medicaid, the balance of the claim after the Medicare allowable payment has been applied must be billed on the CMS 1500 form.

Durable medical equipment such as devices, prostheses, and appliances and medical supplies such as lancets, nebulizers, tubing and pumps as well as nutritional supplements may be reimbursed through the Medicaid durable medical equipment program, home health services program, or the home and community-based waiver program. See Covered Services in this chapter.

A pharmacy may enroll as a durable medical equipment provider and a home and community-based services waiver provider. To receive reimbursement for durable medical equipment, the pharmacy must bill on the correct claim form (the CMS-1500 form for the durable medical equipment program and the Non-Institutional 081 form for the home and community-based waiver program) using its assigned location code for that program.

Note: See Provider Enrollment in Chapter 1 for instructions on enrolling to provide durable medical equipment. Call your area Medicaid office for information on enrolling as a home and community-based services waiver provider.

Oxygen and Blood

The Medicaid prescribed drug services program does not reimburse for oxygen, blood and blood plasma.

Inpatient Drugs

The Medicaid prescribed drug services program does not reimburse for:

- Drugs administered to recipients who are hospitalized or receiving emergency room treatment;
- Drugs given by an outpatient hospital or ambulatory surgery center in conjunction with laboratory, x-ray and other medical procedures; and
- Drugs dispensed to recipients in a skilled nursing facility who are covered by Medicare Part A.

Experimental

Medicaid does not reimburse for experimental drugs.

Covered Services, *continued*

DESI	Medicaid does not reimburse for Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective.
Dialysis Facility Infusion Therapy	The Medicaid prescribed drug services program does not reimburse for infusion therapy or other injectable drugs, including epoetin alfa or darbepoetin alfa and parenteral nutrition, that are administered by a dialysis facility to dually eligible Medicare and Medicaid beneficiaries. The facility or the supplier must bill Medicare for the services provided to the recipient.
Fertility Enhancing Drugs	Medicaid does not reimburse for clomiphene, menotropins, or other drugs used to enhance fertility.
Drugs Unlawfully Acquired	Medicaid will only reimburse those drugs that are lawfully acquired from entities licensed in accordance with Chapter 499, Florida Statutes.

Coverage and Limitations for Institutionalized Recipients

Introduction	The Medicaid prescribed drug services program policies described in this section apply to Medicaid recipients in nursing homes and intermediate care facilities for the developmentally disabled (ICF-DD).
Vaccines and Immunizations	Medicaid reimburses for influenza and pneumococcal vaccines and for shingles vaccine for adults for institutionalized recipients who do not have Medicare benefits. Influenza vaccine is limited to one per year per recipient. Pneumococcal vaccine is limited to one every five years per recipient. Shingles vaccine is limited to once per lifetime.
Non-Covered Services	The following pharmacy items must be provided by the institution as floor stock: • All over-the-counter medications; • Syringes; • Vitamins, minerals and iron; • Sterile saline for wound irrigation and other wound care dressings; • Durable and non-durable equipment and supplies; • Dietary supplements, salt and sugar substitutes, and tube feedings; and • Laxatives and anti-diarrhea medications. These items are reimbursed as part of the institutional provider's per diem rate.

Covered Services, *continued*

Billing the Recipient Prohibited

Federal law prohibits charging any Medicare or Medicaid institutionalized recipient for medically necessary over-the-counter drugs or personal care supplies, even if Medicaid does not reimburse the pharmacy for these items. The institution must reimburse the pharmacy for these items, as payment has been made to the institution within the per diem rate.

Medicaid and Medicare Part A Recipients

Medicaid prescribed drug services does not reimburse for any drugs dispensed to a dually eligible Medicaid and Medicare recipient whose nursing home or hospice stay is reimbursed by Medicare.

The Medicare payment to the nursing or hospice facility is all-inclusive. No additional services can be billed to Medicaid.

It is the pharmacy's responsibility to determine when a recipient's stay is covered by Medicare Part A or by a hospice. If prescribed drug claims have already been submitted during the time a recipient's stay was reimbursed by Medicare Part A or hospice, the provider must void all prescribed drug claims paid by Medicaid.

Coverage and Limitations for Family Planning Waiver Services

Introduction

Through the Family Planning Waiver program, Medicaid eligibility is extended for 24 months postpartum, for family planning services, for women whose delivery or pregnancy-related service was covered by Medicaid.

Note: See the Florida Medicaid Provider General Handbook for additional information on Family Planning Waiver Services.

Coverage and Limitations for Family Planning Waiver Services, *continued*

Covered Services

Family Planning Waiver recipients are eligible for all Medicaid-covered family planning services, contraception pharmacy services, antibiotics and vaginal antifungals and anti-infectives to treat sexually transmitted diseases (STDs), sterilization, and colposcopy. Drugs covered under this program are listed in the Family Planning Plan in the pharmacy point of sale system, and are listed on the Medicaid Family Planning website at http://ahca.myflorida.com/Medicaid/Family_Planning/index.shtml ..

All other Medicaid services are excluded.

Contraceptives

Most contraceptives available in a pharmacy are covered.

Services that are provided in a physician's office such as IUDs and subdermal implants for contraception are reimbursed by Medicaid to the physician, and are not covered as a pharmacy service.

Covered Services, *continued*

Antibiotic Treatment of STDs	Antibiotic treatment of STDs is a covered pharmacy service, if the antibiotic is dispensed by a pharmacy pursuant to a valid prescription.
Vaginal Antifungals and Anti-infectives	Vaginal antifungals and anti-infectives are covered if dispensed by a pharmacy pursuant to a valid prescription to treat a STD other than HIV or hepatitis. Generic over-the-counter products are covered by Medicaid. Many products used to treat vaginal yeast infections in women are available over-the-counter.

Coverage and Limitations for Injectable Drugs

Injectable Drugs Administered in Outpatient Settings	Injectable drugs purchased by providers and administered to patients being treated in provider office settings and dialysis units are reimbursed according to the fee schedules posted on the AHCA website at http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx The posted reimbursement is calculated per 409.908(14), Florida Statutes and 59G-4.251, F.A.C. Drugs listed on the fee schedules are subject to evaluation by the Medicaid Pharmaceutical and Therapeutics Committee, and may be subject to prior authorization criteria and billing limitations based on medical diagnosis codes; maximum dose limits; and age limitations. Provider offices and dialysis units should bill claims through Medicaid Services according to the individual drug Healthcare Common Procedure Coding System (HCPCS) codes and billing units listed on the fee schedules. Coverage policies for drug administration Current Procedural Terminology (CPT) codes and supplies will continue to be managed by the Bureau of Medicaid Services. See the provider handbook(s) for coverage policies and billing instructions. http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx .
Injectable Drugs Administered in the Home	Injectable drugs used in home infusion therapy are reimbursed by Medicaid through the prescribed drug program. Providers may submit claims on the Universal Claim Form (UCF) or by the Point of Sale system. Home infusion providers may bill Medicaid weekly or monthly. Daily billing is not permitted. The provider can submit most claims electronically. Ancillary equipment and supplies are not reimbursed through Medicaid prescribed drug services, but may be reimbursed through other Medicaid services such as home health, durable medical equipment and medical supplies, or home and community-based waiver programs. Please call the area Medicaid office for additional information on these services. Area office contact information may be found on the AHCA website at http://ahca.myflorida.com/Medicaid/Areas/index.shtml .
Place of Service	Covered drugs may be delivered to the recipient's home or brought to an outpatient clinic for infusion, but may not be intended for used while the recipient is an inpatient in a hospital or undergoing procedures in an outpatient hospital or ambulatory surgical center.
Billing Restrictions	Drugs billed to Medicaid prescribed drug services may not be billed again as physician services or included in any facility's cost report.

Coverage and Limitations for Injectable Drugs, *continued*

Liquid Dosage Forms	Liquid filled products such as vials, ampules or prefilled syringes contain a specific volume (ml or cc). These dosage forms must be billed as the total number of ml or cc of drug used in dispensing the prescription.
Dry Powder Injectables for Reconstitution	Solid filled products such as powder in a vial contain a specific weight of a drug. The provider must bill for the total number of vials used in a prescription, regardless of the actual quantity of the drug. Neither the final reconstituted volume nor the total grams of drug can be used as the quantity.

Compound Drugs

Covered Compound Drugs	Medicaid may reimburse for a compound drug if it is a combination of two or more pharmaceuticals and satisfies all of the following criteria: 1. At least one pharmaceutical is a reimbursable legend drug; 2. The finished product is not otherwise commercially available in strength and formulation; and 3. The finished product is being prepared to treat a specific recipient's condition. 4. Compounding may not be used in place of commercially available formulations (i.e., compounded inhalation products). All sterile compounded products must be made in compliance with USP standards and in accordance with Chapter 465, F. S.
Reconstitutions of Oral Powders	Reconstitution of oral powders is not considered compounding. The provider must bill the NDC of the product used in the quantity of final reconstituted volume.

Unit Dose Packaging

In-House Preparation Fee	See Chapter 3 of this handbook for information on completing the claim.
Limitation on Unit Dose Fee	Providers may not bill for the in-house unit dose preparation fee for products that are already packaged in unit-of-use packaging such as drops, ointments, inhalers, nutritional supplements, etc.
Credit for Returns	The pharmacy must credit Medicaid when unit dose packaged drugs are returned to the pharmacy. See Chapter 4 of this handbook for instructions on unit dose returns.

Drug Quantities and Units of Measurement

Metric Decimal Drug Quantities

After July 1, 1999, providers must bill for drug quantities using decimal numbers—rounding to whole numbers is no longer permitted. The provider must ensure that the correct quantity is entered in the metric decimal field (i.e., 0.030 does not equal 30.000). Rounding up is no longer allowed (i.e., 3.500 cannot be billed as 4.000).

Metric Measurements

Drug quantities must always be billed in metric units. For example, one-ounce liquid is billed as 30.00 ml dispensed.

Billing Unit Standard

Medicaid requires the National Council for Prescription Drug Programs (NCPDP) unit of measurement or the billing unit standard, which recognizes only three billing units to describe all drug products: "each," "ml," and "gm." The use of "tablet," "patch," "kit," etc. is not appropriate, since these are dosage forms or package descriptions.

Dosage Forms Expressed as "Each"

The dosage forms that are expressed as "each" are:

- Solid oral medications such as tablets, capsules, etc., even when presented in dosepacks or cycles;
- Suppositories;
- Transdermal patches;
- Powder packets;
- Disposable syringes (not prefilled);
- Most products packaged in; and
- Powder-filled vials, amp and syringes for injection; irrigation; or inhalation (the quantity is the total number of vials dispensed, not the mls or gms of the final product).

Dosage Forms Expressed as "ml"

Dosage forms that are expressed as "ml" are:

- Liquid oral medications;
- Ophthalmic and otic drops and suspensions
- Reconstitutable oral products (the quantity is the number of milliliters in the bottle after reconstitution);
- Topical lotions or solutions;
- Liquid-filled vials, amps, or syringes for injection, irrigation, or inhalation (the quantity is the total number of milliliters dispensed); and
- Inhalers and aerosols that are specified in milliliters by the manufacturer on the labeling.

Dosage Forms Expressed as "gm"

Dosage forms that are expressed as "gm" are:

- Topical or ophthalmic ointments and creams; and
- Inhalers and aerosols that are specified in grams by the manufacturer on the labeling.

Drug Quantities and Units of Measurement, continued

Exceptions to the NCPDP Standard

Generally tablets and capsules should be billed by the number of tablets/capsules; liquids should be billed by the number of milliliters (ml); ointments and creams should be billed by the number of grams (gm); dry powders that must be mixed before dispensing for oral use such as antibiotic suspensions should be billed by the total number of mls as dispensed; and dry powders that must be mixed before dispensing for injection (i.e, some immune globulins) should be billed by the vial or ampule. For injectable drugs, the total billable units per vial cannot exceed the manufacturer's labeled quantity, which is the number of NCPDP units for that vial. Medicaid does not reimburse for overfill.

Some examples of exceptions to the NCPDP billing unit standard are as follows:

- Antihemophilic products must be expressed as the number of antihemophilic units dispensed, which will vary from vial to vial;
- Cordran Tape and EpiPens must be expressed as "each";
- One Imitrex kit with two syringes must be expressed as one "each";
- One tube of Emla cream with Tegaderm patches must be expressed as one "each";
- Helidac® combination therapy must be expressed as 56 dosing units;
- Some powder packets may require billing by gms.

Medicaid Boards and Panels

Drug Utilization Review Board

The Drug Utilization Review Board (DUR) was established pursuant to Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990 (OBRA '90), which mandated that the Agency develop and adopt regulations for a drug use review program for covered outpatient drugs. The Board attempts to ensure that prescriptions written for Medicaid beneficiaries are appropriate, medically necessary, and are not likely to result in adverse clinical outcomes. The activities of the Board include making recommendations for the following activities:

- Retrospective and prospective utilization reviews;
- Development of review materials; and
- Implementation of intervention programs.

Medicaid Prescribing Pattern Review Panel

The Medicaid Prescribing Pattern Review Panel shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. AHCA and its Drug Utilization Review Board (DUR) shall consult with the panel to:

- Identify inappropriate prescribing patterns;
- Design and perform educational appraisals for prescribers;
- Design restrictions within the Medicaid program for physicians who continue to exceed the norm; and
- Establish recommendations for criteria to determine when the Agency may discontinue or restrict payment for a physician's prescriptions

Medicaid Boards and Panels *(continued)*

Medicaid Pharmaceutical and Therapeutics Committee (P&T)	Created pursuant to section 409.91195, Florida Statutes, the Florida Medicaid Pharmaceutical and Therapeutics committee develops preferred drug list recommendations for consideration by AHCA by considering the clinical efficacy, safety, and cost-effectiveness of products. The committee also makes recommendations regarding prior authorization protocols for specific drugs. The committee ensures that pharmaceutical manufacturers that contract to provide a supplemental rebate to the state have an opportunity to present evidence supporting inclusion of their products on the preferred drug list. Meetings are held quarterly. For current information about the committee, see the Medicaid website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/index.shtml . Medicaid recipients can appeal Agency preferred drug list decisions using the Medicaid fair hearing process administered by the Department of Children and Family Services.

CHAPTER 3
CLAIMS

Overview

Introduction

This chapter describes the codes and fees that Medicaid uses to reimburse for prescribed drug services, explains the codes to use for special services, and explains how drug quantities are expressed. This chapter also describes the methods of claim submission, time limits for claims submission, and how to complete and submit claims for payment.

In This Chapter

This chapter contains:

National Drug Code (NDC)

Description

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an 11-digit number. The first 5 digits identify the manufacturer or supplier; the next 4 digits identify the product; and the last 2 digits identify the package size.

Using NDCs

The provider must enter the entire 11-digit NDC for the actual product dispensed on the claim. Billing an NDC number other than the one for the product dispensed is a false claim and a violation of Medicaid policy.

NDC Information (continued)

NDC Code Not On the Drug File

Medicaid reimburses pharmacies only for those drugs for which NDC codes are listed on the Medicaid drug file. Generally, all legend drugs for which the manufacturer has a rebate agreement with the Secretary of the U.S. Department of Health and Human Services are listed, although some are subject to prior authorization requirements (see Service Limitations in Chapter 2 of this Handbook.). A list of the participating manufacturers is available from the Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov. Click on "Medicaid Drug Rebate Program". If the NDC code is not on the Medicaid drug file, the provider can call Medicaid Prescribed Drug Services at 850-412-4166 for information.

Drugs Unlawfully Acquired

Medicaid will only reimburse those drugs that are lawfully acquired from entities licensed in accordance with Chapter 499, Florida Statutes.

General Reimbursement Information

Reimbursement Methodology

Reimbursement for prescribed drug claims is made in accordance with the provisions of 42 CFR 447.512-516. The reimbursement methodology for covered drugs dispensed by a licensed pharmacy or administered in a provider office or a dialysis unit that is approved as a Medicaid provider, or by an enrolled dispensing physician filling his own prescriptions is described in Rule 59G-4.251, Florida Administrative Code.

For drugs purchased by qualified entities under Section 340B of the Public Health Service Act: Covered entities and Federally Qualified Health Centers or their contracted agents that fill Medicaid patient prescriptions with drugs purchased at prices authorized under Section 340B of the Public Health Service Act must bill Medicaid for reimbursement at the actual acquisition cost plus the allowable dispensing fee as described in Rule 59G-4.251, F.A.C., *Florida Medicaid Prescribed Drugs Reimbursement Methodology.* These providers should enter "05" or "08" in the Basis of Cost Determination field (NCPDP 423-DN) on the Point-of-Sale claim, and the Submitted Ingredient Cost (NCPDP 409-D9) must be the "lesser of" in the statutory pricing logic in order to receive the 340B dispensing fee..

Dispensing Fees

Dispensing fees payable to retail pharmacies that purchase drugs through normal commercial channels, and dispensing fees payable to covered entities and Federally Qualified Health Centers or their contracted agents that fill Medicaid patient prescriptions with drugs purchased at prices authorized under Section 340B of the Public Health Service Act are described in Rule 59G-4.251, F.A.C., *Florida Medicaid Prescribed Drugs Reimbursement Methodology*.

Partial Fill

Pharmacies will be reimbursed for a partial fill of a prescription due to inventory constraints or other reasons. The dispensing fee will be applied to the initial fill. No dispensing fee will be payable when the prescription is completed. Pharmacy providers must use the partial fill coding designated in National Council for Prescription Drug Program (NCPDP) standards.

General Reimbursement Information (continued)

Automatic Fills	Automatic fill dispensing is prohibited. Each fill (original or refill) must be specifically requested by the recipient or the recipient's agent prior to the dispensing period. Dispensing scheduled automatic refills without such a request is prohibited.
Compound Drugs	All ingredients used in a compound prescription must be listed using the NCPDP standard.
Unit Dose Preparation Fee	An additional $0.015 per unit is paid to pharmacies for in-house unit dose packaging of tablets or capsules. Providers must indicate this with a "3" in the unit dose indicator field per NCPDP standards.
Brand Name Drugs that Exceed the FULP or SMAC	If a recipient requests a brand name drug with an acquisition cost that exceeds the maximum allowable cost, the pharmacist cannot dispense the brand name drug, bill for the generic price, and charge the recipient the difference. Providers must accept the Medicaid payment as payment in full or not bill Medicaid for the prescription. If the prescriber writes a prescription for a brand name product that has an applicable state maximum allowable cost (SMAC) or federal upper limit price (FULP), the prescriber must complete a Florida Medicaid Clinical Prior Authorization form or Miscellaneous Prior Authorization form and a Request for Multi-Source Brand Drug form. The completed forms must describe the reason the generic product is not appropriate or effective. Fax both forms, relevant medical records, and a copy of the prescription, with the "brand medically necessary" statement handwritten on the face of the prescription form, to: Medicaid Pharmacy Services at (850) 922-0685; or mail to 2727 Mahan Drive, MS 38, Tallahassee, FL 32308. In addition, the prescriber is encouraged to submit the FDA MedWatch report form, which is available at: http://www.fda.gov/Safety/MedWatch/DownloadForms/default.htm . The Request for Multi-Source Brand Drug and the Prior Authorization forms may be found at: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml. Providers can override the FULP or SMAC for Florida Negative Formulary drugs (as defined in Rule: 64B16-27.500, Florida Administrative Code), by using a "dispense as written" (DAW) code of "7", which states that substitution is not allowed and brand name is mandated by law.
Source of Price Data	Ingredient cost reimbursement is based on acquisition cost in accordance with the provisions of 42 CFR 447.512-516 and Rule 59G-4.251, F.A.C. Florida Medicaid Prescribed Drugs Reimbursement Methodology. Medicaid refers to ingredient cost pricing data published by the First DataBank National Drug File electronic service. Further, individual review of invoices is required in some situations in setting SMAC prices based on actual acquisition cost.

General Reimbursement Information (continued)

Quantities

Quantities are expressed in metric decimal amounts. Rounding up any quantity to the nearest number is not necessary, and can result in a false claim and overpayment. Attention should be paid to billing calculations for all inhalation solutions that are frequently packaged in 2.500ml vials, and for injectables such as Neupogen (1.600ml) and Lovenox (0.300ml - 0.800ml), and for all eye ointments (i.e. 3.500 gm).

Types of Pharmacy Claims

Types of Claim Submissions

Providers can submit prescribed drug claims through the Point-of-Sale (POS) system, the Medicaid Fiscal Agent's electronic claim submission system, or on paper claim forms. The paper claim form for Medicaid prescribed drug services is the Universal Claim Form (UCF).

Point-of-Sale (POS) Claim Submission

Introduction

Medicaid pharmacy providers can submit Medicaid claims using on-line, real time, POS processing. The transaction is processed through the claims processing cycle, and the disposition of the claim is returned to the pharmacy within seconds of submission.

POS processing is available through authorized telecommunication vendors that are connected to virtually every pharmacy in the United States.

Features of Point-of-Sale

The POS system is designed to use standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication that are in place for pharmacy POS processing by other payers in addition to Medicaid. POS uses the latest telecommunication standard specified by the NCPDP Version.

The POS system is available 24 hours per day, seven days per week, except for scheduled down time for system maintenance.

Point-of-Sale (POS) Claim Submission (continued)

Equipment

To use POS, the pharmacy provider must:

- Contact a certified system software vendor to provide and install the necessary processing system and to provide a system vendor manual. The vendor will assign the pharmacy a system certification number that must be included on the pharmacy's Medicaid Pharmacy Point-of-Sale Agreement.
- Select and contract with an authorized telecommunication switch vendor. The provider can obtain a list of the authorized certified software and telecommunication switch vendors from the Medicaid PBM Technical Call Center at (800) 603-1714.

Role of the Tele-communication Switch Vendor

A switch vendor is a telecommunications services vendor that facilitates the transfer of prescription transactions from the pharmacy to any authorized payer, including the Medicaid PBM, via telephone lines or internet connectivity. The switch vendor receives all the claim data for all payers and routes it to the appropriate processing sites.

The provider remains responsible for complete records of all claims submitted for payment.

Authorization to Use Point-of-Sale (POS)

To obtain authorization to submit Medicaid claims through POS, the provider must submit the POS authorization agreements to the Medicaid Fiscal Agent. For detailed information on enrollment and authorization, see "Point-of-Sale Enrollment" in Chapter 1 of this handbook.

Number of Claims that Can Be Submitted

Up to four prescriptions for the same recipient can be transmitted at one time. The provider must contact the system vendor for information on transmitting multiple claims.

Type of Claims that Can Be Submitted

New claims, resubmitted denied claims, and claim reversals (voids) can be submitted through POS.

Claims on which a third party has made payment can be submitted if the provider has the capability to enter the amount paid by the third party in the claim record.

Types of Claims that Cannot Be Submitted

The following types of claims cannot be submitted through POS. They must be submitted on the paper UCF:

- Adjustments to claims not originally submitted through POS;
- Claims requiring supporting documentation or attachments; and
- Claims that must be manually reviewed prior to payment, as described below.

Point-of-Sale (POS) Claim Submission (continued)

Claims that Must be Manually Reviewed

The following types of claims must be manually reviewed prior to payment:

- Claims for a recipient with third party liability when the third party has not made a payment on the claim;
- Claims for a recipient with third party liability for which the provider is unable to transmit the "Other Payer Amount" via POS; and
- Any claims received by Medicaid more than twelve months after the date of service. Claims more than 12 months from the date of service should be sent to the local Medicaid area office for special processing. Medicaid Area Office locations and contact information may be found at http://www.fdhc.state.fl.us/Medicaid/Areas/index.shtml .

Provider Software Responsibilities

It is the responsibility of the pharmacy provider to ensure that software accurately receives, formats, and displays all data and free text fields that are transmitted by Medicaid.

Electronic Claim Submission (Batch) (ECS)

Introduction

Providers who do not use POS processing can submit Medicaid claims via electronic media (batch) to take advantage of speed and accuracy in processing. Providers submit electronic claims themselves or choose a billing agent that offers electronic claim submission services. Billing agents must enroll as Medicaid providers.

Format Specifications

The National Council for Prescription Drug Programs (NCPDP) publishes specifications detailing electronic formats and communications requirements, accessible through their website at http://www.ncpdp.org/pdf/Basic_guide_to_standards.pdf . These standards are for use in formatting practice management systems, billing agent systems, and claim clearinghouses.

Initial Assistance to Begin Electronic Claims Submission

Florida Medicaid fiscal agent Field Representatives are available to assist providers with software installation and initial testing and training for claims submission. To schedule an appointment with a representative, call the fiscal agent's Provider Contact Center at (800) 289-7799, Option 7.

Types of Claims that Can Be Submitted

New claims and resubmitted denied claims can be submitted through Electronic Claim Submission (ECS) (also termed "batch" processing).

Electronic Claim Submission (Batch) (ECS), continued

Types of Claims that Cannot Be Submitted

The following types of claims cannot be submitted through (ECS). These must be submitted on paper Universal Claim Forms (UCFs):

- Voids;
- Adjustments for claims not originally submitted through POS;
- Claims requiring supporting documentation or attachments;
- Claims for compounded drugs—these need to be done on the UCF or at Point-of-Sale; and
- Claims for a recipient with third party liability whether or not the third party has made a payment on the claim.

Technical Support

The Electronic Data Interchange (EDI) Help Desk assists providers who have questions about electronic claims submission. The Fiscal Agent's EDI Help Desk is available to all providers Monday through Friday from 8:00 a.m. to 5:00 p.m. at 800-289-7799, Option 3.

EDI Help Desk will:

- Provide information on available services;
- Assist in enrolling users for electronic claims submission and report retrieval;
- Process test transmissions; and
- Provide technical assistance on transmission difficulties.

Claim Certification

Because an electronic claim cannot be submitted with an electronic signature at this time, the provider's endorsed signature on the back of the remittance check issued by the Medicaid Fiscal Agent takes the place of a signature on a paper claim form. It acknowledges the submission of the claim and the receipt of the payment for the claim. It certifies that the claim complies with the conditions stated on the back of the paper claim form, and with all federal and state laws.

Any provider who utilizes the electronic funds transfer system is certifying with each use of the electronic funds transfer system that the claim(s) for which the provider is being paid is in compliance with the provisions found on the back of the paper claim form and with all federal and state laws.

Pharmacy Universal Claim Form (UCF)

Introduction

To request payment for Medicaid covered services, the provider can submit a NCPDP Universal Claim Form (UCF) to the Fiscal Agent at the appropriate address in the next section. A copy of the UCF is displayed on page 14 of this chapter. See the Florida Medicaid Handbook or call the fiscal agent's help desk at 800-289-7799, Option 3 for instructions on ordering the forms. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com

Where to Send Pharmacy Universal Claim Forms (UCF)

Original and Resubmitted Claims	Mail original and resubmitted UCF claim forms to: Medicaid PBM UCF Claims P.O. Box 7082 Tallahassee, Florida 32314-7082
Adjustments and Voids	Mail adjustments and voids to: Medicaid PBM Adjustments and Voids P.O. Box 7082 Tallahassee, Florida 32314-7082

Time Limit for Submission of Medicaid Claims

Timely Claim Submission	Medicaid providers should submit claims immediately after providing services so that any problems can be corrected and the claims resubmitted before the filing deadline.
Clean Claim	In order for a claim to be paid, it must be a clean claim. Per Rule 59G-1.010(42), F.A.C., a clean claim is a Medicaid claim that: • Has been accurately and fully completed according to Medicaid billing guidelines; • Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment; and • Can be processed and adjudicated by the Fiscal Agent without obtaining additional information from the provider or from a third party. A clean claim does not confirm compliance with Medicaid policies. A clean claim includes a claim with errors originating in the claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state of federal Medicaid laws, rules, regulations, policies, or directives or a claim under review for medical necessity.
12-Month Filing Limit	A clean claim for services rendered must be received by Medicaid or its fiscal agent no later than twelve months from the date of service.
Out-Of-State Claims	Claims submitted by out-of-state providers must be received by Medicaid or its fiscal agent no later than twelve months from the date of service to be considered for payment. Prescription medications are not specifically covered with respect to out of state care. Only hospitals and physicians are enrolled as providers of emergency care. Prescription medications are covered as part of the hospitalization or medical treatment, and are not separately reimbursable.

Time Limit For Submission of Medicaid Claims (continued)

Out-Of-State Exemption	Out-of-state providers must comply with all Florida Medicaid claim filing regulations including adherence to claim filing time limits. If the original claim was filed within 12 months from the date of service but did not pay and it is now beyond 12 months, the provider must mail the claim to the Medicaid office for the area in which the recipient resides, rather than to the Fiscal Agent. Medicaid Area Office locations and contact information may be found at http://www.fdhc.state.fl.us/Medicaid/Areas/index.shtml .
Date Received Determined	The date stamped on the claim by any Medicaid office or by the Medicaid Fiscal Agent is the recorded date of receipt for a paper claim. The Fiscal Agent date stamps the claim the date it is received in the Fiscal Agent's mailroom. The date electronically coded on the provider's electronic transmission by the Medicaid Fiscal Agent is the recorded date of receipt for an electronic claim.
Third Party Payer Insurance Claims	Claims for recipients who have Medicare or other insurance must be submitted to the third party payer prior to sending the claim to Medicaid. Medicaid is the payer of last resort. Medicaid or the Medicaid Fiscal Agent must receive claims by no later than 12 months from the date of service or six months from the date Medicare or other insurance pays or denies payment.
Claim Adjustment Requests	AHCA or its Fiscal Agent must receive all clean claim adjustment requests by no later than 12 months from the date of the original payment.
Claim Void Requests	The 12-month filing limit does not apply to claim void requests. Claim void requests are submitted at any time.

Time Limit For Submission of Medicaid Claims (continued)

Exceptions to the 12-Month Time Limit

Exceptions to the 12-month claim submission time limit are allowed, if the claim meets one or more of the following conditions:

- Original payment voided within six months of resubmission;
- Court or hearing decision;
- Delay in recipient eligibility determination;
- Agency delay in updating eligibility file;
- Court ordered or statutory action, or
- System error on a claim that was originally filed within 12 months from the date of service.

Any claim filed on a UCF more than 12 months from the date of service that meets an exception must be sent to the area office for processing, not to the Fiscal Agent.

Medicaid Area Office locations and contact information may be found at http://www.fdhc.state.fl.us/Medicaid/Areas/index.shtml .

Each of these exceptions is discussed in detail in the following sections.

Original Payment Is Voided

When an original Medicaid claim is voided, the provider may submit a new claim and a written request for assistance to the area Medicaid office no later than six months from the void date.

Court or Hearing Decision

When a recipient is approved for Medicaid as a result of a fair hearing or court decision, there is no time limit for the submission of a claim.

Medicaid Delay in Recipient Eligibility Determination

The Department of Children and Families or the Social Security Administration can grant an exception in case of a delay in the determination of an individual's Medicaid eligibility. The provider must send in specific documentation to the area Medicaid office no later than 12 months from the date the recipient's eligibility is posted to the Florida Medicaid Management Information System (FMMIS) file. The claim submission must include:

- A clean claim;
- A copy of the recipient's proof of eligibility; and
- Documentation of the reason for late submission.

AHCA Delay in Updating Eligibility File

If AHCA delays updating a recipient's eligibility on the Florida Medicaid Management Information System (FMMIS), an exception may be granted. The provider must submit the related clean claims to the area Medicaid office no later than 12 months from the date the recipient's eligibility file was updated.

Time Limit For Submission of Medicaid Claims (continued)

Court Ordered or Statutory Action	If AHCA takes corrective action due to a court order or due to final Agency action taken under Chapter 120, Florida Statutes, there is no time limit for claim submission.
System Error	If a clean claim denies due to a system error or any error that is the fault of Medicaid or the Fiscal Agent, an exception can be granted if the provider submits another clean claim along with documentation of the denial to the area Medicaid office no later than 12 months from the date of the original denial.
Evaluate the Claim	The provider must evaluate any claim that is denied and determine if the claim fits any of the conditions for an exception to the 12-month filing limit.
Submit a New Medicaid Claim Form	The provider must complete and submit a new Medicaid claim form that meets the following criteria: • The new claim must be a clean claim; • A signed or initialed legible photocopy of the original claim is acceptable; and • All required attachments that were necessary for processing the original claim must be attached to the exception claim. Corrections can be made to a photocopy of the claim, but the system will not accept claims with correction fluid, whiteout or highlighted areas. Use correction tape to make corrections.
Supporting Documentation	The provider must send a letter explaining the circumstances of the request for an exception to the time limit, and attach documents that support the exception request. One or more of the following items must be attached: • A copy of a hearing decision or court order; • A copy of the recipient's proof of eligibility; or • A copy of the Remittance Advice that indicates the incorrect denial from Medicaid.
Where to Send Requests	All requests for an exception to the 12-month filing time limit must be sent to the area Medicaid office. Medicaid Area Office locations and contact information may be found at http://www.fdhc.state.fl.us/Medicaid/Areas/index.shtml .

How to Complete a Pharmacy Claim

Introduction

This section contains the field descriptions for pharmacy claims. The required claim information is the same for all pharmacy claims regardless of whether the claim is submitted through Point-of-Sale, electronic claims submission, or on a paper Universal Claim Form (UCF). The data elements of the NCPDP transmission standard are described in detail and are matched with the corresponding paper claim item.

Before Submitting the Claim

Before submitting a claim, the provider should answer the following questions:

- Was the recipient eligible for Medicaid on the date of service?
- Has recipient's eligibility been verified?
- Was the service or item provided covered by Medicaid?
- Was prior authorization obtained, if applicable?
- Has a claim been filed and a response received for all other insurance held by the recipient?
- Is the claim a new claim, a resubmitted denied claim, or a claim reversal?

Basic Instructions for Paper Claims

The following are some basic instructions for completing a paper claim form:

- Make sure the UCF is the correct form to use for the type of claim.
- Use a separate claim form for each recipient.
- Enter all information with a typewriter or computer using black type or a pen using black ink. The Fiscal Agent can only process clean claims with black type or ink.
- The provider signature is required in the patient/authorized representative box.
- Be sure the information on the form is legible.
- Enter information within the allotted spaces.
- If necessary, use correction tape, not correction fluid.

Basic Instructions for Electronic Claims

The following are some basic instructions for submitting a claim electronically:

- Make sure that the pharmacy is authorized to submit claims electronically either via Point-of-Sale (POS), tape or modem transmission.
- If submitting via POS, use computer software that supports the National Council for Prescription Drug Programs (NCPDP) transmission standards.
- Complete all required data fields. Claims with missing or invalid data will be rejected.
- If the claim is an adjustment, requires supporting documentation or attachments, or has to be manually reviewed prior to payment, it must be submitted on a paper UCF.

How to Complete a Pharmacy Claim (continued)

Basic Instructions Concerning Denied Claims

There are specific procedures for pharmacies concerning Medicaid recipients whose prescription drug claims are denied by Medicaid if the pharmacy cannot resolve the denial during that day's pharmacy visit. Please see Rule 59G-4.255, F.A.C., Florida Medicaid Prescription Drug Coverage Denials. This Rule may be accessed on the internet at https://www.flrules.org/gateway/RuleNo.asp?id=59G-4.255 . Current versions of the pamphlets and posters mentioned below are incorporated by reference in Rule 59G-4.255, F.A.C.

The recipient should first call the prescriber and the Medicaid Ombudsman at 1-866-490-1901 for assistance in resolving service denials.

Medicaid-participating pharmacies shall provide the pamphlet, *Important Information About Your Florida Medicaid Prescription Drug Benefits*, or *Información Importante Acerca de sus beneficios de medicamentos con receta del Medicaid de la Florida*, to Medicaid recipients whose prescription drug claims are denied by Medicaid if the pharmacy cannot resolve the denial during that day's pharmacy visit. The pharmacy must write on the pamphlet the date, the recipient's name, the drug name, and the reason for the denial or write on the pamphlet the date and recipient's name and attach a printout of the computer screen stating the drug name and the reason for the denial. The pamphlet order forms are available from the Agency for Health Care Administration's website at http://portal.flmmis.com/FLPublic/0/StaticContent/Public/Pharmacy/Pharmacy%20Ombudsmans%20Re-order%20Form%20v4.pdf .

Medicaid-participating pharmacies shall post two signs, *Important Notice to Medicaid Recipients,* and *Aviso Importante a Recipientes de Medicaid* in a conspicuous location that is visible to recipients. The signs inform recipients of a toll-free number that can be called if the prescription is denied and the pharmacy failed to provide the denial information and an *Important Information About Your Florida Medicaid Prescription Drug Benefits or Información Importante Acerca de sus beneficios de medicamentos con receta del Medicaid de la Florida* pamphlet to the recipient. The sign order forms are available from the Agency for Health Care Administration's website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml .

Pharmacy Claim Form

A copy of the UCF is on the following pages for information only.

Do not use a copy of this form. To order forms, call the fiscal agent's help desk at 800-289-7799 for instructions.

Illustration 3.1 Sample of a Universal Claim Form

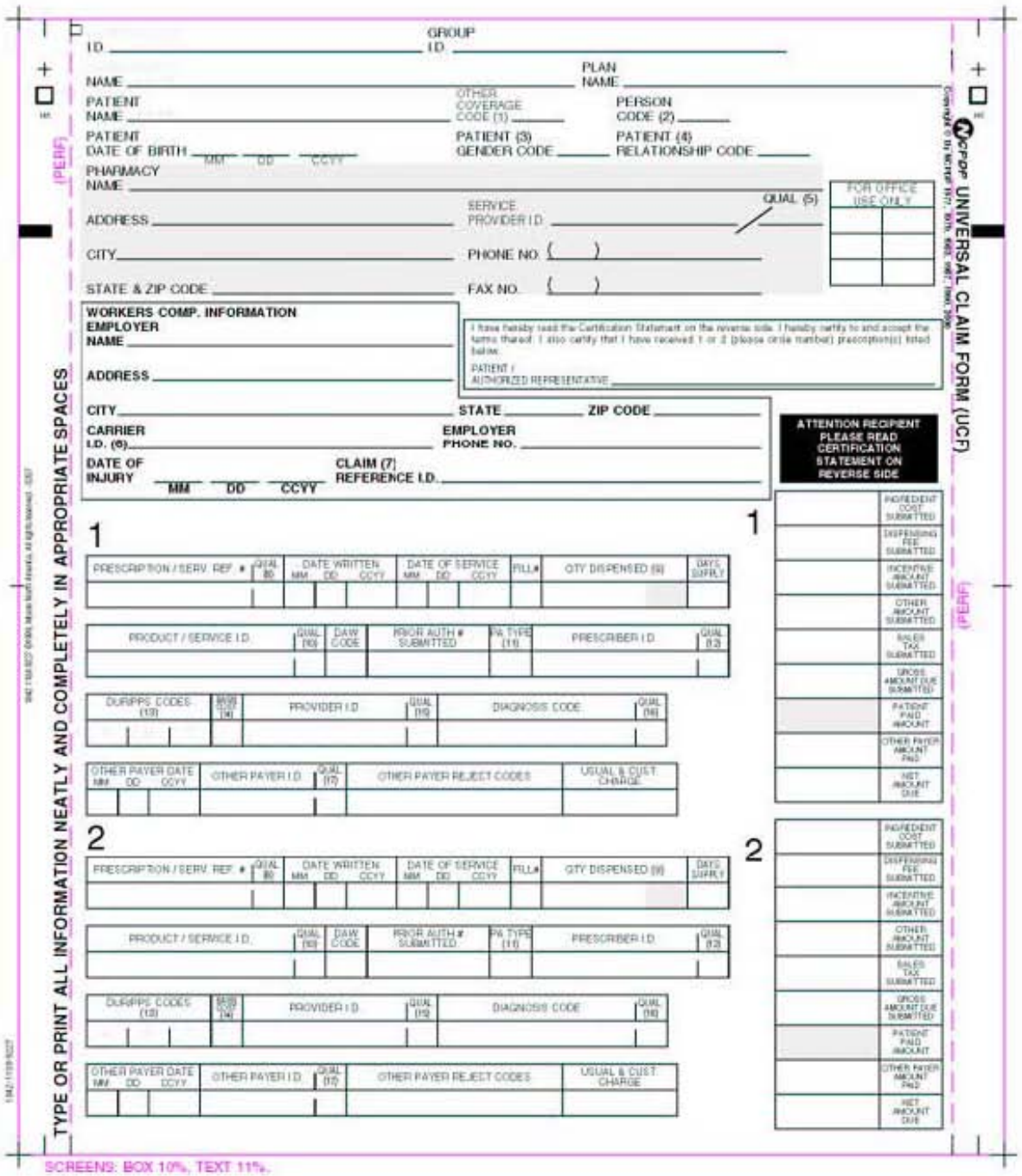
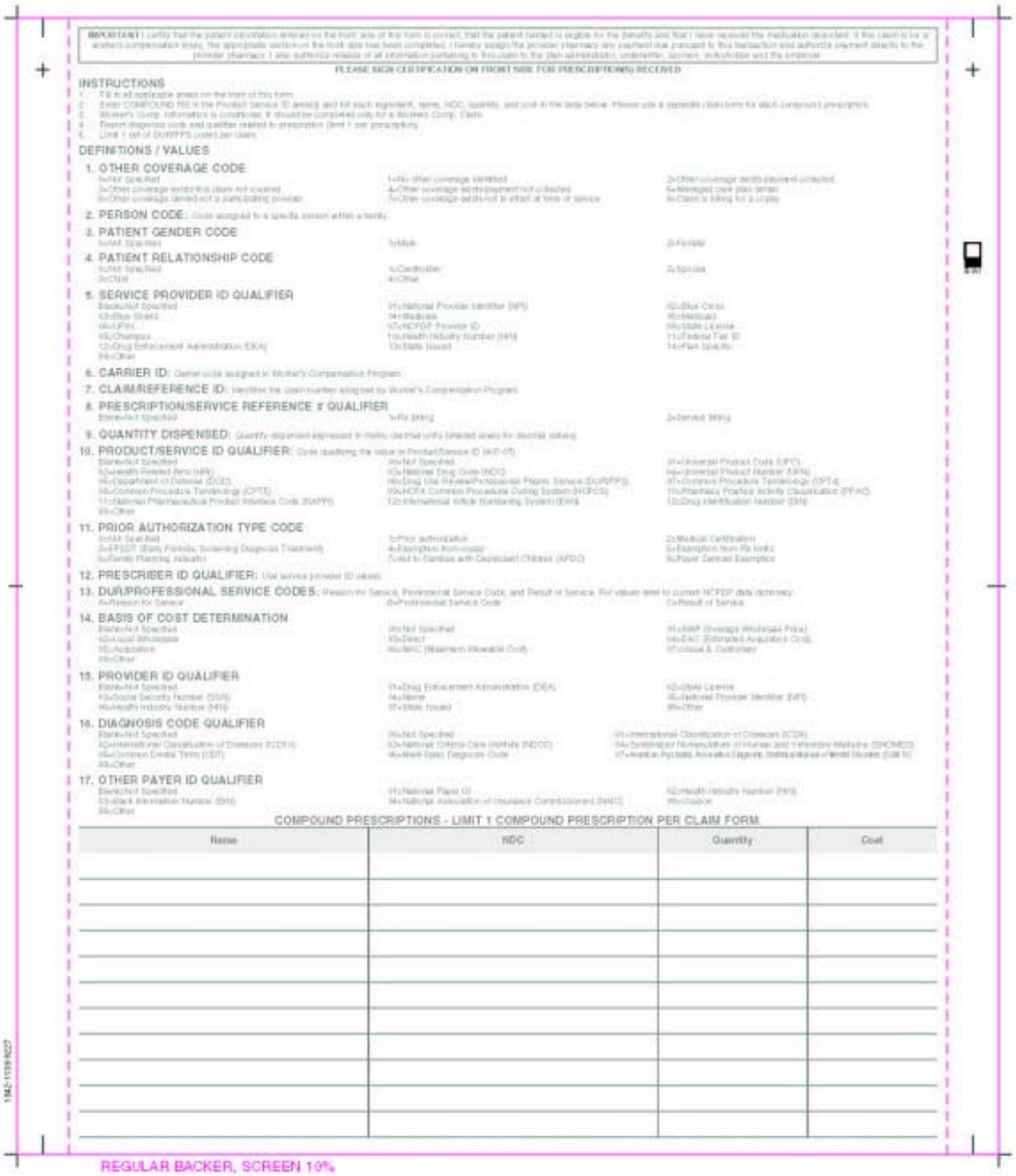


Illustration 3.2 Sample of a Universal Claim Form (Back of Form Instructions)



PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE
2. PERSON CODE:
3. PATIENT GENDER CODE
4. PATIENT RELATIONSHIP CODE
5. SERVICE PROVIDER ID QUALIFIER
6. CARRIER ID:
7. CLAIM/REFERENCE ID:
8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER
9. QUANTITY DISPENSED:
10. PRODUCT/SERVICE ID QUALIFIER:
11. PRIOR AUTHORIZATION TYPE CODE
12. PRESCRIBER ID QUALIFIER:
13. DUR/PROFESSIONAL SERVICE CODES:
14. BASIS OF COST DETERMINATION
15. PROVIDER ID QUALIFIER
16. DIAGNOSIS CODE QUALIFIER
17. OTHER PAYER ID QUALIFIER

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM

Name	NDC	Quantity	Cost

1842-1139-NCCF

REGULAR BACKER, SCREEN 10%

Instructions for Completing a Pharmacy Claim

The following table contains the fields that must be entered on pharmacy claims. The first column contains the electronic data elements on Point-of-Sale (POS) and other types of electronic billing. The second column contains the corresponding fields on the paper Universal Claim Form (UCF). The third column explains the required action for each type of claim submission.

How to Complete a Pharmacy Claim, *continued*

Data Element	*UCF Field*	*Action*
Cardholder ID Number	Cardholder ID Number	Enter the recipient's 9 or 10-digit Medicaid Identification Number. This is the cardholder ID#. Point-of-Sale: The 8-digit card control number from the front of the recipient's plastic Medicaid ID card may be entered if the provider does not know the recipient's Medicaid ID number. The response on the POS device will contain the recipient's Medicaid ID number in the message area. The provider must record this number to use in all future Medicaid transactions.
Group ID	Group ID	FLMEDICAID Note: See Chapter 1 of this Handbook and the Florida Medicaid Provider General Handbook for information on Medicaid ID numbers. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com
Patient's First Name, Patient's Last Name	Patient Name	Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility.
Plan Name	Plan Name	N/A
Person Code	Person Code	N/A
Patient Location	N/A	03- Nursing Home
Other Coverage Code	Other Coverage Code	On UCF enter appropriate code number as identified on the back of the UCF.
Birth Date	Patient Date of Birth	Point-of-Sale: Enter the recipient's birth date in century, year, month, date format: CCYYMMDD. For example, enter 2003/03/01 for March 1, 2003. UCF: Enter the recipient's birth date in month, date, century, and year format: MMDDCCYY. For example, enter 03/01/2003 for March 1, 2003
Patient Gender	Patient Gender	M/F
Patient Relationship Code	Patient relationship code	N/A

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***
Pharmacy Number	Service Provider ID Number	Point-of-Sale and Other Electronic Billing: For electronic media, the pharmacy's provider number is built into the software and does not have to be entered with each prescription. UCF: Enter the provider's name, address, and NPI or nine-digit Medicaid Provider Number. This entry must be typed or printed in black ink.
Provider Qualifier	Provider Qualifier	UCF: 05- Medicaid 01- NPI
Patient Certification Statement	Patient Certification Statement	N/A
Worker's Comp Information	Workers Comp. Information	N/A
Prescription Number	Prescription/Service Reference ID #	Enter the pharmacy's internal number that was assigned to the prescription. Enter up to seven digits for all claim types.
Prescription/Service Reference ID # Qualifier	Prescription/Service Reference ID # Qualifier	This qualifier is 01 (Rx billing)

How to Complete a Pharmacy Claim, *continued*

Submission Clarification Code	N/A	Point-of-Sale: If the recipient is not showing as eligible on the Medicaid system, a POS claim will deny. If the provider has proof of eligibility, such as an ES Form 2014 or a temporary Medicaid Identification Form (AMIC), enter a "2" in this field to override the edit. The claim will remain in suspense for up to 14 days. If after 14 days the recipient is still not showing as eligible on the Medicaid system, the claim will be denied. Enter "8" in this field to process compound for approved ingredient only Enter "9" in this field for encounters Enter "20" in this field for 340B providers Enter "99" in this field for Enhanced Benefit claims This field is not available on UCFs or other electronic billing systems, because claims submitted through these types of billing will automatically suspend for up to 14 days if edits are posted.) Note: See the Florida Medicaid Provider General Handbook for information on recipient eligibility. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com
Data Element	***UCF Field***	***Action***
Date Prescription Written	Date Written	Point-of-Sale: Enter the date that the prescription was written in the century, year, month, date format: CCYYMMDD. For example, enter 2003/03/01 for March 1, 2003. UCF: Enter the date that the prescription was written in the month, date, century, and year format: MMDDCCYY. For example, enter 03/01/2003 for March 1, 2003. Medicaid cannot reimburse for a claim submitted more than 12 months from the date the prescription was written for non-controlled substances, or more than six months for controlled substances..
Date Filled	Date of Service	Point-of-Sale: Enter the date that the prescription was filled in the century, year, month, and date format: CCYYMMDD. For example, enter 2003/03/01 for March 1, 2003. UCF: Enter the date that the prescription was filled in the month, date, century, year format: MMDDCCYY. For example, enter 03/01/2003 for March 1, 2003. Refills must show the refill date, not the date of the original filing. Medicaid cannot reimburse for a refill made after twelve months from the date the prescription was written; six months for controlled substances.

How to Complete a Pharmacy Claim, *continued*

New/Refill Code	Fill Number	Enter the number "0" if the prescription is being filled for the first time; "1" if it is the first refill; "2" if it is the second refill, etc. The field will hold two digits.
Quantity Dispensed	Quantity Dispensed	Enter the number of tablets, capsules, suppositories, patches or packets dispensed. If the drug is a liquid or a reconstituted oral suspension, enter the number of milliliters dispensed. If the drug is measured in grams, such as an ointment, cream, bulk powder, or aerosolized inhaler, enter the number of grams dispensed. If the drug is reconstitutable powder for injection, enter the number of total vials used in preparing the prescription. For anti-hemophilic factor products measured in AHFU units, enter the total number of AHFU units dispensed. Medicaid accepts decimal quantities; use 99999.999 format for all quantities. Rounding up any quantity to the nearest number is not permitted, and could result in a false claim and overpayment. Some injectable products are prepackaged in unit-of -dose kits, such as saline flush kits (2-saline-filled syringes and 1 heparin-filled syringe all in one plastic bag). Each "kit" is billed as a quantity of "1." Note: See Drug Quantities and Units of Measure in Chapter 2 for additional information on billing units for common drugs.
Compound	Compound	0 – not specified 1 – not compound 2 – compound

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***
Days' Supply	Days' Supply	Enter the estimated number of days that the prescription will last if it is consumed at the prescribed rate, based on the pharmacist's professional judgment and the prescription date. Understating the days supply in order to facilitate early refills is a violation of Medicaid policy. If the directions for use are "PRN," the pharmacist must still enter an estimated number of days the prescription will last based on professional judgment. The early refill edit NCPDP 79 will deny when the days supply has been exceeded. The provider must call the Medicaid PBM Therapeutic Consultation Call Center at 877-553-7481 for a system override. Medicaid will not reimburse for any prescription with more than a 34 day supply unless the minimum marketed package size is greater than 34 days or the drug is designated as a maintenance drug approved for 100 day supplies. Drugs approved for 100 day supplies dispensing will be approved by the Pharmacy & Therapeutics (P&T) Committee and posted on the Agency website.
NDC Number	Product/Service ID	Enter the 11 digit National Drug Code (NDC) from the package for the drug dispensed. (This is the product/service ID#.) Billing for a NDC other than the one on the package (including package size) from which the drug was dispensed is a violation of Medicaid policy. Compounds – POS System can accept up to 25 ingredients per multi-line compound. Each line is adjudicated separately and is subject to all applicable edits. If one or more ingredients requires a PA, one PA should cover the entire compound. In the Compound Segment there are fields that repeat. These fields will accept the NDC numbers up to 25 ingredients. When submitting a compound, only one transaction per UCF or POS can be done at a time. On the UCF, include the NDC numbers in the spaces that are provided on the back of the form.
Product/Service Qualifier Code	Product/Service Qualifier Code	This code is 03 (NDC).

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***

How to Complete a Pharmacy Claim, *continued*

Prescriber ID	Prescriber's Florida License Number	Providers located in Georgia or Alabama within 50 miles of the Florida state line are allowed to enroll as in-state providers if they regularly provide services to Florida Medicaid recipients. All the enrollment requirements that apply to in-state providers apply to Georgia and Alabama providers, except that they must have the licenses and permits applicable to the state in which they are located and are indicated with the prefixes GA and AL respectively. Use Prescriber ID GA1111111 and AL1111111. If the prescriber has three alpha characters, drop the third alpha character and replace with a zero so that the two alpha and seven numeric characters fit into the 9-byte field. (For example, ARNP—use ARXXXXXXX; TRN—use TRXXXXXXX; PA—use PAXXXXXXX.) If the claim is for a recipient who is using an EBA credit, enter a Prescriber ID=EB1111111. Claims will be rejected without a valid state license number. Do not enter the prescriber's name or DEA number. Excessive or deliberate errors will result in sanction or termination from the program. Claims for prescribers terminated by the Agency will not pay.
Prescriber ID Qualifier	Prescriber ID Qualifier	01 NPI 08 State License Number 14 Plan Specific
DAW	DAW code	Enter the applicable "Dispense as Written" (DAW) code; do not leave blank. If a single source drug or a generic drug is dispensed, enter a "0." If the drug is on the negative formulary or the brand name allowed by Florida Medicaid is dispensed, enter a "7." Enter other codes 1 - 9 as appropriate with the software standards.
Unit Dose Indicator		Enter a "Y" in this field if this was an in-house unit dosed prescription. The drug must have a tablet or capsule dosage form. Enter a "3" for pharmacy repackaging.
Prior Authorization Number Submitted	Prior authorization number submitted	The field formerly called "medical certification field" is now known as "prior authorization number submitted". For partial returns, enter 20000000000. For Enhanced Benefit Account claims, enter 80012345678.

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***

How to Complete a Pharmacy Claim, *continued*

Prior Authorization Type Code	Prior Authorization Type Code	Enter type codes as appropriate for conditions listed below: To indicate family planning prescription contraceptives and prenatal vitamins, enter PA Type Code "6". To indicate vitamins or phosphate binders prescribed for dialysis patients, enter PA Type Code "8". To indicate the claim is a three day emergency supply to override a non-PDL rejection, enter PA Type Code "1". Enter PA Type Code "0" to indicate partial return. Enter PA Type Code "2" to indicate that the informed consent form required pursuant to section 409.912(51), F.S. is on file in the pharmacy. (This requirement applies to reimbursement for certain drugs prescribed for children. Additional information and forms are available on the Medicaid website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml .) Other use of these codes will be considered Medicaid fraud.
DUR Codes	DUR codes	Point-of-Sale: The Drug Utilization Review (DUR) Conflict Code, Intervention Code and Outcome Code fields are required when claims are submitted after a DUR conflict warning. Note: See Chapters 1 and 6 in this handbook for additional information about on-line prospective DUR in POS processing.
NA		UCF: Enter Reason for Service, Professional Service Code and Result of Service. For values refer to current NCPDP data dictionary. A=Reason for Service, B=Professional Service Code, C=Result of Service.
NA		UCF: If billing for a compound prescription requiring manual pricing, enter the compounding information in the space available (name of drug used and quantities of each) in space provided on the back of UCF. In order that correct payment can be calculated, include the NDC number and the quantity of each ingredient used in compounded prescriptions.
NA	Net amount due	UCF: The provider enters the total amount billed for all prescribed drugs entered on the claim form.

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***
Other Payer Amount	Other Payer Amount	Point-of-Sale: The "Other Payer Amount" field is used when the recipient has private HMO or other third party (other than Medicare) prescription insurance. The third party insurers must be billed before Medicaid. Enter the amount paid by the other insurer. Medicaid will reimburse the Medicaid allowable amount less the amount paid by the third party. If the other third party denied the claim, a paper UCF must be submitted. Enter $0.00 in the TPL Payment field and attach documentation of rejection to the claim. Other Electronic Billing: Providers who use electronic claims submission other than POS cannot submit claims with third party payment electronically. They must submit these claims on paper UCFs. UCF: If the recipient has private HMO or other third party prescription insurance, enter the amount paid by the other insurer in the TPL Payment field. Documentation of payment or rejection by the other insurer must be attached to the claim. Note: See the Florida Medicaid Provider General Handbook for special instructions for drugs that are covered by Medicare. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com
Other Payer Date	Other Payer Date	Point-of-Sale: Enter the date paid in the century, year, month, date format: CCYYMMDD. For example, enter 2003/03/01 for March 1, 2003. UCF: Enter the date that the date paid in the month, date, century, year format: MMDDCCYY. For example, enter 03/01/2003 for March 1, 2003.
	UCF	Partial fills cannot be submitted using the UCF.
	N/A	When submitting a partial fill claim through POS using the NCPDP format, fields 343-HD, 344-HF and 345-HG in the claim segment are required.

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***
Dispensing Status (343-HD)		343-HD – Dispensing status. The valid values are 'P' for initial claim; 'C' for completion fill. 344-HF – Quantity Intended to be Dispensed. This value is the quantity that the original prescription was written for. 345-HG – Days Supply Intended to be Dispensed. This value will be the original days supply on the prescription.
Quantity Intended to be Dispensed (344-HF)	N/A	The quantity and days' supply dispensed on each submission (P and C) will be compared to the quantity and days' supply in fields 344 and 345. If there is a discrepancy, the claim will be denied.
Days' Supply Intended to be Dispensed (345-HG)	N/A	The quantity and days' supply submitted on the initial and completion fill claim must be equal the amounts in fields 344 and 345. Compounds cannot be submitted as partial fills. 100% of the dispensing fee will be paid at the time of the initial fill.
Ingredient Cost Submitted	Ingredient Cost Submitted UCF	Point-of-Sale: Enter the ingredient cost for the claim. This should equal the total claim charge minus the dispensing fee. The NCPDP format is $$$.¢¢. Enter value in right hand column of UCF.
Dispensing Fee	Dispensing Fee	Enter the appropriate dispensing fee. Allowable dispensing fees may be found in the Florida Medicaid Prescribed Drugs Reimbursement Methodology, Rule 59G-4.251, F.A.C.

How to Complete a Pharmacy Claim, *continued*

Data Element	***UCF Field***	***Action***
Usual and Customary Charge	Usual and Customary Charge	Enter the pharmacy's usual and customary charge. The provider must ensure that the average charge to Medicaid does not exceed the average charge to all other customers during the same calendar quarter for the same drug, quantity and strength. This is known as the usual and customary charge for the provider. Public health entities purchasing under the Public Health Services Act and amended by Section 602 of Public Law 102-585 at prices set under the provisions of Section 340-B, must enter their actual acquisition cost, plus the appropriate dispensing fee, in this field. Allowable dispensing fees may be found in the Florida Medicaid Prescribed Drugs Reimbursement Methodology, Rule 59G-4.251, F.A.C. If a third party payer has already paid the pharmacy, and the pharmacy is submitting a claim to Medicaid for the remaining co-payment or deductible, the provider must enter the Usual and Customary charge for the whole prescription. The Medicaid claim system will automatically subtract the amount paid by the third party. Institutional Pharmacies: If the pharmacy normally charges non-Medicaid patients for in-house unit dose packaging, add $0.015 per dose to the "Amount Billed" for Medicaid patients.

Illustration 3.3 Sample of a Completed Universal Claim Form

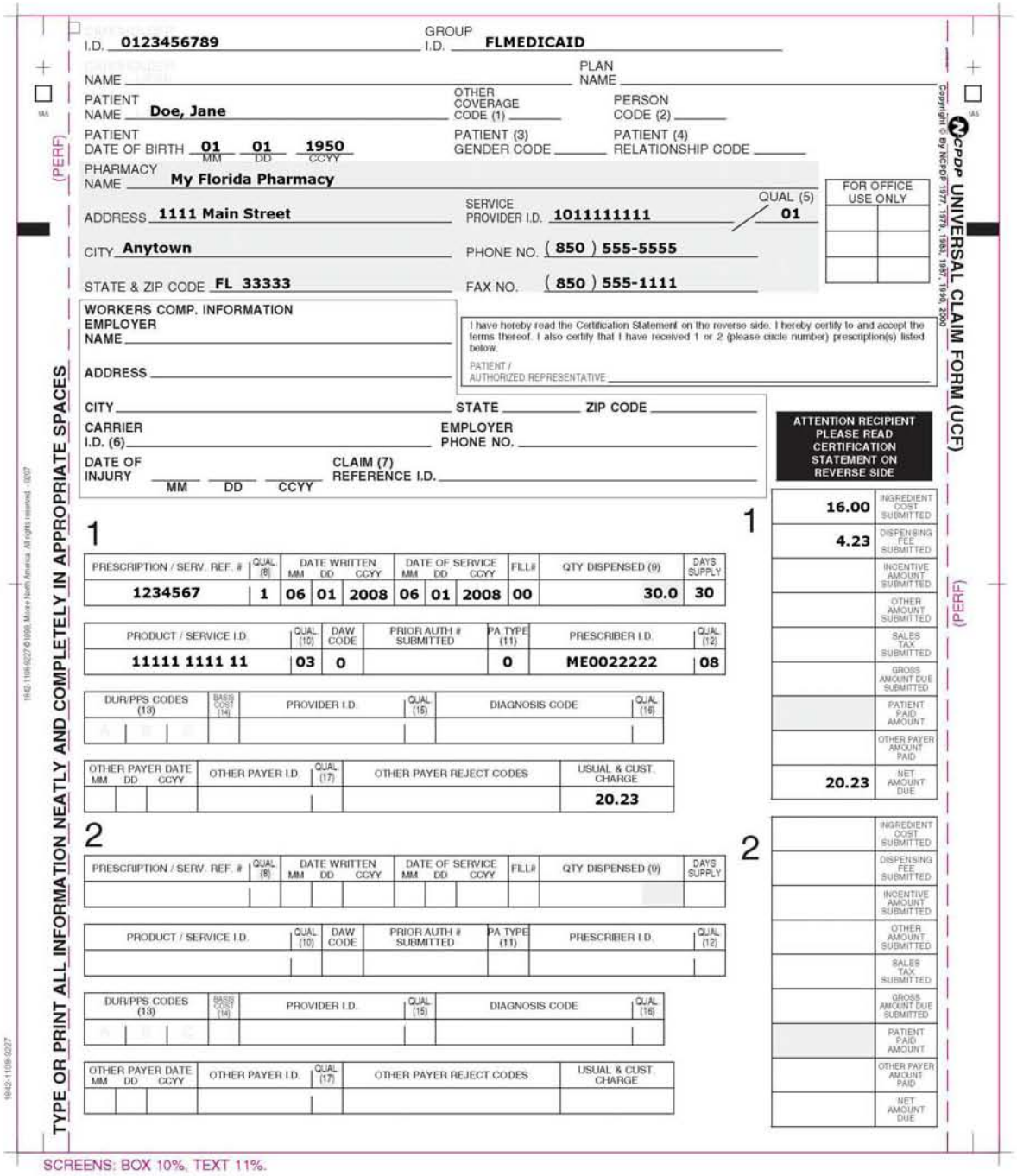


Illustration 3.4 Sample of Completed Form for Compound Drugs on UCF, Front

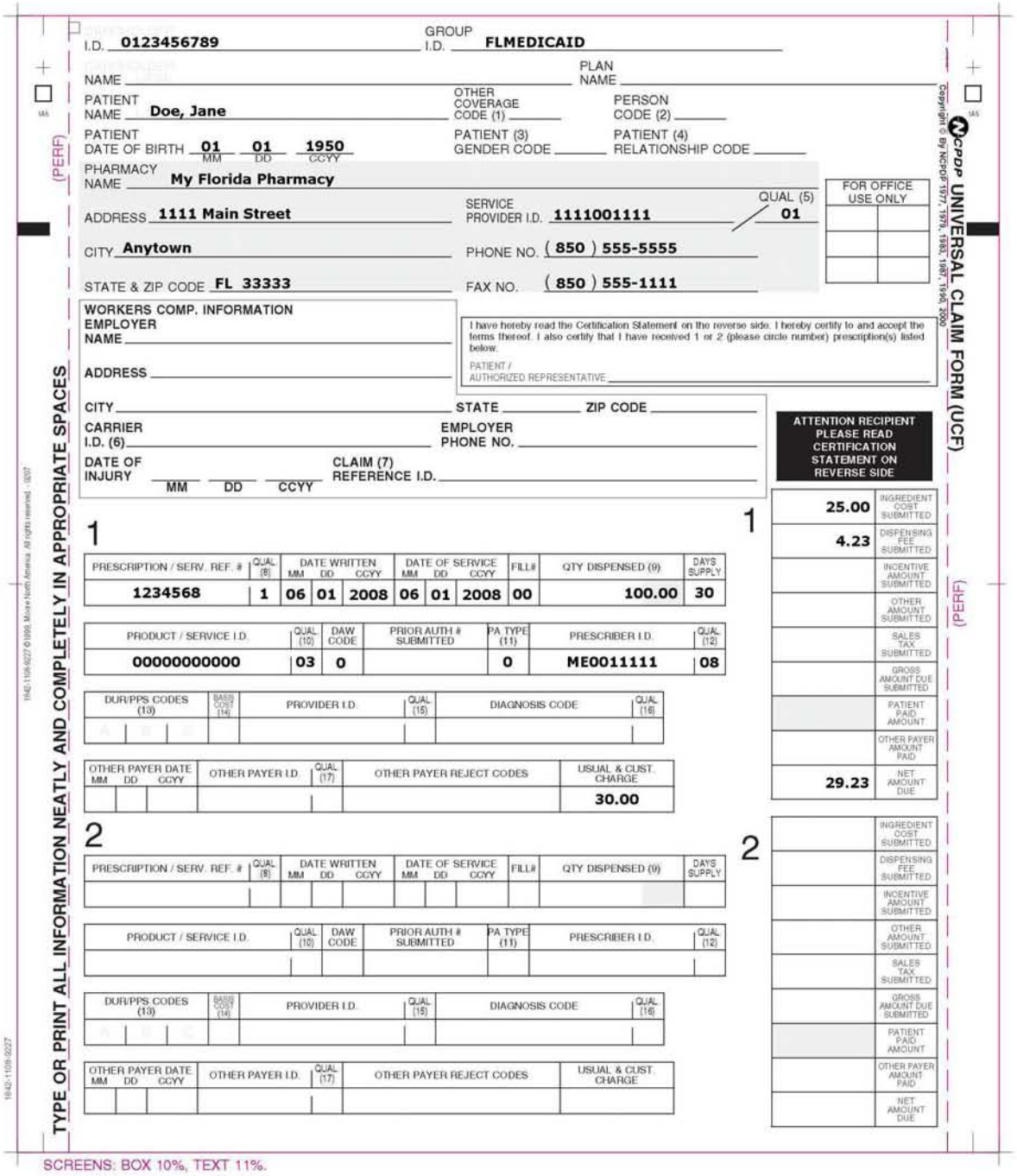
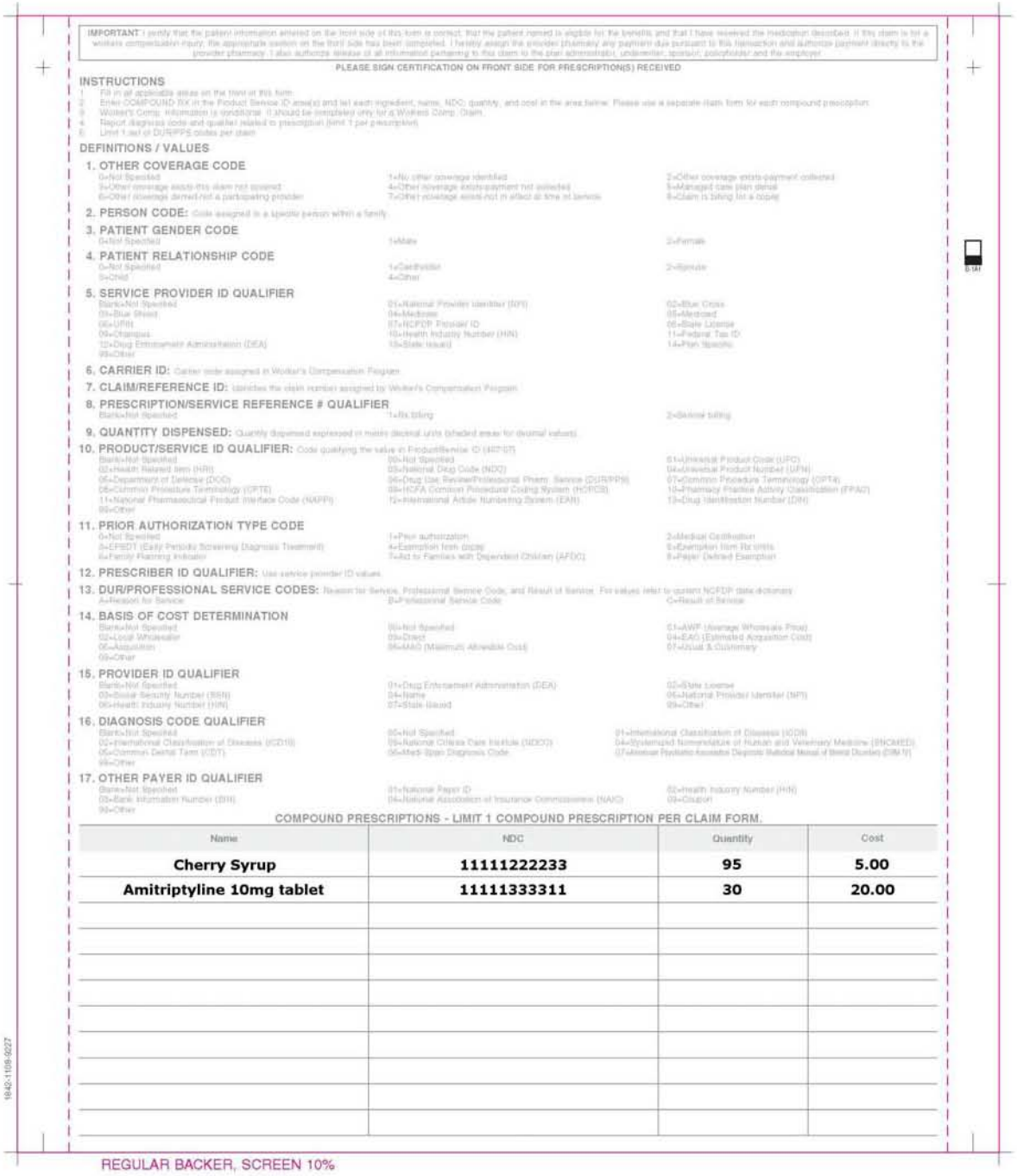


Illustration 3.5 Sample of Completed Form for Compound Drugs on UCF, Back



IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider (pharmacy) any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE
   0=Not Specified; 1=No other coverage identified; 2=Other coverage exists-payment collected; 3=Other coverage exists-this claim not covered; 4=Other coverage exists-payment not collected; 5=Managed care plan denial; 6=Other coverage denied-not a participating provider; 7=Other coverage exists-not in effect at time of service; 8=Claim is billing for a copay
2. PERSON CODE: Code assigned to a specific person within a family.
3. PATIENT GENDER CODE
   0=Not Specified; 1=Male; 2=Female
4. PATIENT RELATIONSHIP CODE
   0=Not Specified; 1=Cardholder; 2=Spouse; 3=Child; 4=Other
5. SERVICE PROVIDER ID QUALIFIER
   Blank=Not Specified; 01=National Provider Identifier (NPI); 02=Blue Cross; 03=Blue Shield; 04=Medicare; 05=Medicaid; 06=UPIN; 07=NCPDP Provider ID; 08=State License; 09=Champus; 10=Health Industry Number (HIN); 11=Federal Tax ID; 12=Drug Enforcement Administration (DEA); 13=State Issued; 14=Plan Specific; 99=Other
6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.
7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.
8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER
   Blank=Not Specified; 1=Rx billing; 2=Service billing
9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).
10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in ProductService ID (407-D7)
    Blank=Not Specified; 00=Not Specified; 01=Universal Product Code (UPC); 02=Health Related Item (HRI); 03=National Drug Code (NDC); 04=Universal Product Number (UPN); 05=Department of Defense (DOD); 06=Drug Use Review/Professional Pharm. Service (DUR/PPS); 07=Common Procedure Terminology (CPT4); 08=Common Procedure Terminology (CPT5); 09=HCFA Common Procedural Coding System (HCPCS); 10=Pharmacy Practice Activity Classification (PPAC); 11=National Pharmaceutical Product Interface Code (NAPPI); 12=International Article Numbering System (EAN); 13=Drug Identification Number (DIN); 99=Other
11. PRIOR AUTHORIZATION TYPE CODE
    0=Not Specified; 1=Prior authorization; 2=Medical Certification; 3=EPSDT (Early Periodic Screening Diagnosis Treatment); 4=Exemption from copay; 5=Exemption from Rx limits; 6=Family Planning Indicator; 7=Act to Families with Dependent Children (AFDC); 8=Payer Defined Exemption
12. PRESCRIBER ID QUALIFIER: Use service provider ID values.
13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.
    A=Reason for Service; B=Professional Service Code; C=Result of Service
14. BASIS OF COST DETERMINATION
    Blank=Not Specified; 00=Not Specified; 01=AWP (Average Wholesale Price); 02=Local Wholesaler; 03=Direct; 04=EAC (Estimated Acquisition Cost); 05=Acquisition; 06=MAC (Maximum Allowable Cost); 07=Usual & Customary; 09=Other
15. PROVIDER ID QUALIFIER
    Blank=Not Specified; 01=Drug Enforcement Administration (DEA); 02=State License; 03=Social Security Number (SSN); 04=Name; 05=National Provider Identifier (NPI); 06=Health Industry Number (HIN); 07=State Issued; 99=Other
16. DIAGNOSIS CODE QUALIFIER
    Blank=Not Specified; 00=Not Specified; 01=International Classification of Diseases (ICD9); 02=International Classification of Diseases (ICD10); 03=National Criteria Care Institute (NDCI); 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED); 05=Common Dental Term (CDT); 06=Med-Span Diagnosis Code; 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV); 99=Other
17. OTHER PAYER ID QUALIFIER
    Blank=Not Specified; 01=National Payer ID; 02=Health Industry Number (HIN); 03=Bank Information Number (BIN); 04=National Association of Insurance Commissioners (NAIC); 05=Group; 99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost
Cherry Syrup	**11111222233**	**95**	**5.00**
Amitriptyline 10mg tablet	**11111333311**	**30**	**20.00**

1842-1109-9227

REGULAR BACKER, SCREEN 10%

UCF Submission Checklist

Introduction	Use the following checklist before submitting a UCF to the Medicaid PBM for reimbursement.
Checklist	☐ Is the form typed or printed in black ink? The Medicaid PBM cannot process claims submitted with red or blue ink.
	☐ Is the copy legible?
	☐ Were instructions in the handbook followed? Some fields are not self-explanatory or can be used for other purposes.
	☐ Are the provider name and number entered?
	☐ Are attachments required? Claims cannot be paid without the required attachments.
	☐ Is the P.O. Box number for submitting the claim correct? Note: See Appendix C of the Florida Medicaid Provider General Handbook for a complete list of addresses to submit claims and other forms. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com .
	☐ For help with any questions, call the Medicaid PBM Pharmacy Technical Call Center at 800 603-1714.

Mailing Pharmacy UCF Claims Checklist

Introduction

The following checklist should be used when mailing UCF claims to the Medicaid PBM for reimbursement.

Checklist

- ☐ The claims envelope should be addressed to the correct P.O. Box and corresponding nine-digit zip code for each claim type being mailed. Typewritten or machine-printed addresses speed up post office processing.

- ☐ If possible, use a letter-sized envelope. Letter-sized envelopes are processed more quickly by the post office.

- ☐ Claims mailed in a large envelope or “flat” need to be marked “First Class” and paid for as first class postage. If First Class is not specified, the post office will send large envelopes as third class mail.

CHAPTER 4
ADDITIONAL FILING REQUIREMENTS

Overview

Introduction

This chapter provides a description of and instructions for special procedures that are required for certain prescribed drug claims. It describes unit dose returns and medically needy recipient claims.

In This Chapter

This chapter contains:

Unit Dose Return

Introduction

The pharmacy must return to inventory within 45 days of receipt unit dose medication returns that were intended for use in long term care or nursing home after having billed Medicaid, the amount reimbursed by Medicaid to the pharmacy must be credited to Medicaid. The submitted ingredient cost must be greater than or equal to $15.00, The provider should transmit a NCPDP B-3 reversal transaction through Point-of-Sale and re-bill the corrected quantity or comply with Agency unit dose return policies.

Partial Returns

A dispensing fee is paid on partial returns. A $5.00 restocking fee is paid to the provider for partial returns if the criteria noted below are met.
A unit dose repackaging fee is paid for the product quantity submitted on the re-bill transaction.

LTC Full returns

Claims for full returns should be voided/reversed using a NCPDP B2 transaction.

LTC Partial returns

Adjustments should be handled using the NCPDP B3 transaction (Re-bill) as follows:
1. In Days Supply (NCPDP #405-D5) enter the days supply used.
2. In Quantity Dispensed (NCPDP #442-E7) enter quantity consumed.
3. In Prior Authorization Type Code (NCPDP #461-EU) enter 0 (zero) 4. In Prior Authorization Number submitted (NCPDP #462-EV) enter 20000000000.
5. All other information should be identical to the original claim.

Point-of-Sale
Unit dose return

When the pharmacy returns unit dose medications intended for use in long term care to inventory after having billed Medicaid, the amount reimbursed by Medicaid to the pharmacy must be credited to Medicaid.

For claims where the full quantity has been returned, the pharmacy must reverse the entire transaction using a B-3 transaction at Point-of-Sale.

When a partial quantity of a prescription is being returned to stock, the claim may be eligible for a restocking fee. The claim must be resubmitted using the following guidelines:

- Correct the quantity on the claim;
- Enter 0 (Zero) in the Prior Auth Type Code field;
- Enter 20000000000 in the Prior Auth number submitted field; and
- Transmit the corrected claim as a "B3" transaction.

1. Submitted Ingredient Cost (NCPDP #409-D9) must be greater than or equal to $15.00.
2. Must be for nursing home recipient.
3. Must be re-billing of previously paid claim.

Special Billing for Medically Needy Recipients

Introduction

A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits. On a month-by-month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called a "share of cost."

Out-Of-State Claims

Covered Services

Out of state pharmacies seeking to enroll as Medicaid providers must be physically located within 50 miles of the Florida State border.

For other pharmacies, prescription medications are not specifically covered with respect to out of state care. Only hospitals and physicians are enrolled as providers of emergency care. Prescription medications are covered as part of the hospitalization or medical treatment, and are not separately reimbursable.

For information regarding coverage of other prior-authorized services through out-of-state providers, see the Provider General Handbook at http://mymedicaid-florida.com .

CHAPTER 5
PHARMACY CLAIMS PROCESSING

Overview

Introduction

The Medicaid fiscal agent processes claims for Medicaid reimbursement. Pharmacy claims are initially processed by the Pharmacy Benefits Manager (PBM) contractor. This chapter describes claim processing and gives the provider information about the Remittance Advice as well as how to obtain help with claim processing problems.

In this Chapter

This chapter contains:

Claim Processing

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including staff, contracted staff, and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements.

For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com . The handbook is incorporated by reference in 59G-5.020, F.A.C.

Paper Claim Handling

When the PBM receives a Universal Claim Form (UCF) paper claim, it is screened for missing information. The provider signature is required in the patient/authorized representative box.

If information is missing, the claim will not be entered into the POS system. It will be returned to the provider with a Return to Provider (RTP) letter that will state the reason the claim is being returned.

The provider needs to correct the error, attach any missing documentation, and return the claim to the PBM contractor for processing at the following address:
Florida Medicaid PBM Contractor
P.O. Box 7082
Tallahassee, FL 32314-7082

Claim Entry

Point of Sale (POS) claims enter the POS system directly through a telecommunications network and adjudicate in real time. Paper claims are imaged and then keyed by data entry operators directly into the POS to adjudicate in real time. Other electronic claims, except POS claims, are loaded in batch into the PBM adjudication system by the PBM vendor's data processing staff.

Claim Adjudication

The POS system analyzes the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition Of Claim

A claim disposition can be:

- Paid: payment is approved in accordance with program criteria.
- Suspended/captured: the claim is put on "hold" so the PBM vendor or AHCA Medicaid can analyze it in more detail.
- Denied: payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

Point of Sale Paid Claim Responses

Processing Time Frames

Claims are processed daily. Payments are made on a weekly basis. Under normal conditions a claim can be processed from receipt to payment within 3 to 7 days for POS claims, and 10 to 40 days for paper claims.

Transaction Header

The Point of Sale (POS) claim "header" contains information that is necessary for the telecommunications network to identify the transaction, such as a valid provider number and benefit identification number (BIN). The transaction header information is programmed into the provider's computer and is not dependent upon specific data regarding the prescription.

If the header information is acceptable, the header response status will be "A," and the claim will continue to process.

Claim Payable

The claim status for a payable claim is "P." When a claim adjudicates and has a "P" status, the claim will appear on the provider's next remittance advice in the "Paid" claims section.

The POS response on a paid claim contains data in the following fields:

- Authorization Number
- Ingredient Cost Paid
- Contract Fee Paid (dispensing fee)
- Total Amount Paid

The Ingredient Cost Paid plus the Contract Fee will equal the Total Amount Paid.

Paid Claim DUR Message Areas

The POS system will return important information regarding drug utilization review (DUR) on any paid claim that triggers a DUR clinical event. Medicaid uses the NCPDP standard on all DUR responses.

Note: See Chapter 6 for information regarding on-line DUR and required actions when a clinical event message is received.

Point of Sale Rejected and Suspended/Captured Claim Responses

Header Data Is Rejected

If an error occurs and the header information is rejected, the provider will receive a NCPDP rejection code, which is translated by the software or POS device into a short reject message. There will not be any additional information in the message areas.

For multiple prescription claims, the claim information section is repeated for each prescription. When there is an error in the header information, a header reject code will appear in the first prescription, but will also apply to the second, third and fourth prescriptions. The claims will not be further adjudicated.

Point of Sale Rejected and Suspended / Captured Claim Responses, *continued*

Claim Detail Is Rejected

When a claim is denied payment by Medicaid, the claim status will be "R." The POS system will translate Medicaid's reason for denying payment into the NCPDP 2-byte reject codes.

Note: See Appendix A in this handbook for a list of NCPDP reject codes and corrective actions.

Rejected Claim Message Area

When a claim is denied, the POS Message Area will contain the NCPDP reject code for up to 10 reasons why reimbursement for the prescription was denied. For multiple prescription claims, the claim information section is repeated for each prescription.

The Message Area is formatted as follows:

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

Note: See Appendix A in this handbook for a list of NCPDP reject codes and corrective actions.

Rejected Claims Additional Message Area

The Additional Message Area will contain the recipient's Medicaid identification number. The provider must record the recipient's ID number for future claim submissions.

RRRRRRRRRR

Example: 0123456789

When a claim is rejected for HMO coverage, the Additional Message Area will read: Patient enrolled in HMO that covers this service

Please refer the patient to call Florida Medicaid Options Help Line at (888) 367-6554 for assistance.

Rejected Claims DUR Message Area

The POS system will return important information regarding Drug Utilization Review (DUR) on any rejected claim that triggers a DUR clinical event. Medicaid uses the NCPDP standard on all DUR responses.

Note: See Chapter 6 for information regarding on-line DUR and required actions when a clinical event message is received.

Point of Sale Rejected and Suspended / Captured Claim Responses, *continued*

Duplicate Claim Response	When a claim is identified as a duplicate of a claim already paid by Medicaid, it will be denied payment and the claim status will be "D." The data fields returned on a duplicate claim response contain the same information displayed in the original paid claim response, including Authorization number and Amount Paid so the provider can verify that the claim has already been paid. Message Area will contain a duplicate NCPDP code. See Appendix A in this handbook for a list of NCPDP reject codes and corrective actions.
Captured Claim Response Deleted	Effective 1/1/2012, point of sale claims will no longer "Capture" pending determination of Medicaid eligibility. If a submitted prescription claim denies because the recipient does not appear to be Medicaid eligible, the claim will be denied.
Captured Claims Message Area	The Message Area will contain eligibility NCPDP codes. See Appendix A in this handbook for a list of NCPDP reject codes and corrective actions. The Additional Message Area will contain the recipient's 10-digit Medicaid Identification Number. RRRRRRRRRR Example: 0123456789
Description	The Remittance Advice (RA) displays the disposition of all claims processed during a claims processing cycle. The remittance advice is available through the secure provider portal at http://mymedicaid-florida.com under "Secure Information for Providers".
Role of the Remittance Advice	The Remittance Advice (RA) plays an important role in communication between the provider and Medicaid. It describes disposition of claims submitted as paid; suspended / captured; or denied. The RA provides a record of all processed transactions and assists the provider in resolving errors so that denied claims can be resubmitted. The provider must reconcile the Remittance Advice to the claim in order to determine if correct payment was received. The Remittance Advice contains one or more of the following sections, depending on the type of claims filed, the disposition of those claims, and any new billing or policy announcements: • Remittance Advice Banner Page Message • Disposition Category by Groups • Summary Section
Remittance Advice Banner Page Message	The first page of the Remittance Advice banner message contains current suggestions for avoiding problems, explanations of policy, and announcements of upcoming provider training sessions.

Point of Sale Rejected and Suspended / Captured Claim Responses, continued

Disposition Category by Groups	Claims are listed by disposition category (paid, denied, or suspended/ captured) in alphabetical order by the recipient's last name. Voids and adjustments are also listed separately.
Suspend/Captured Status	All claims in the "Suspend/Captured" status are reported each week until adjudicated as "Paid" or "Denied." If one line on a claim form suspends, then the entire claim will suspend until all of the claim lines can be adjudicated.
Summary Section	The Remittance Advice Summary Section reports the number of claim transactions, and the total payment or check amount. If the account shows a prior negative balance, it will be carried forward weekly until eliminated.

When the Recipient Has Other Insurance

Third Party Liability	If the recipient has other insurance that covers prescription drugs, Medicaid payment will be denied unless the provider indicates receipt of a third party payment or attaches a denial from the other insurance company or documentation that the other insurance company will not cover the service.
Insurance Information on the Remittance Advice	The following information is on the Remittance Advice directly under the denied claim and provides information regarding the other insurance: • Insurance carrier name, • Name of insured, • Policy number, • Insurance carrier address, • Group number, if applicable, and • Group employer name and address, if applicable.
Record Recipient Insurance Information	The provider should record other insurance coverage information reported on the Remittance Advice in the recipient's file for future use. Remittance Advice insurance information is specific to the individual recipient.

How to Read the Remittance Advice (RA)

Introduction

The Remittance Advice (RA) displays the disposition of all claims processed during the claims cycle for each provider service location. The RA may be accessed through the secure provider portal at http://mymedicaid-florida.com under "Secure Information for Providers".

The Remittance Advice lists explanation of benefits (EOB) codes to indicate why a service was denied, payment was reduced, or why the claim is suspended/captured. Multiple EOB codes can apply per detail lines. At least one code is printed next to each claim line item reported on the remittance advice. A translation of these codes is included in the EOB Reason Code section of the remittance advice. A table containing a legend with field titles and descriptions is included below, with RA examples for single ingredient and compound drug claims which are paid; denied; in process; or contain adjustments.

How to Read The Remittance Advice, *continued*

Field Title ID	***Field Title***	***Field Title Description***
1	RA #	A unique identified assigned to the remittance advice.
2	REPORT	A unique identifier for each of the two pharmacy claim types in any of the four disposition categories (either paid; denied; in process; or adjusted).
3	SERVICE DATE	The date the service was rendered; if multiple dates are billed the first date of service is the FROM date and the last date of service is the THRU date.
4	RECIPIENT NAME	The recipient's name as found on the Florida Medicaid eligibility file.
5	BILLED AMOUNT (header)	The total submitted claim charges from the claim.
6	ALLOWED AMOUNT (header)	The computed dollar amount allowable for the claim. For compound drug claims, this is the total of the individual detail allowed amounts for each drug.
7	TPL AMOUNT (header)	The computed third party liability (TPL) amount for the claim. For compound drug claims, this is the total of the individual TPL amounts for each drug.
8	CO-PAY AMOUNT	The dollar amount of recipient responsibility on a claim to be collected by the provider at the time the service is rendered.
9	PAID AMOUNT (header)	The computed dollar amount paid for the claim. For compound drug claims, this is the total of the individual detail paid amounts for each drug.
10	DATE	The date the financial cycle began.
11	PAYEE ID	A unique identifier for the billing entity receiving payment or remittance activity. This applies to a provider or a lien holder.
12	NPI ID	The National Provider Identifier number that is associated with the provider on the remittance advice.
13	CHECK or EFT NUMBER	If a check was generated, this is the check number. If the provider is an electronic funds transfer (EFT) participant, this is the control number of the EFT transaction.
14	ISSUE DATE	The date the payment or remittance advice was issued.
15	DETAIL EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. There may be up to twenty EOB codes per detail line. These codes explain why a service was denied, payment was reduced, or why the claim is in process. At least one code is printed next to each claim line item reported on the remittance advice. A translation of each code shown is included in the EOB Reason Code Section of the Remittance Advice.
16	PAID AMOUNT (detail)	The amount paid by Medicaid for the service billed by the provider.
17	TPL AMOUNT (detail)	The dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.
18	ALLOWED AMOUNT (detail)	System calculated allowed amount for the service billed.

How to Read The Remittance Advice, *continued*

Field Title ID	***Field Title***	***Field Title Description***
19	BILLED AMOUNT (detail)	The detail submitted claim charges from the claim.
20	RENDERING PROVIDER	The provider treating the patient, who may or may not be part of a provider group practice. The three digits preceding the provider number will indicate whether the number is the National Provider Identifier (NPI) or Medicaid (MCD).
21	PREV PAID DT	When a claim is denied for duplicate reason(s), the paid date and the internal control number of the original paid claim are indicated for reference.
22	REMITTANCE TOTALS	The Summary Section is used to denote the total of all claims for the provider's remittance advice including Claims Data, Earnings Data, and Current Deductions.
23	DTL	The number of the detail line that was a duplicate of the detail shown. This field is only shown when the claim detail was denied because there was a duplicate claim detail. If the entire claim denies, each detail number is not identified with this field, instead, the duplicate ICN and date will display in the header area of the remittance advice.
24	UNITS	The units of service for the claim line item. This is the units of service for which the provider is to be paid.
25	DUPLICATE ICN	The ICN of the claim that was a duplicate of the claim shown. This field is only shown when the claim header or detail was denied because there was a duplicate claim header or detail.
26	MODIFIERS	Up to four alpha or numeric 2-digit codes added to the procedure code to clarify the services or procedures that are performed on the same calendar day.
27	PROC CD	The procedure code for the service billed and up to four modifiers.
28	PL SERVICE	A 2-digit place of service code placed on health care professional claims to indicate the setting in which a service was provided.
29	HEADER EOBS	Explanation of Benefits (EOB) codes that apply to the claim or adjustment header. These codes are used to explain how the claim or adjustment was processed or priced. There could be a maximum of twenty EOB codes. These codes explain why a service was denied, payment was reduced, or why the claim is in process. At least one code is printed next to each claim header item reported on the remittance advice. A translation of these codes is included in the EOB Reason Code Section of the remittance advice.
30	PATIENT NUMBER	The provider-assigned patient account number if entered on the claim. This field can contain up to 38 characters.

How to Read The Remittance Advice, *continued*

Field Title ID	***Field Title***	***Field Title Description***
31	INTERNAL CONTROL NUMBER (ICN)	The ICN is the unique identifying number assigned to each claim submitted. The ICN is the primary number used to identify the claim in the system. The format for the ICN is RRYYJJJSSSSSS, in which: RR= Region YY=2 Digit Year (e.g. 10 for 2010) JJJ=Julian Day SSSSSS=Sequence Number Applicable regions for pharmacy claims: 10 Paper Claim 11 Paper Claim with Attachments 20 Electronic Claims without Attachments (designated for batch claims submitted electronically rather than through Point of Sale) 25 Point of Sale Claim 50 Adjustment, Non-Check Related 57 Void, Check Related 59 Point of Sale Reversal 69 Encounter Reversal 70 Encounters
32	MEDICAID ID	The recipient's Medicaid Identification number.
33	ADDRESS	The "Mail To" address of the Payee displayed in the upper left corner of the remittance advice. This address could be different from the "Home Office", "Pay-To", or "Service Location" address. If payment is issued by check, the check is sent to the "Pay-To" address.
34	ADDITIONAL PAYMENT	The amount paid to the provider, which is the difference between the original claims paid and the adjusted claims paid.
35	NET AMOUNT OWED TO STATE	The amount owed by the provider, which is the difference between the original claims paid and the adjusted claims paid.
36	PROVIDER REFUND AMOUNT APPLIED	The refund amount received from the provider and is listed under each applicable ICN.
37	ADJ RSN	The 4-digit adjustment reason code indicating the reason for adjusting the original claim. A translation of these codes is included in the EOB Reason Code Section of the remittance advice.
38	DATE SVC PERF	The date the service was rendered.
39	SURGACE	A code used to identify the tooth surface ID. Up to five surface IDs will be displayed
40	TOOTH	A code used to identify the tooth ID. Up to two IDs will be displayed
41	*V* or *VOID*	Voided claim indicator when the adjustment claim voids the original claim.
42	DISPENSE DATE	The date the pharmacy filled the prescription or provided pharmaceutical care.
44	METRIC QTY	Number of metric units of medication dispensed.
45	NDC	National Drug Code: an 11-digit number assigned by the Food and Drug Administration (FDA) which uniquely describes a product and its dose, strength, and packaging.
46	NDC DESC	The description of the drug dispensed.

How to Read The Remittance Advice, *continued*

Field Title ID	***Field Title***	***Field Title Description***
47	RX NO.	The prescription number of the drug dispensed.
48	HSID	The Health Service Identifier (HSID) is a unique number used to identify and track a claim processed through the Medicaid Pharmacy Benefits Manager Point-of-Sale System

How to Resubmit a Denied Paper Claim

Resubmission Checklist

Use the following checklist to ensure that resubmittals are completed correctly before submitting.

- Did you wait thirty days after the original submittal before resubmitting a missing claim?
- If using a photocopy of a claim, did you make sure it was legible and properly aligned?
- If you chose to fill out a new claim, did you type or print the form in black ink? Are all multi-part copies legible?
- If you have corrected or changed the original claim form, have strikeovers been corrected using correction tape on each copy? (Do not use whiteout.)
- Have you clipped all required attachments and documentation to the claim form?
- Is the claim clean of all highlighting and whiteout?
- Do you have the correct P.O. Box Number and corresponding nine-digit zip code for mailing the resubmittals? Resubmittals should be sent to the same P.O. Box 7082 as the original claim.
- Has the claim form been properly signed by the Pharmacist?

For other questions about resubmittals, please contact:

Medicaid PBM Technical Call Center for assistance with drug coverage, DUR issues or Eligibility problems, at 800- 603-1714.

Resolving an Incorrect Payment

Introduction

A provider who receives an incorrect payment for a claim or receives payment from a third party after Medicaid has made payment is required to submit an adjustment or a void to correct the payment.

Adjustment

An adjustment is needed if the correction to the payment would result in a partial refund or the claim was underpaid. Only paid claims can be adjusted.

Resolving an Incorrect Payment, *continued*

Void	A void is needed if the correction to the payment would result in a complete refund of the Medicaid payment.
All Claims Are Incorrect on the Remittance Advice	If a provider receives a payment for claims that the provider did not submit, return the check issued by the fiscal agent only when every claim payment listed on the Remittance Advice was paid to the provider in error. If the payment was made by electronic funds transfer, the provider sends a check for the refund amount to the address noted below. Make the check payable to either "Florida Medicaid" or "Agency for Health Care Administration". If the incorrect payment was made by check, the provider returns the check, with a short note of explanation, to the following address: Florida Medicaid P.O. Box 14597 Tallahassee, FL 32314-4597
Partially Incorrect Claims on the Remittance Advice	If the Remittance Advice contains some correct payments and some incorrect payments, do not return the Medicaid check. Deposit the check and file a void request for each individual claim payment that should be completely refunded to Medicaid. File an adjustment request for each individual claim payment that was partially incorrect. Claims can be voided by Point of Sale reversal transactions or the paper claim form can be used..
Incorrectly Billed or Keyed Claims	An adjustment or void request will be processed as a replacement to the original, incorrectly paid claim. All claim items on the request must be correctly completed. An adjustment or void must be for the entire amount, not for remaining unpaid amounts or units. For example, if a provider billed for and received payment for three units of a drug and should have billed for five units, the provider must void the original claim and then submit a claim for the full five units as an adjustment.
Adjustments for Keying Errors	If the pharmacy claim denial was the result of a keying error, the provider can photocopy the claim, circle the item that was incorrectly keyed, sign and date the form, and resubmit it to the fiscal agent. The provider should check to be sure that it was a keying error that caused an incorrect payment. In some cases, the claim payment must be reduced due to service limitations.

Resolving an Incorrect Payment, continued

Third Party Recovery After Medicaid Payment

If a provider receives payment from a third party after Medicaid paid the claim, the provider must submit an adjustment or void request.

A void is required if another carrier's payment was equal to or higher than Medicaid's maximum allowable amount. An adjustment is required if the other carrier's payment was less than the Medicaid maximum allowable amount.

Note: See the Florida Medicaid Provider General Handbook for information on filing adjustments to Medicare crossover claims. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com

Point of Sale Claim Reversals

Introduction

A pharmacy can void or adjust a claim paid in error by transmitting a reversal transaction through Point of Sale. The reversal transaction completely reverses the previously processed claim. The reversal appears as a credit on the next Remittance Advice.

To Reverse an Incorrect Claim

To void or adjust an incorrectly paid claim, the provider transmits a reversal and re-transmits a new, corrected claim. The provider must enter the actual dispense date, not the current date.

Only one reversal can be submitted per transaction.

The difference between the original claim and the replacement claim will be added to or deducted from the payment amount on the next Remittance Advice.

Return to Stock Reversals

Reversal transactions must also be done when a prescription has been filled, a claim has been submitted and paid, but the drugs have not been dispensed to the recipient. When a prescription is returned to stock, the provider must transmit a reversal transaction. This transaction allows the provider to remain in compliance with Medicaid regulations that prohibit the submission of claims for services that were not provided.

Reversal Transaction Data Elements

The data elements that must be entered for a claim reversal vary by the type of Point of Sale software and the telecommunications vendor.

The following data elements are required:

Pharmacy Provider Number
Date Filled
Prescription Number

Accepted Reversal Response

If the reversal has been accepted and processed, the reversal status will be "A."

Point of Sale Claim Reversals, *continued*

Rejected Reversals

If an error occurs and the reversal rejects, the reversal's status will be "R." In addition, a NCPDP reject code will be returned with the claim response. The provider must correct the error and resubmit the reversal. The rejected reversal will not appear on the Remittance Advice.

How to File a Void Request on a Paper Claim

Requirements for Filing a Void Request

A void request will be processed as a replacement to the original, incorrectly paid claim. When a claim is voided, the total payment for the original claim is deducted.

There is no time limit on submitting a void.

The provider can submit a paper void request on a legible photocopy of the original claim, or an entirely new claim.

Voiding Claims on a Paper Claim Form

When requesting a void, the provider must:

- Resubmit a photocopy of the original claim or a new claim form;
- Write in "VOID" next to the #1 in the claim section of the UCF as illustrated on the next page;
- Enter the items listed below, and
- Mail the void request to the fiscal agent for processing to:

MEDICAID PBM
Voids and Adjustment
P.O. Box 7082
Tallahassee, Florida 32314-7082

Item	Action
Adjustment or Void	Enter a "V" for a void.
Internal Control Number (ICN)	N/A
Recipient's Name	If using a new claim form, enter the recipient's last name, first name and middle initial exactly as it appears on the gold plastic Medicaid ID Card or other proof of eligibility.
Recipient's Medicaid ID No.	If using a new claim form, enter the recipient's ten-digit Medicaid ID Number. Note: See Chapter 3 of the Florida Medicaid Provider General Handbook for information on Medicaid ID numbers. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com .
Pharmacy Identification, Address & Provider Number	If using a new claim form, enter the provider's name, address, and Medicaid Provider Number.
Billing Date	If using a new claim form, it must be dated. Use the month, day, and year format: MM/DD/YY. Example: 08/21/09 for August 21, 2009.

Sample of a Void Request

I.D. 0123456789 GROUP I.D.

NAME PLAN NAME Florida Medicaid

PATIENT NAME Doe, Jane OTHER COVERAGE CODE (1) PERSON CODE (2)

PATIENT DATE OF BIRTH 01/01/1960 (MM DD CCYY) PATIENT (3) GENDER CODE PATIENT (4) RELATIONSHIP CODE

PHARMACY NAME My Florida Pharmacy

ADDRESS 111 Main Street SERVICE PROVIDER I.D. 1111111 00 QUAL (5) 05

CITY Anytown PHONE NO. (850) 555-5555

STATE & ZIP CODE FL 33333 FAX NO. (850) 555-1111

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION
EMPLOYER NAME
ADDRESS
CITY STATE ZIP CODE
CARRIER I.D. (6) EMPLOYER PHONE NO.
DATE OF INJURY (MM DD CCYY) CLAIM (7) REFERENCE I.D.

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

Void TCN 12345678910124563

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
7654321	1	01 01 2004	01 01 2004	00	30 00	30

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)
22222 1111 22	03			0	ME0022222	08

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
				47.50

INGREDIENT COST SUBMITTED	DISPENSING FEE SUBMITTED	INCENTIVE AMOUNT SUBMITTED	OTHER AMOUNT SUBMITTED	SALES TAX SUBMITTED	GROSS AMOUNT DUE SUBMITTED	PATIENT PAID AMOUNT	OTHER PAYER AMOUNT PAID	NET AMOUNT DUE
43.00								

2

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

INGREDIENT COST SUBMITTED	DISPENSING FEE SUBMITTED	INCENTIVE AMOUNT SUBMITTED	OTHER AMOUNT SUBMITTED	SALES TAX SUBMITTED	GROSS AMOUNT DUE SUBMITTED	PATIENT PAID AMOUNT	OTHER PAYER AMOUNT PAID	NET AMOUNT DUE

How to File an Adjustment Request on a Paper Claim

Requirements for Filing an Adjustment

An adjustment request is processed as a replacement to the original, incorrectly paid claim. The original payment for the claim is completely deducted. All claim items on the request must be correctly completed. An adjustment must be for the entire amount, not just for remaining unpaid amounts or units.

For example, if a provider billed for and received payment for two units and he should have billed for five units, the provider must submit a claim for the full 5 units as an adjustment.

A legible photocopy of the original claim or an entirely new claim can be used when submitting an adjustment.

The Medicaid fiscal agent must receive adjustments within one year of the date of payment.

Adjustment Instructions

When requesting an adjustment, the provider must:

- Resubmit a legible photocopy of the original claim or a new claim form;
- Write in "ADJUSTMENT" next to the #1 in the claim section of the UCF as illustrated on the next page;
- Enter the items listed on the next page;
- Ensure that the items on the adjusted claim match the items on the original claim, except for the corrections that are made and circled in black ink;
- Attach copies of the documents that were required for the original claim to the adjustment request; and
- Mail the adjustment request to the fiscal agent for processing.

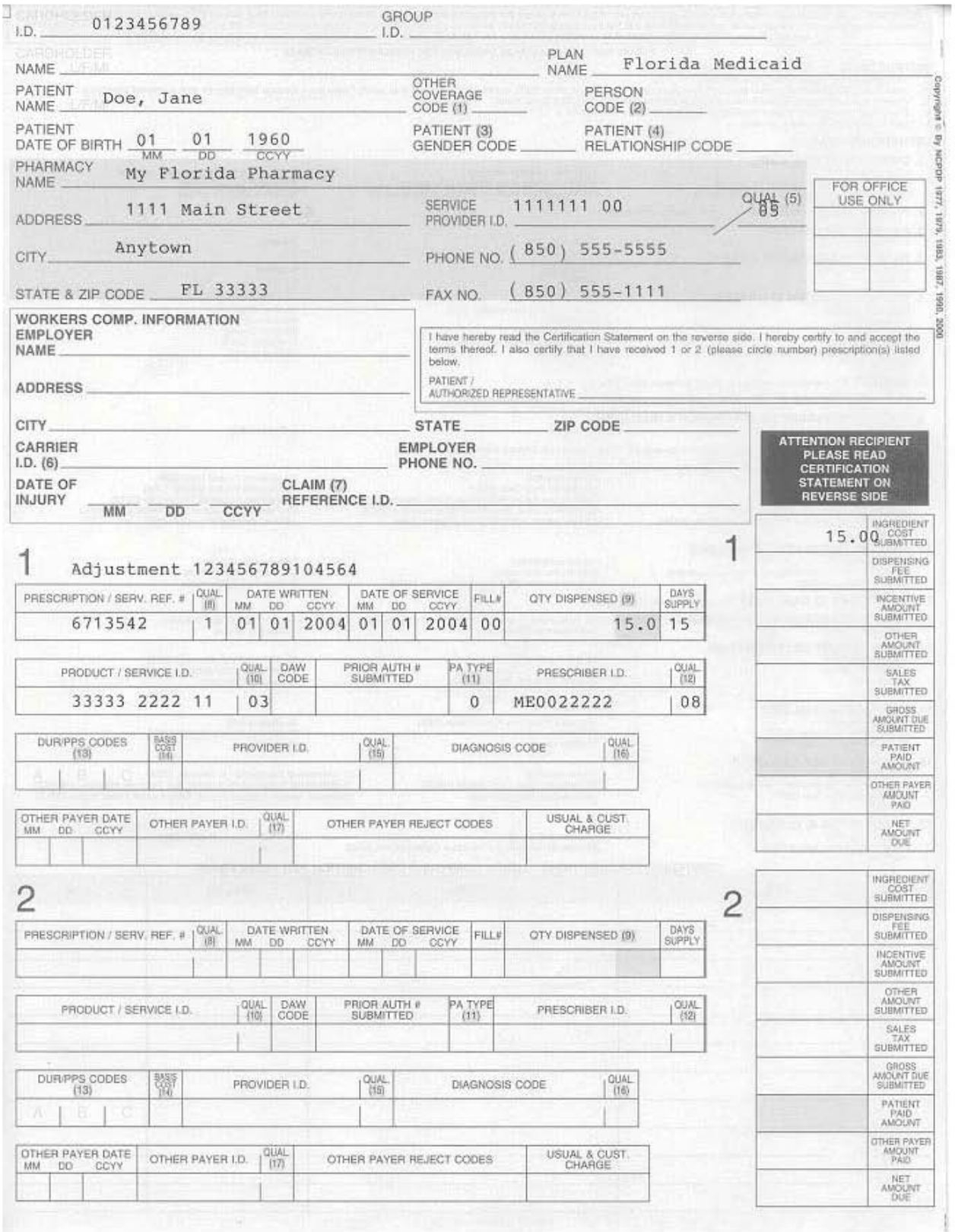
MEDICAID PBM
Voids and Adjustments
P.O. Box 7082
Tallahassee, Florida 32314-7082

Form Item	Action
Adjustment or Void	Enter an "A" for an adjustment.
Internal Control Number (ICN)	N/A
Recipient's Name	Enter the recipient's last name, first name and middle initial exactly as it appears on the gold plastic Medicaid ID Card or other proof of eligibility.
Recipient's Medicaid ID No.	Enter the recipient's ten-digit Medicaid ID Number. Note: See the Florida Medicaid Provider General Handbook for information on Medicaid ID numbers. The Florida Medicaid Provider General handbook is available at www.mymedicaid-florida.com
Pharmacy Identification, Address & Provider Number	Enter the provider's name, address, and nine-digit Medicaid Provider Number.

***How to File an Adjustment Request on a Paper Claim**, continued*

Form Item	Action
Remarks through TPL Payment	• Correct any errors or add missing information, which caused the incorrect payment; for example: wrong number of units; incorrect billed amount; or wrong NDC code. • Circle the corrected information in black ink. • If the error was because the Medicaid PBM incorrectly keyed the item(s) and the claim is correct, no correction is necessary to the original claim. However, the provider must circle the item that was incorrectly keyed in black ink. (The Remittance Advice is the record of what was keyed.) • Do not record previous Medicaid payments on the claim form for void or adjustment requests. • Each claim must be submitted on a separate claim form.
Attach Photocopy of RA (optional)	The provider may attach a photocopy of the Remittance Advice to the void or adjustment request, with the incorrectly paid claim(s) circled in black ink. This is optional.
Billing Date	If using a new claim form, it must be dated. Use the month, day, and year format: MM/DD/YY. Example: 08/21/09 for August 21, 2009.
Attachments	If the adjustment is for a claim that required any attachments, copies of the attachments must be resubmitted with the adjustment request.

Sample of an Adjustment Request



I.D. 0123456789 GROUP I.D.

NAME PLAN NAME Florida Medicaid

PATIENT NAME Doe, Jane OTHER COVERAGE CODE (1) PERSON CODE (2)

PATIENT DATE OF BIRTH 01 01 1960 (MM DD CCYY) PATIENT (3) GENDER CODE PATIENT (4) RELATIONSHIP CODE

PHARMACY NAME My Florida Pharmacy

ADDRESS 1111 Main Street SERVICE PROVIDER I.D. 1111111 00 QUAL (5) 05

CITY Anytown PHONE NO. (850) 555-5555

STATE & ZIP CODE FL 33333 FAX NO. (850) 555-1111

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION
EMPLOYER NAME
ADDRESS
CITY STATE ZIP CODE
CARRIER I.D. (6) EMPLOYER PHONE NO.
DATE OF INJURY (MM DD CCYY) CLAIM (7) REFERENCE I.D.

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1 Adjustment 123456789104564

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
6713542	1	01 01 2004	01 01 2004	00	15.0	15

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)
33333 2222 11	03			0	ME0022222	08

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

15.00	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

Requesting Help

By Telephone

The Medicaid PBM has a Pharmacy Technical Call Center which handles technical pharmacy inquiries for all pharmacy providers at (800) 603-1714.

Pharmacy Technical Call Center hours:

Monday through Friday from 7 a.m. to 6 p.m. Eastern time

Pharmacy Therapeutic Consultation Call Center

Monday through Friday from 8 a.m. to 8 p.m. Eastern time

The fiscal agent also has a Provider Inquiry Unit, which handles all non-pharmacy inquiries, recipient eligibility information, and pharmacy final payment information. To reach the Provider Inquiry unit, call (800) 289-7799, Option 2.
Provider Inquiry telephone lines are open Monday through Friday from 7 a.m. to 6 p.m. Eastern time.

Routine Inquiries

Routine pharmacy claim inquires should be mailed to:

Medicaid PBM Pharmacy Claims/Prior Authorization
P.O Box 7082
Tallahassee, Florida 32314-7082

Routine pharmacy enrollment, payment, and recipient inquiries and requests for forms and handbooks should be sent to the fiscal agent's Provider Inquiry Unit in Tallahassee at:

Florida Medicaid Fiscal Agent
Provider Inquiry Unit
P.O. Box 7054
Tallahassee, Florida 32314-7054
800- 289-7799

Getting Help On-Site

The Florida Medicaid fiscal agent has Provider Field Representatives who are located in 14 different areas throughout the state to help providers with billing questions and concerns. Field Representatives are responsible for:

- Training newly-enrolled providers
- Training new staff members at established offices
- Installing and training on electronic claims submission software; and
- Assisting the provider with claim questions

Providers who encounter problems that cannot be resolved via telephone or in writing can call to schedule an on-site visit with a Field Representative. Call the Florida Medicaid Fiscal Agent Provider Contact Center at (800) 289-7799, Option 7.

Requesting Help with Point of Sale

Introduction

Help with Point of Sale is available from the telecommunications switch vendor, the system software vendor, and the Medicaid fiscal agent. Each source helps the provider with different types of problems.

Telecommunications Switch Vendor

The provider should contact the telecommunications switch vendor for help when:

- There is a network problem;
- Response time is slow; or
- No response is being received.

System Vendor

The provider should contact the system software vendor:

- To request a software user's manual;
- To verify what value to enter in a field or how to access a field; or
- When response time is slow, if the system vendor will contact the telecommunications vendor for the provider as a service.

Medicaid PBM Pharmacy Technical Call Center

The provider should contact the Medicaid PBM Pharmacy Technical Call Center at (800) 603-1714 to:

- Confirm the receipt of submitted claims;
- Obtain a claim's status;
- Verify accuracy of transmission and response;
  Obtain information on billing procedures

Medicaid PBM Therapeutic Consultant Call Center

- Obtain Prior Authorization information
- Request Drug Inquiry
- Request Override Inquiry
- Obtain information on billing procedures;
- Verify accuracy of transmission and response

CHAPTER 6
DRUG UTILIZATION REVIEW (DUR), PATIENT COUNSELING AND ON-LINE ELECTRONIC PROSPECTIVE DUR

Overview

Introduction

Federal and state laws require that pharmacists provide the pharmaceutical care services described below with each dispensed prescription. The intent of the federal law and state regulations is to improve the quality of pharmaceutical care by ensuring that medications are appropriate, medically necessary, and not likely to have adverse medical results.

In This Chapter

This chapter contains:

Drug Utilization Review Requirements

Required Pharmaceutical Care Services

Pharmacy providers must:

- Keep patient medication records;
- Review each prescription for medical appropriateness; and
- Offer to counsel the recipient on use of the medication.

Patient Record

The pharmacy must maintain a patient record for each recipient for whom new or refill prescriptions are dispensed. The record may be electronic or paper.

The pharmacy's patient record system must enable the dispensing pharmacist to immediately retrieve all records of previously dispensed drugs when filling a new or refill prescription.

Note: See Chapter 1 for additional information on patient record keeping requirements.

Drug Utilization Review Requirements, continued

Prospective Drug Utilization Review	Prior to filling or refilling a prescription, a pharmacist or pharmacy intern must review the prescription and the patient record for therapeutic appropriateness. If there is an indication of possible drug contraindication or abuse, the pharmacist must take appropriate steps to resolve the problem, including consultation with the prescriber, if necessary.

Patient Counseling

Offer to Counsel	The pharmacist must ensure that a verbal and printed offer to counsel is made to the recipient or the recipient's representative regarding the prescription. If the prescription is delivered or mailed, the pharmacy must send a written offer to the recipient that includes a toll-free telephone number to the pharmacist.
Components of Patient Counseling	If the recipient requests counseling, the pharmacist or the pharmacy intern acting under the direct and immediate supervision of a licensed pharmacist must discuss the issues that will enhance or optimize drug therapy. The counseling should be in person if possible, or if not, by telephone. The telephone call must be toll-free for the recipient. The counseling should include the following information: • Drug name and description; • Dosage and duration of therapy; • Special directions and precautions; • Potential side effects; • Storage and refill information; and • Action to take in the event of a missed dose.
Documentation of Counseling	The pharmacist or his designee must document that counseling was offered when the prescription was dispensed. The designee can be whomever the pharmacist designates in accordance with the pharmacy's procedures. The documentation must include the following information: • The date the counseling was offered; • The prescription number; • The recipient's or his representative's signature; • An acknowledgment as to whether counseling was received or refused; and • The pharmacist's or the designee's signature or initials.

Patient Counseling, *continued*

Exceptions to Counseling Requirement	Counseling is not required for inpatients in a hospital or institution where other licensed health care professionals administer the medications.

On-Line Electronic Prospective Drug Utilization Review (Pro-DUR)

Features of Pro-DUR	Pro-DUR has the following features: • Pro-DUR provides real-time screening of all point-of-service prescription drug claims against Florida Medicaid's clinical database maintained by First DataBank, the Medicaid Prescription Benefit Manager (PBM), and the Agency for Health Care Administration (AHCA); • Pro-DUR reports "clinical events" as defined by Florida Medicaid. The events are based on extensive development research done at First DataBank and are continuously adapted by the Medicaid PBM and AHCA; and • Pro-DUR provides an on-line response to the pharmacy within seconds of significant Pro-DUR events with the disposition of the claim.
How Pro-DUR Works	The Pro-DUR system accepts POS transactions from the Medicaid claims adjudication system, and screens each prescription against the recipient's prescription profile. The profile includes the recipient's active drug products, medical problem profile, sex and age. Screening occurs using one or more of the clinical screening modules that are based upon the screening criteria defined by Medicaid. The results of the screening are returned to the claims adjudication system in the form of clinical events. The system then completes the adjudication of the claim according to Medicaid-established parameters and sends a response back to the pharmacy.

On-Line Electronic Prospective Drug Utilization Review (Pro-DUR), continued

Clinical Events

If a potential drug problem is identified, a clinical event is triggered, and the pharmacy will receive a Pro-DUR message. The Point-of-Sale (POS) system screens submitted prescription claims for the following potential drug problems:

- Compliance Monitoring—refills too early or too late;
- Prescribing Limits—excessive or inadequate dosages, or duration of therapy;
- Therapeutic Overlap—two or more prescriptions with duplicative or conflicting actions, whether prescribed by the same or different physicians;
- Drug - Drug Interactions—drugs that should not be taken concurrently;
- Drug - Disease Precautions—specific drugs that may cause harm in patients with certain known medical conditions;
- Age Precaution—warning message when use of the drug should be cautioned;
- Pregnancy Precaution—drugs with high risk of fetal harm dispensed to childbearing women; and
- Drug – Gender—drugs with risk of harm to a particular gender.

Medicaid Responses to a Clinical Event

Depending on the severity of the clinical event, Medicaid will:

- Suppress the response to the pharmacy, but report it in aggregate to Medicaid staff;
- Return the response to the pharmacy for informational purposes, not require any action, and pay the claim as submitted;
- Return the response to the pharmacy and require the pharmacist to take action and report that action in the form of a claim override. Medicaid will deny payment if the pharmacist does not correctly override the claim; or
- Deny the claim and require a prior authorization for reimbursement.

Required Action

When a Pro-DUR response is received, the pharmacist must verify the information against the patient's drug profile and current prescription, evaluate the conflict, and decide whether or not to dispense the drug. Actions can range from conferring with the patient and checking the patient's profile, to consulting with the prescriber.

If the pharmacist or recipient is unaware of any conflicting prescriptions and decides that the prescription should be filled, the pharmacist may call the Medicaid PBM Prior Authorization Help Desk at (877) 553-7481 for assistance.

On-Line Electronic Prospective Drug Utilization Review (Pro-DUR), *continued*

Required Action, continued	If the message is "therapeutic duplication", the pharmacist must determine whether the prescription should be filled, refused, or changed. "Therapeutic duplication" can be over-ridden in the pharmacy without prior authorization. Early refill responses (NCPDP 79) for refills exceeding this limit require an override action. Unless there is a plan limit for the drug, eighty percent of the most recent fill must have been consumed. Call the Medicaid PBM Prior Authorization Help Desk at (877) 553-7481 for an override of the code.

Pro-DUR Response Messages

Translating a Pro-DUR Response Message	If a clinical event is triggered by a prescription claim, the pharmacy will receive a Pro-DUR message in the response record from the POS system, using the NCPDP transmission standard field #525-FP, "DUR Response Data." Each claim record can hold up to three Pro-DUR messages of 53 bytes each. The messages have information on the conflicting prescription's fill date, quantity, and whether the previous claim had the same provider number and the same prescriber or the same prescriber as the current prescription.
Format of the NCPDP DUR Message	Each 53-byte standard DUR message is divided into eight data fields. Since the codes are standard and in fixed fields, the software vendor may translate them. Providers must contact their software vendors about the formatting and interpretation of the NCPDP standard transmission for their specific software. The data fields and their values are described below.

Format of the NCPDP DUR Message*, *continued

Positions 01-02 DUR Reason for Service Code

Positions 01-02 of the response message contain one of the following drug conflict codes:

DA	Drug allergy alert
DC	Drug-disease (inferred) precaution
DD	Drug-drug interaction
ER	Overuse precaution, early refill
HD	High dose alert
ID	Ingredient duplication
LD	Low dose alert
LR	Under use precaution, late refill
MC	Drug-disease (reported) precaution
MN	Insufficient duration alert
MX	Excessive duration alert
PA	Drug-age precaution
PG	Drug-pregnancy alert
SE	Side-effect alert
SX	Drug-gender alert
TD	Therapeutic duplication or overlap

Position 03 Clinical Significance Code

Position 03 of the response message contains one of the following clinical significance codes:

Blank = Not specified
1 = Major
2 = Moderate
3 = Minor

Position 04 Pharmacy Indicator

Position 04 of the response message indicates where the previous prescription was filled:

0 = Not specified
1 = The provider's pharmacy
2 = Other pharmacy in same chain (currently not used by Medicaid)
3 = Other pharmacy

Positions 05-12 Previous Date of Fill

Positions 05-12 of the message contain the date the previous prescription that triggered the clinical event was filled. The date is in the year, month, date format (CCYYMMDD) such as 20090821 for August 21, 2009.

Pro-DUR Response Messages, continued

Positions 13-17 Quantity of Previous Fill

Positions 13-17 of the response message contain the quantity of the previous prescription that triggered the clinical event.

Position 18 Database Indicator

Position 18 of the response message indicates the database that generated the clinical event:

Blank = Not specified
1 = First DataBank
2 = Medi-span
3 = Red Book
4 = Processor developed
5 = Other

Position 19 Other Prescriber Indicator

Position 19 of the response message indicates whether the prescriber of the previous prescription was the same or different from the current claim:

0 = Not specified
1 = Same Prescriber
2 = Other Prescriber

Positions 20-49 Free Text

Positions 20-49 contain free text that gives additional details about the clinical event. The text varies depending on the nature of the event. For example, if an early refill is detected, the free text will give the earliest date that the prescription can be refilled and whether the Rx # is the same or different. A drug-drug interaction will generate a text message of the previous drug's name and prescription number.

Pro-DUR Action Codes

Required Action

After pharmacists resolve the drug conflict, they can translate their actions or interventions into Pro-DUR action codes that define the conflict, the intervention, and the dispensing result; and enter these codes into the POS claim. If no conflict exists, do not enter any action codes.

Format of the NCPDP DUR Message

Medicaid uses the current NCPDP Version standard action codes, which consists of three components, two bytes each. Pharmacists must consult their software vendor for instructions on how to input the DUR action codes in their specific software programs.

The action codes and their values are described below.

Pro-DUR Action Codes, *continued*

DUR Reason for Service Code

The pharmacist enters the same two-character conflict code as the DUR response. If a claim has not yet been submitted, the provider should enter the applicable conflict code.

Professional Service Code

The pharmacist enters whom he or she consulted with to resolve the conflict. This field uses the number "0," not the letter.

M0	Prescriber consulted
P0	Patient consulted
R0	Pharmacist consulted another source
00	No intervention

Result of Service Code

The pharmacist enters the outcome code that indicates the result of the DUR. Outcome codes that begin with "1" indicate that the prescription was dispensed. Outcome codes that begin with "2" indicate that the prescription was not dispensed. The outcome codes are as follows:

1A	Filled, false positive
1B	Filled prescription as is
1C	Filled prescription, different dose
1D	Filled prescription, different directions
1E	Filled prescription, different drug
1F	Filled prescription, different quantity
1G	Filled prescription with prescriber approval
2A	Prescription not filled
2B	Prescription not filled, directions on other Rx clarified

Provider Responsibility

DUR action codes can be used, if appropriate, to override DUR edits that have caused a claim to deny.

Medicaid monitors the use of DUR action codes to override claim edits. Professional judgment regarding appropriate drug use is the responsibility of the pharmacist. Improper use of override codes by pharmacy staff can result in the disallowance of these claims and administrative sanctions by Medicaid and the Board of Pharmacy.

Appendix A
Pharmacy Troubleshooting Guide

Overview

Introduction

This section explains how to correct common errors that occur when completing and submitting pharmacy claims to Florida Medicaid. Its purpose is to help a provider detect or avoid mistakes found by Medicaid that delay claim payment.

In This Appendix

This Appendix contains:

General Information

NCPDP Codes

When payment is made to a provider, Medicaid provides a Remittance Advice, (RA), listing the status of any claims Medicaid has paid, denied or suspended/captured. In the far right column of the RA is the NCPDP Reject Code. This code explains Medicaid's reason for denying or pending a claim payment. On the last page of each RA is a summary section.

Errors sometimes occur because of incorrect information stored in the Florida Medicaid Management Information System (FMMIS). The FMMIS claims processing component is updated daily with any new eligibility information on recipients as well as any new policy changes. If the information stored in the FMMIS is incorrect, contact the area Medicaid office for help. Click on http://ahca.myflorida.com/Medicaid/Areas/index.shtml for a list of Medicaid Area Offices.

Point-of-Sale Rejection Messages

When a Point-of-Sale (POS) claim is rejected or captured/suspended, the provider will receive a rejection message on the POS device. The rejection codes and messages and corresponding NCPDP codes are explained under the topic, “POS Rejection Codes” in this Appendix.

Corrective Action Required

If a claim denies, the provider must correct the claim before resubmitting it. Resubmitting a denied claim without taking a corrective action will result in another claim denial. Repeated resubmission increases the provider’s telecommunications charges and Medicaid claim processing costs. Providers should become familiar with the NCPDP Reject Codes used by the Medicaid program and the necessary corrective actions noted in this Appendix.

Area Office Assistance

The corrective action for certain NCPDP Reject Codes requires the provider to contact the area Medicaid office for assistance. The addresses and telephone numbers of the area Medicaid offices may be found at http://ahca.myflorida.com/Medicaid/Areas/index.shtml .

Fiscal Agent Assistance, Provider Services Group

The corrective action for certain NCPDP Reject Codes requires that the provider contact the Medicaid PBM Pharmacy Technical Call Center. The Call Center's address and phone number are:

Medicaid PBM
P.O Box 7082
Tallahassee, Florida 32314-7082
(800) 603-1714

Correcting Keying Errors

If a fiscal agent keying error caused a paper claim to deny or pay incorrectly, the provider may either:

- Call the fiscal agent at (800) 289-7799, Option 7, and request that the claim be reprocessed (this procedure only applies to paper claims); or
- Photocopy the claim, circle the incorrectly keyed item(s), sign and date the form, and resubmit it to the fiscal agent.

Note: See Chapter 5 in this Handbook for information on resubmitting denied claims.

Point-of-Sale Rejection Codes

Introduction

POS claims processing uses the National Council for Prescription Drug Program (NCPDP) rejection codes and messages. The following chart contains the rejection codes.

Note: See "NCPDP Reject Codes and Corrective Actions" in this Appendix for information on correcting claims.

Point-of-Sale Rejection Codes, *continued*

NCPDP REJECT CODE	DESCRIPTION
01	Missing or Invalid (M/I) BIN
02	M/I Version number
03	M/I Transaction code
04	M/I Processor control number
05	M/I Pharmacy number
06	M/I Group number
07	M/I Cardholder ID
08	M/I Person code
09	M/I Birthdate
10	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Patient Location
13	M/I Other coverage code
14	M/I Eligibility Clarification Code
15	M/I Date Of Service
16	M/I Prescription number
17	M/I New-refill code
18	M/I Metric quantity
19	M/I Days supply
1C	M/I Smoker/Non-Smoker Code
1E	M/I Prescriber Location Code
20	M/I Compound code
21	M/I NDC number
22	M/I Dispense as written code
23	M/I Ingredient cost
24	M/I Sales tax
25	M/I Prescriber Id
26	M/I Unit Of Measure
28	M/I Date prescription written
29	M/I Number refills authorized
2C	M/I Pregnancy Indicator
2E	M/I Primary Care Provider ID Qualifier
30	M/I P.A/M.C. code and number
32	M/I Level of service
33	M/I Prescription origin code
34	M/I Submission Clarification Code
35	M/I Primary Prescriber ID
36	M/I Clinic Id

Point-of-Sale Rejection Codes, *continued*

38	M/I Basis of cost
39	M/I Diagnosis code
3A	M/I Request Type
3B	M/I Request Period Date-Begin
3C	M/I Request Period Date-End
3D	M/I Basis Of Request
3E	M/I Authorized Representative First Name
3F	M/I Authorized Representative Last Name
3G	M/I Authorized Representative Street Address
3H	M/I Authorized Representative City Address
3J	M/I Authorized Representative State/Prov Address
3K	M/I Authorized Representative Zip/Postal Zone
3M	M/I Prescriber Phone Number
3N	M/I Prior Authorized Number Assigned
3P	M/I Authorization Number
3R	Prior Authorization Not Required
3S	M/I Prior Authorization Supporting Documentation
3T	Active Prior Auth Exists Resubmit At Expiration
3W	Prior Authorization In Process
3X	Authorization Number Not Found
3Y	Prior Authorization Denied
40	Pharmacy Not Contracted With Plan On Date Of Serv
41	Submit bill to other processor or primary payor
4C	M/I Coordination Of Benefits/Other Payments Count
4E	M/I Primary Care Provider Last Name
50	Non-matched pharmacy number
51	Non-Matched Group ID
52	Non-matched cardholder id
53	Non-matched person code
54	Non-matched NDC number
55	Non-matched NDC package size
56	Non-matched prescriber id
57	Non-matched P.A./M.C. number
58	Non-matched primary prescriber
59	Non-matched clinic id
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch

Point-of-Sale Rejection Codes, *continued*

63	Institutionalized Patient Prod/Service Not Covered
64	Claim Submitted Does Not Match Prior Authorization
65	Patient is not covered
66	Patient age exceeds maximum age
67	Filled before coverage effective
68	Filled after coverage expired
69	Filled after coverage terminated
6C	M/I Other Payer ID Qualifier
6E	M/I Other Payer Reject Code
70	NDC not covered
71	Prescriber is not covered
72	Primary prescriber is not covered
73	Refills are not covered
74	Other carrier payment meets or exceeds payable
75	Prior authorization required
76	Plan limitations exceeded
77	Discontinued NDC number
78	Cost exceeds maximum
79	Refill too soon
7C	M/I Other Payer ID
7E	M/I DUR/PPS Code Counter
80	Drug-diagnosis mismatch
81	Claim too old
82	Claim is post-dated
83	Duplicate paid/Captured claim
84	Claim has not been captured
85	Claim Not Processed
86	Submit manual reversal
87	Reversal not processed
88	DUR reject error
89	Rejected claim fees paid
8C	M/I Facility ID
8E	M/I DUR/PPS Level Of Effort
90	Host hung up
91	Host response error
92	System unavailable/Host unavailable
93	Planned unavailable
94	Invalid message
95	Time out
96	Scheduled downtime

Point-of-Sale Rejection Codes, *continued*

97	Payor unavailable
98	Connection to payor is down
99	Host processing error
A9	M/I Transaction Count
AA	Patient Spenddown Not Met
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill Claim Type
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Package Payable Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification
B2	M/I Service Provider ID Qualifier
BE	M/I Professional Service Fee Submitted
CA	M/I Patient first name
CB	M/I Patient last name
CC	M/I Cardholder first name
CD	M/I Cardholder last name
CE	M/I Home plan
CF	M/I Employer name
CG	M/I Employer street address
CH	M/I Employer City Address
CI	M/I Employer state address
CJ	M/I Employer zip code
CK	M/I Employer phone number
CL	M/I Employer contact name
CM	M/I Patient Street address
CN	M/I Patient city address
CO	M/I Patient State Address
CP	M/I Patient zip code
CQ	M/I Patient phone number
CR	M/I Carrier ID
CT	M/I Patient social security number
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID

Point-of-Sale Rejection Codes, *continued*

DA	Drug-Allergy Alert
DC	M/I Dispensing Fee Submitted
DD	Drug-drug Interaction
DF	Drug-Food Interaction
DI	Drug Incompatibility
DL	Drug-Lab Conflict
DN	M/I Basis Of Cost Determination
DP	M/I Drug type override
DQ	M/I Usual And Customary Charge
DR	M/I Prescriber last name
DS	M/I Postage Amount Claimed
DT	M/I Unit dose indicator
DU	M/I Gross amount due
DV	M/I Other payer amount paid
DW	M/I Basis of days supply determination
DX	M/I Patient Paid Amount Submitted
DY	M/I Date of injury
DZ	M/I Claim/Reference id
E1	M/I Product/Service ID Qualifier
E2	Alternate product code
E3	M/I Incentive amount submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result Of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other payer date
E9	M/I Provider ID
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EH	M/I Compound Route Of Administration
EJ	M/I Originally Prescribed Product ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Ref Number Qualifier
EN	M/I Associated Prescription/Service Ref Number
EP	M/I Associated Prescription/Service Date

Point-of-Sale Rejection Codes, *continued*

ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EW	M/I Intermediary Authorization Type ID
EX	M/I Intermediary Authorization ID
EY	M/I Provider ID Qualifier
EZ	M/I Prescriber ID Qualifier
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
H1	M/I Measurement Time
H2	M/I Measurement Dimension
H3	M/I Measurement Unit
H4	M/I Measurement Value
H5	M/I Primary Care Provider Location Code
H6	M/I DUR Co-Agent ID
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
HF	M/I Quantity Intended To Be Dispensed
HG	M/I Days Supply Intended To Be Dispensed
ID	Ingredient Duplication
J9	M/I DUR Co-Agent ID Qualifier
JE	M/I Percentage Sales Tax Basis Submitted
KE	M/I Coupon Type
LD	Low Dose Alert
LR	Underuse Precaution
M1	Patient not covered in this aid category
M2	Recipient locked in
M3	Host PA/MC error
M4	Prescription number/time limit exceeded
M5	Requires manual claim
M6	Host eligibility error
M7	Host drug file error
M8	Host provider file error

Point-of-Sale Rejection Codes, *continued*

M9	Host provider file error
MC	Drug-Disease (Reported) precaution
ME	M/I Coupon Number
MN	Insufficient Duration Alert
MS	Host processing error
MX	Excessive Duration Alert
MZ	Error overflow
N/A	No external reject code. Internal error code only.
NE	M/I Coupon Value Amount
NN	Transaction Rejected At Switch Or Intermediary
NR	Lactation/Nursing Interaction
OH	Alcohol Precaution
P1	Associated Prescription/Service Ref No Not Found
P2	Clinical Information Counter Out Of Sequence
P3	Compd Ingr Component Cnt Not Match No. Repetitions
P4	COB/Other Payments Cnt Not Match No. Repetitions
P5	Coupon Expired
P6	Date Of Service Prior To Date Of Birth
P7	Diagnosis Code Cnt Not Match No. Repetitions
P8	DUR/PPS Code Counter Out Of Sequence
P9	Field Is Non-Repeatable
PA	PA Exhausted/Not Renewable
PB	Invalid Transaction Cnt For This Transaction Code
PC	M/I Claim Segment
PD	M/I Clinical Segment
PE	M/I COB/Other Payments Segment
PF	M/I Compound Segment
PG	M/I Coupon Segment
PH	M/I DUR/PPS Segment
PJ	M/I Insurance Segment
PK	M/I Patient Segment
PM	M/I Pharmacy Provider Segment
PN	M/I Prescriber Segment
PP	M/I Pricing Segment
PR	M/I Prior Authorization Segment
PS	M/I Transaction Header Segment
PT	M/I Workers Compensation Segment
PV	Non-Matched Associated Prescription/Service Date
PW	Non-Matched Employer ID
PX	Non-Matched Other Payer ID

Point-of-Sale Rejection Codes, *continued*

PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID
R1	Other Amt Claimed Sub Cnt Not Match No.Repetitions
R2	Other Payer Reject Count Not Match No. Repetitions
R3	Procedure Modifier Cd Cnt Not Match No.Repetitions
R4	Procedure Modifier Cd Invalid For Product ID
R5	Product ID Must Be 0 When ProductID Qualifier = 06
R6	Product/Service Not Appropriate For This Location
R7	Repeating Segment Not Allowed In Same Transaction
R8	Syntax Error
R9	Value In Gross Amt Due Not Follow Pricing Formulae
RA	PA Reversal Out Of Order
RB	Multiple Partials Not Allowed
RC	Different Drug Entity Between Partial & Completion
RD	Mismatched Cardhdr/Group ID-Partial To Completion
RE	M/I Compound Product ID Qualifier
RF	Improper Order Of 'Disp Status' Cd On Partial Fill
RG	M/I Associated Rx/Service Ref No.On Completion Txn
RH	M/I Associated Rx/Service Dt On Completion Txn
RJ	Associated Partial Fill Transaction Not On File
RK	Partial Fill Transaction Not Supported
RM	Complet'n Not Permitted On Same Service Dt Partial
RN	Plan Limit Exceeded On Intended Partial Fill Value
RP	Out Of Seq 'P' Reversal On Partial Fill Txn
RS	M/I Associated Rx/Service Dt On Partial Txn
RT	M/I Associated Rx/Service Ref No. On Partial Txn
RU	Mandatory Data Before Optional Data In A Segment
SE	M/I Procedure Modifier Code Count
SR	Suboptimal Regimen
SX	Drug-Gender Alert
TD	Therapeutic Duplication
TE	M/I Compound Product ID
UE	M/I Compound Ingredient Basis Cost Determination
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
XE	M/I Clinical Information Counter
ZE	M/I Measurement Date

09 **Missing or Invalid Birth Date**

The edit occurred because the recipient's birth date is missing from the claim or is invalid or does not match the recipient's birth date that is on the recipient eligibility file.

Corrective Action:

- Review the recipient's birth date for accuracy (MMDDYYYY).
- If it is incorrect due to provider error, enter the correct information and resubmit the claim.
- If all the fields are accurate and the provider believes the recipient's birth date on the recipient eligibility file is incorrect, he should contact the area Medicaid Pharmacy Bureau for assistance at (850) 412-4166.

23, 28 **Missing or Invalid Ingredient Cost**

Missing or Invalid Date Prescription Written

This edit occurred because the Ingredient Cost or the Date Prescription Written fields were not correctly completed.

Corrective Action:

- Review the "Ingredient Cost" or "Date Prescription Written" fields for accuracy.
- If either item is incorrect due to provider error, enter the correct information and resubmit the claim.
- If your software is not transmitting these new required fields, contact your software vendor.

DV **Invalid Other Payor Amount**

This edit occurred because the "Other Payor Amount" field is less than required.

Corrective Action:

- Review the "Other Payor Amount" and "Total Submitted Charge" for accuracy.
- If either item is incorrect due to provider error, enter the correct information and resubmit the claim.
- If all the fields are accurate, the provider should Pharmacy Technical Call Center at (800) 603-1714 for assistance.

41 **Submit Bill to Other Processor or Primary Payer**

This edit occurred because the Florida Medicaid Third Party Liability (TPL) file shows that the recipient has third party insurance coverage or Medicare that covers all or some of the charges billed.

The Remittance Advice (RA) lists the insurance carrier's name, address and policy number so that the provider can file the claim with that carrier.

Corrective Action:

- If the insurance company paid the claim and if the provider has appropriate POS software, enter a "2" in the Other Coverage Code Field (NCPDP field 308-C8), and enter the amount paid in the field called "Other Payor Amount" and resubmit the claim.
- If the insurance company paid the claim and POS isn't used or the TPL fields are not available, resubmit the claim as a paper claim, enter the amount paid in the TPL Payment Field (Item 18), and attach the receipt showing the other insurer's payment.
- If the insurance company denied the claim, resubmit the claim as a paper claim, enter "$0.00" in the TPL Payment Field (Item 18), and attach the insurance company's denial letter.
- If there is an error on the TPL file, contact the area Medicaid office for assistance.

Please refer to the Florida Medicaid Provider General Handbook information on billing Medicare, including automatic crossover to Medicaid. Medicare crossover claims are NOT billed under the pharmacy provider number. For additional information on third party liability, please refer to the Florida Medicaid Provider General Handbook at the following link http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

Corrective action:

- Review the claim for accuracy and then submit to Medicare or other third party payer. Medicare will pay the covered charges and cross the claim over to Medicaid.
- If Medicare denies the claim, complete the claim according to Medicaid billing instructions and attach Medicare's denial letter.

50 **Non-Matched Pharmacy Number**

This edit posts when the recipient is locked into a pharmacy different than the pharmacy submitting the claim. When this message posts, the recipient should be directed to the pharmacy to which he/she is assigned.

52 **Non-Matched Cardholder ID Number**

This edit occurred because the recipient's 10-digit Medicaid ID number is incorrect. The error may occur because the number is missing, is all zeros, has one or more invalid digits, or does not match a number currently on the FMMIS eligibility files. Determine the correct recipient ID number by reviewing the Point-of-Sale response in the Additional Information Area or checking the recipient's proof of eligibility.

For information on obtaining a recipient ID number, please refer to the Florida Medicaid Provider General Handbook, available on the internet at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

Corrective action:

- Review the recipient ID number for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the recipient's ID number is incorrect on the FMMIS eligibility file, contact the area Medicaid office for assistance. Medicaid Area Office locations and contact information may be found at http://www.fdhc.state.fl.us/Medicaid/Areas/index.shtml .

54 **Non Matched Product/Service ID Number**

This edit occurred because the National Drug Code (NDC) for the prescription billed is not on the FDB file on the date the prescription was filled. It also occurs when the NDC is invalid.

If the NDC code is correct and should be covered by Medicaid, the provider can request the addition of the drug to the FDB by calling the Medicaid Pharmacy Bureau at (850) 412-4166. If the drug is added to the FDB directory, the provider can then resubmit the claim.

Corrective Action:

- Review the NDC code for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the NDC is for a drug that is not covered by Medicaid, Medicaid cannot pay the claim. No further action is necessary.

56 **Non Matched Prescriber ID**

This edit occurred because the prescriber's Florida professional license number on the claim does not match a valid license number. The license numbers are issued by the Department of Health, Division of Medical Quality Assurance, and Medical Boards. Providers may access the Florida Department of Health website at http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP to check licensure.

Please see Chapter 3 for information on license numbers. The system will not accept DEA numbers or the prescriber's name. The provider should review the records for the valid license number or contact the prescriber if necessary.

Corrective action:

- Review the license number for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the license number is unavailable, call the Bureau of Pharmacy Services at (850) 412-4166 for assistance.

Note: Medicaid will not process claims for prescriptions written by a prescriber who has been terminated from Medicaid or Medicare or whose prescribing rights were terminated by the PPRP committee for cause.

67 **Filled Before Coverage Effective**

The edit occurred because the recipient ID number is not active on the FMMIS eligibility file. The claim will pend in a suspense file for 14 days, and be matched automatically once a week against the eligibility file to determine if the recipient ID number was added. If the recipient ID number is not on the FMMIS eligibility file after 14 days, the claim will be denied.

If the provider is billing through POS and has proof of the recipient's eligibility for the date of service, the provider may enter the Eligibility Override Code and resubmit the claim. This will allow the claim to pend for 14 days to determine if the recipient's eligibility for the date of service has been added.

To determine if the recipient's ID number is correct, the provider should review the Point-of-Sale response in the Additional Information Area or check the recipient's proof of eligibility. For information on obtaining a recipient ID number, please refer to the Florida Medicaid Provider General Handbook, which may be accessed on the internet at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

69 **Filled After Coverage Terminated**

This edit occurred because the recipient's Medicaid ID number entered on the claim form is not active in the FMMIS eligibility file, and the claim has been denied after 14 days of being pended with no match found.

To determine if the recipient's ID number is correct, the provider should review the Point-of-Sale response in the Additional Information Area or check the recipient's proof of eligibility. For information on obtaining a recipient ID number, please refer to Florida Medicaid Provider General Handbook.

Corrective Action:

- Review the recipient ID number for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the recipient ID number is incorrect on FMMIS, contact the area Medicaid office for assistance.

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70 **NDC not covered**

This edit occurred because the National Drug Code (NDC) for the prescription billed is not a covered drug on the date the prescription was filled.

If the NDC code is correct and should be covered by Medicaid, the provider can request the addition of the drug to the FDB by calling the Medicaid Pharmacy Bureau at (850) 412-4166. If the drug is added to the FDB directory, the provider can then resubmit the claim.

Corrective Action:

- Review the NDC code for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the NDC is for a drug that is not covered by Medicaid, Medicaid cannot pay the claim. No further action is necessary.

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71 **Prescriber is not Covered**

This edit posts when a prescriber's privileges are restricted for the medication on the claim.

Corrective Action:

The pharmacy should contact the prescriber and direct them to contact Medicaid Contract Management at (850) 922-2726 for resolution.

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75 **Prior Authorization Required**

This edit occurred because the provider submitted a claim for a prescription that requires prior authorization and there is not a current prior authorization approval on the file. Please see Chapter 2 in this handbook for information on prior authorization.

For pharmacy prior authorization, the provider does not enter a prior authorization approval number on the claim form. When the prior authorization is approved, the recipient's Medicaid Profile will be updated in the claim system.

Corrective Action:

- Call the Pharmacy Technical Call Center at (800) 603-1714 to inquire about the prior authorization status. The provider must have the recipient's ten-digit Medicaid identification number available.
- If prior authorization was approved for the prescription, the provider may resubmit the claim for payment.
- If prior authorization was not approved for the prescription, Medicaid cannot pay the claim. No further action is necessary.
- Prior authorization may be resubmitted with additional information.

76 **Plan Limitation Exceeded**

This edit occurred because the claim has exceeded a limitation such as duration of therapy; a quantity limit; or a maximum number of fills that will be reimbursed by Medicaid, or the total of the days supplied on the current claim and any previously paid claims exceed this maximum allowed limit for a time period.

Corrective Action:

- Review the claim for accuracy, particularly quantity dispensed and days supplied.
- If any of the items are incorrect due to provider error, enter the correct information and resubmit the claim.
- Review the recipient's profile for previous claims for that therapy and check the product labeling for recommended therapy limits. If the current prescription exceeds those limits, a prior authorization may be submitted for review.

81 **Claim Too Old**

This edit occurred because a clean claim was received more than 12 months after the date the prescription was dispensed. For information on the 12-month filing limit, please refer to Chapter 3 of this handbook.

Corrective action:

- Review the date of service for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim. If resubmitting on paper UCF, date format is MM/DD/YY.
- If service was provided more than 364 days before the claim was submitted and an exception is not granted, Medicaid cannot reimburse the claim. No further action is needed.

82 **Claim is Post-Dated**

This edit occurred because the date the prescription was dispensed on the claim is later than the date the claim was billed. This error is most commonly an omitted year or incorrect year. The date must be entered in a mm/dd/yyyy format, for example 08/21/2009. For information on the date of service, please refer to the Chapter 3 of this handbook.

Corrective action:

- Review the date for accuracy.
- If it is incorrect due to provider error, enter the correct information, and resubmit the claim.

Note: If resubmitting the claim on the UCF, the date format is MM/DD/YY.

83 **Claim Duplicate Found**

This edit occurred because the claim is a duplicate of a previous claim (same provider, recipient, drug, and service date) that was already paid or captured/suspended.

The date of the Remittance Advice (RA) for the previous claim is listed on the RA for the duplicate claim. If the previous date is “00/00/00,” the claim was either paid or pended on the same RA as the duplicate claim. If the claim has already been paid, Medicaid cannot reimburse the duplicate claim. No further action is needed.

Corrective action:

- Review the recipient’s Medicaid ID number, NDC code, and date the drug was dispensed for accuracy.
- If any of the items are incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the error is on the FMMIS claims history file, contact the area Medicaid office for assistance.

83 **Claim Duplicate - Different Pharmacy Provider**

This edit occurred because the claim is a duplicate of a previous claim that was paid to a different provider for the same recipient, drug, and service date. If a claim for the prescription has already been paid, Medicaid cannot reimburse the duplicate claim. No further action is needed.

Corrective action:

- Review the recipient's Medicaid ID number, NDC code, and date of service for accuracy.
- If any of the items are incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the error is on the FMMIS claims history file, contact the Medicaid PBM at (800)603-1714 for assistance.

88 **DUR Reject Error—Early Refill**

This edit occurred because the recipient has another prescription claim for the same drug and the existing supply of the drug has not been exhausted.

Corrective Action:

- Review the recipient's prescription history to determine current medications on hand.
- If the existing supply is sufficient, the new prescription should not be dispensed. No further action is needed.
- If the previous prescription supply has been exhausted due to a dosage increase ordered by the recipient's physician, call the Medicaid PBM Pharmacy Technical Call Center at 800-603-1714 for an override and resubmit the claim. Some restrictions apply. If a drug requires a prior authorization a new PA can be submitted.

Note: See Chapter 6 for information regarding on-line DUR.

88 **DUR Reject Error—Therapeutic Duplication**

This edit occurred because the recipient has another active prescription claim for a drug with similar or overlapping therapeutic actions. The DUR message will indicate whether the previous prescription was from the same or a different prescriber and the same or different pharmacy, along with the date that it was filled.

Corrective Action:

- Review the recipient's prescription history to determine current medication regimen.
- Consult with the physician(s) if necessary to determine if duplicative or overlapping therapy is desired.
- If, after reviewing the DUR information, the physician and pharmacist agree that duplicative therapy is medically indicated for the recipient, override the code and resubmit the claim.
- If the existing supply of medication is sufficient and duplicative therapy cannot be justified, the new prescription should not be filled. No further action is necessary.

Note: See Chapter 6 for information regarding on-line DUR.

EE **Missing or Invalid Compound Ingredient Drug Cost**

The edit occurred because insufficient manual pricing information for a drug on a compound prescription was entered on the claim. Please see Chapter 3 in this handbook for information on entering compound drugs on the claim form. The provider must enter the names of drugs used, the NDC codes and the quantities of each.

Corrective Action:

- Review the claim for accuracy.
- If any of the items are incorrect due to provider error, enter the correct information, and resubmit the claim.
- If any of the items are incorrect due to keying error, either:
- Call the Medicaid PBM at (800) 603-1714 and request that the claim be reprocessed; or
- photocopy the claim, circle the items that were incorrectly keyed, sign and date the form, and resubmit it to the Fiscal Agent.

EF **M/I Compound Dosage Form Description**

This edit posts when a completion fill is being billed prior to a partial fill being dispensed. The correct sequence is to bill a partial fill followed by a completion fill.

EF **M/I Compound Dosage Form Description Code**

This edit posts when a missing/invalid dosage form is submitted on a compound claim.
Valid values for this field are:
01=Capsule
02=Ointment
03=Cream
04=Suppository
05=Powder
06=Emulsion
07=Liquid
10=Tablet
11=Solution
12=Suspension
13=Lotion
14=Shampoo
15=Elixir
16=Syrup
17=Lozenge
18=Enema

EH **Missing or Invalid Compound Route of Administration**

This edit posts when a missing/invalid compound unit dispensing form indicator is submitted on a compound claim.

NCPDP Codes and Corrective Action, *continued*

EH **Missing or Invalid Compound Route of Administration**

This edit posts when an incorrect compound route of administration is submitted on the claim.

Valid values for this field are:
1=Buccal
2=Dental
3=Inhalation
4=Injection
5=Intraperitoneal
6=Irrigation
7=Mouth/Throat
8=Mucous Membrane
9=Nasal
10=Ophthalmic
11=Oral
12=Other/Miscellaneous
13=Otic
14=Perfusion
15=Rectal
16=Sublingual
17=Topical
18=Transdermal
19=Translingual
20=Urethral
21=Vaginal
22=Enteral

E4, E5, E6

Missing or Invalid (M/I) Reason for Service Code/ M/I Professional Service Code/M/I Result of Service Code

These edits occur because the DUR action codes were not entered on the claim correctly. The fields for DUR Conflict, Intervention and Outcome have valid sets of values that are defined by the National Council for Prescription Drug Programs (NCPDP). All three fields must be correctly entered. These edits also occur when DUR action codes are entered when none are needed.

Corrective Action:

- Review the DUR Action Codes for accuracy.
- If any of them is incorrect or missing, enter the correct value(s) and resubmit the claim.
- If the DUR action codes have been entered on a claim when no DUR conflict is present, remove the codes from the claim and resubmit.

Note: See Chapter 6 for information regarding on-line DUR or call your software vendor for assistance. .

E7

Missing or Invalid Quantity Dispensed

This edit posts when there is a quantity error on the pharmacy claim. When this edit posts, the pharmacist needs to verify that the quantity submitted is correct according to the presciber's directions, quantity dispensed and the NDC involved.

M1

Patient not Covered in this Plan

The edit occurred because a pharmacy claim was submitted for a Qualified Medicare Beneficiary (QMB), SLMB or Q1I. QMBs are Medicare eligible and Medicaid pays for their Medicare premiums, deductibles and coinsurances. QMBs, SLMb's and Q1I are not eligible for any Medicaid services, including prescribed drugs.

For additional information on recipient eligibility groups, see the Florida Medicaid Provider General Handbook , available on the internet at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

If the recipient is not eligible for Medicaid under another coverage group, Medicaid cannot reimburse the prescribed drugs. No further action is necessary.

M1

Patient not Covered in this Aid Category

The edit occurred because on the date of service the recipient was enrolled in a health maintenance organization (HMO) that covers the service. For information on HMOs, please refer to Chapter 1 of this handbook. For information on verifying a recipient's HMO enrollment, please refer to the Florida Medicaid Provider General Handbook, available on the internet at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf .

Corrective Action: Contact the HMO to determine if it will reimburse the service.

M4

M4 Prescription/Service Reference Number/Time Limit

This edit occurred because the date the prescription was dispensed is more than 365 days after the date of another paid prescription claim for the same recipient with the same prescription number. State and federal laws prohibit refilling a prescription more than one year or 180 days if a controlled substance or five refills after it was written.

Corrective action:

- Review the date and the Rx # for accuracy.
- If either of the items is incorrect due to provider error, enter the correct information, and resubmit the claim.
- If the original prescription is over one year old, Medicaid cannot reimburse the claim. No further action is needed.

PZ

Non-Matched Unit of Measure to Product/Service ID

This edit occurred because the drug quantity submitted on the claim was outside Medicaid's established parameters for appropriate dispensing. It also may occur when the provider is using incorrect billing units on the claim, for example, billing a tube of cream as a quantity of "1" instead of "15" grams.

Corrective Action:

- Review the drug quantity, day's supply and NDC for accuracy, particularly the appropriate units of measurement to state the quantity of drug. Check the prescription and the drug compendia for appropriate dosing and maximum dose per day.
- If any of the items are incorrect due to provider error, enter the correct information and resubmit the claim.
- If the prescription's dosing is outside Medicaid's parameters, consult with the prescriber concerning the recipient's drug regimen.

RB

Multiple Partials Not Allowed

This edit posts when multiple partials fills are submitted. A partial fill should always be followed by a completion fill.

RM	**Missing or Invalid Associated Prescription/Service** This edit posts when a completion fill is submitted with the same DOS as the partial fill. If the medication is available for the completion fill on the same day as the partial fill, the partial fill claim should be voided and the entire prescription should be billed.
Captured/ Suspended	**Claim is Pending** This edit advises the provider that the Fiscal Agent has suspended/captured the claim for further research. The determination of whether to pay or deny the claim will appear on a future Remittance Advice. No action is necessary by the provider until the Fiscal Agent pays or denies the claim. If it is nearing 12 months from the date of service, the provider should send a letter of explanation and a clean copy of the claim to the area Medicaid office for a date stamp that will serve as proof that the claim was received before the 12-month filing limit.

APPENDIX B

Questions Frequently Asked by Point-of-Sale Users

1. The screen says “No response from Medicaid PBM.” What is happening?

This situation occurs when the telecommunication switch is unable to make contact with the Medicaid PBM’s Data Center. The possible explanations include:

- The telecommunications switch is malfunctioning. Contact the software vendor or the telecommunications switch vendor.
- The PBM Data Center is not operational due to maintenance or emergency downtime. Repeat Point-of-Sale attempt later in the day.

2. The provider filled a prescription and submitted the claim through Point-of-Sale, but the patient never came in to pick it up. What should the provider do?

The provider must void the claim. This can be done through a Point-of-Sale reversal transaction. See Chapter 5 in this handbook for reversal transaction procedures.

3. What action should a provider take when a Medicaid recipient has a temporary proof of Medicaid eligibility that is valid for the month, but the Point-of-Sale claim is denying for “Recipient not on File”?

If the recipient information is not yet entered into the Florida Medicaid Management Information System (FMMIS), the claim will be denied. If, however, the recipient has proof of eligibility, the provider may override the eligibility edit. To override the eligibility edit, enter a “2” or the code the system vendor instructed the provider to enter in the “Eligibility Clarification Code” field. This will allow the claim to pend in a suspense file for 14 days, and be matched automatically against the eligibility file to determine if the recipient’s eligibility for the date of service has been added. If the recipient’s eligibility for the date of service is not on the FMMIS after 14 days, the claim will be denied.

Please retain a copy of the proof of eligibility. If the claim denies after the 14-day pend period, the provider can submit a copy of the claim and the proof of eligibility to the Medicaid area office for their assistance in determining if the claim should be paid.

4. A Medicaid recipient does not have a Medicaid Identification card or other proof of eligibility. Should the pharmacy fill the prescriptions?

If the provider knows either the recipient’s ten-digit Medicaid identification number and can verify identity with a photo identification or the eight-digit plastic ID card control number, the claim can be submitted through the Point-of-Sale system. The Point-of-Sale response will notify the provider of the recipient’s eligibility status before the drugs are actually dispensed. If the claims are adjudicated as payable, then the recipient is eligible and services will be reimbursed.

Providers may also verify eligibility by accessing the Medicaid fiscal agent’s web portal at http://mymedicaid-florida.com . Click on Secure Information for Providers, then Recipient Eligibility. The provider must be enrolled with Medicaid and have a PIN number that allows access to the web portal. Recipient eligibility can be accessed by the card control number, the Medicaid Identification number, or the social security number and date of birth.

If the claims are rejected for recipient ineligibility, then the recipient must produce a valid proof of eligibility. If the recipient has proof, the rejected claim may be resubmitted using the eligibility override feature. If no proof is available, the recipient is probably not eligible and Medicaid will not reimburse the claims. The provider should refer the recipient to the local Department of Children and Families office. officeoffice.resolve his or her eligibility problem.

Note: See the Florida Medicaid Provider General Handbook for information on recipient eligibility.

5. A Medicaid recipient presented a gold, plastic Medicaid card. The number on the card is different from previous Medicaid ID numbers. How are claims submitted?

The number on the card is the card control number, not the recipient's Medicaid ID number. Medicaid recipients are issued permanent gold, plastic identification cards. The recipient may become ineligible after the card was issued, so possession of a card is not proof of eligibility. On the front of the plastic card is an eight-digit card control number that is unique to that recipient. That card control number allows providers to access FMMIS to determine recipient eligibility. The provider may enter either the card control number or the recipient's ten-digit identification number to submit Point-of-Sale claims.

Note: See the Florida Medicaid Provider General Handbook at www.mymedicaid-florida.com for information on recipient eligibility.

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6. Will the provider be charged a transaction fee each time a claim is submitted?

The Medicaid PBM does not charge a Transaction Fee to Medicaid providers. The pharmacy should contact their switching company/and or software vendor to determine if there are any fees for their services.

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7. If the provider processes a claim via Point-of-Sale, and then realizes that an item was entered incorrectly, such as days' supply, recipient identification number, etc., how can the provider correct the error without billing Medicaid twice?

In order to correct a claim on Point-of-Sale, the provider must reverse the transaction. See Chapter 5 in this handbook for claim reversal transaction procedures. Once the provider has reversed (or "voided") the incorrect claim, the provider can resubmit a new, correct claim via Point-of-Sale. Please note that claim adjustments, as described in Chapter 5 in this handbook, cannot be processed through Point-of-Sale. Incorrectly paid claims must be completely reversed, and then the corrected claim resubmitted.

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8. What action does the provider take when the claim is denied for rejection code 83, duplicate claim?

NCPDP rejection code 83, duplicate claim. The provider may receive this error code when a claim for the same drug for the same recipient has already been paid by the claim processing system. The provider may receive this edit when attempting to resubmit a claim and is unaware that it has already been paid. The provider may also receive this edit if the recipient has already had a similar prescription filled at another pharmacy. Check with the recipient and do not dispense the medication.
