October 1, 2020 Medicaid Pharmacy Provider Manual

Wyoming Department of Health

Division of Healthcare Financing

CHANGE HEALTHCARE

Final, Revision 23, October 1, 2020

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SECTION 1. PROVIDER RELATIONS INFORMATION

Change Healthcare Wyoming POS Help Desk/Provider Relations Department:
Phone: 877-209-1264
Times: Monday – Friday 8:00 AM – 5:00 PM MT

Change Healthcare Wyoming Prior Authorization (PA)/Pharmacy Appeals/Clinical Call Center:
Phone: 877-207-1126
Times: Monday – Friday 8:00 AM – 5:00 PM MT
Fax: 866-964-3472 (Fax PA System available 24/7)

Change Healthcare Wyoming Mailing Address:
PO Box 21719
Cheyenne, WY 82003

Provider inquiries regarding client inquiries:
Conduent Provider Relations Unit inside Cheyenne:
307-772-8402
Outside Cheyenne: 800-251-1269
Fax: 307-772-8405

Provider Inquiries regarding health care policy:
Conduent Provider Relations Unit inside Cheyenne:307-772-8401
Outside Cheyenne: 800-251-1268
Fax: 307-772-8405

Provider Inquiries regarding AIDS Drug Assistance Program
ScriptGuide RX Help Desk
855-367-7479

Change Healthcare Processor Control Number (PCN)/Benefit Identification Number (BIN):
PCN Number: WYOPOP
BIN Number: 014293
Current National Council for Prescription Drug Programs (NCPDP) standard version

Wyoming Medicaid Customer Service Center:
Phone: 855-294-2127
Fax: 855-329-5205
TTY/TDD: 855-329-5204
https://health.wyo.gov
Email applications to: wesapplications@wyo.gov

Wyoming Medicaid Customer Service Center Address:
3001 E. Pershing Blvd., Suite 125
Cheyenne, WY 82009

Change Healthcare Wyoming Pharmacy Care Management Program (PCM) Department:
Phone: 877-209-1264 ext 51058
Times: Monday-Friday 9:00 AM -4:00 PM MT

SECTION 2. PRESCRIPTION SERVICES

- Prescription services may be provided by and reimbursed to a licensed enrolled retail pharmacy upon the order of a licensed practitioner allowed to prescribe medications.
- A licensed pharmacist or pharmacy intern(s), under the direct supervision of a licensed pharmacist, must provide prescription services, such as medication counseling, prescription verification, dispensing verification, etc.

MEDI-SPAN® PRODUCT INFORMATION

According to the Centers for Medicare and Medicaid Services (CMS), "the Medicaid drug rebate program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients".

Please note that even though a product may be listed as covered by Medicaid (such as catheters), a particular manufacturer's product may not be covered if the manufacturer has not submitted all product information to Medi-Span®. It is the manufacturer's responsibility to submit their product information to Medi-Span®.

If a pharmacy is aware of a product that is believed to be covered by Medicaid, but is not accepted by the system because the product information is not listed in Medi-Span®, please contact the manufacturer of the product to forward necessary information to Medi-Span®. Sometimes the manufacturer is unwilling to give all the necessary information (usually pricing information) to Medi-Span®; therefore their product will not be covered.

WYOMING MEDICAID SERVICE AREA

All out-of-state provider enrollment applications will be subject to the application of the "Wyoming Medicaid Service Area" (WMSA) rule, as referenced in Wyoming Medicaid Rules Chapters 3 (Provider Participation). Out-of-state providers must meet the requirements of all applicable sections to be eligible to participate as a Wyoming Medicaid Pharmacy Provider.

LEGEND DRUGS

LEGEND DRUGS MAY BE COVERED ONLY IF (ALL PLANS)

- Ordered by a licensed prescribing provider;
- The prescriber ordering prescriptions for Schedule II-V drugs has a valid Drug Enforcement Administration (DEA) number;
- The drug manufacturer has signed the rebate agreement with the Centers for Medicare and Medicaid Services;
- The product has been assigned a National Drug Code (NDC) number;
- The drug manufacturer has submitted all product data to Medi-Span®; and
- The drug is not a Less-than–Effective Drug Efficacy Study Implementation (DESI) drug.

LEGEND DRUG EXCLUSIONS (ALL MEDICAID PLANS)

- Anorexiant products
- Androgenic or anabolic steroids used for weight gain
- Agents used to promote fertility
- Acne agents for clients who are 21 years of age or older
- Agents used for the stimulation of hair growth
- Erectile dysfunction medications
- DESI, as well as similar, related or identical drugs considered to be less effective by the Food and Drug Administration (FDA)
- Compound prescriptions, which include a DESI drug, will deny (refer to Compound Drugs section of this manual for instructions on billing non-DESI ingredients.)
- Promethazine for children 2 years of age and younger
- Medications not approved by the FDA

INJECTABLE MEDICATIONS

Only those injections that are either self-administered by the client or are administered for the client at the client's place of residence are reimbursable. Injections that are to be administered in a clinical setting are not reimbursable through the outpatient pharmacy drug program.

DRUG EFFICACY STUDY IMPLEMENTATION DRUGS

Less-than-Effective DESI drugs (class 5), as well as similar, related or identical drugs considered being less than effective by the FDA and compound prescriptions, which include a DESI drug, are not covered. Claims submitted via the Point-of-Sale (POS) system for a DESI drug will immediately deny. For paper claims, if there are any questions as to DESI status, contact the Change Healthcare POS help desk at 877-209-1264.

NON-FDA APPROVED INDICATIONS

In order to ensure that claims for non-FDA approved indications (off-label use) are appropriate with regard to the current policies of the Division of Healthcare Financing, Pharmacy Services; the following procedures should be followed:

- Review the client's clinical background.
- Ascertain that all reasonable conventional therapy has been tried and failed.
- Establish that the client has ongoing conditions that present significant risk.
- Verify the client is under close medical supervision, with well qualified prescriber(s).
- Research the prescribed therapy to be certain it meets scientifically objective thresholds, and is not "experimental therapy."
- Communicate with the prescriber to be sure the therapy will be closely monitored.

OVER-THE-COUNTER DRUGS

OVER-THE-COUNTER DRUGS MAY BE COVERED ONLY IF (EXCLUDES MEDICAID PLANS 191 AND 291)

- Ordered by a licensed prescribing practitioner;
- Furnished to a client who is NOT residing in a nursing facility;
- The product has been assigned a NDC number;
- The drug manufacturer has signed the rebate agreement with the Centers for Medicare and Medicaid Services;
- The drug manufacturer has submitted all product data to Medi-Span®; and
- It is listed below as a covered product.

COVERED OVER-THE-COUNTER DRUGS (EXCLUDES MEDICAID PLANS 191 & 291)

The following over-the-counter (OTC) drug/therapeutic classes may be covered in a limited capacity. Not all products within a drug/therapeutic class are guaranteed to be covered. Covered products are listed at http://wymedicaid.org.

- Analgesic/non-steroidal anti-inflammatory drug (NSAID) medications (oral)
- Antacids/heartburn medications
- Antidiarrheal medications
- Allergy medications
- Contraceptives
- Cough and cold products, please refer to the OTC list at http://wymedicaid.org
- Insulin
- Laxatives
- Smoking cessation products
- Topical agents (topical antibiotics, antifungals, antiparasitics, and anti-inflammatories)

ADDITIONAL OVER-THE-COUNTER COVERAGE

Additional OTC drugs may be covered, if they are medically necessary, allowed by CMS, and if their use will reduce the cost of therapy when compared to a prescription drug therapy. A prescriber or a pharmacist on behalf of a prescriber may submit a request for coverage in writing to:

Wyoming Department of Health
Division of Healthcare Financing, Pharmacy Services
6101 Yellowstone Ave., Suite 210
Cheyenne, WY 82002

The Division of Healthcare Financing, Pharmacy Services will determine if the OTC drug is medically necessary, allowed by CMS, and will benefit several clients. If approved, Change Healthcare will add the product to the OTC formulary. Prescribers and pharmacies will be notified in writing of the coverage determination by the Division of Healthcare Financing, Pharmacy Services.

CONTRACEPTIVE DEVICES

Contraceptive devices (such as Nexplanon, Implanon, Skyla, Paragard and Mirena) are not covered by Wyoming Medicaid through the pharmacy point-of-sale system. Claims for these products must be submitted to the medical side. Please call Conduent at 1-800-251-1269 for further information.

INFANT FORMULA (ALL MEDICAID PLANS)

Medicaid does not normally cover infant formulas for infants three (3) years and under because they are provided through the Women, Infants, and Children (WIC) program. Eligible Medicaid clients who are also eligible for the WIC program should obtain formula through the WIC program. Any formula not provided by the WIC program, or units prescribed that exceed program benefits may be eligible for coverage through the Medicaid Pharmacy Program. Coverage requests should be submitted on a PA form and faxed to the Change Healthcare pharmacy help desk at 866-964-3472.

MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

DURABLE MEDICAL EQUIPMENT MAY BE COVERED ONLY IF (EXCLUDES MEDICAID PLANS 191 AND 291)

- Ordered by a licensed prescribing practitioner;
- Furnished to a client NOT residing in a nursing facility;
- The manufacturer has submitted all product data to Medi-Span®; and
- It is listed below as a covered product and does not exceed coverage limits.

COVERED DURABLE MEDICAL EQUIPMENT PRODUCTS (EXCLUDES MEDICAID PLANS 191 AND 291)

The following durable medical equipment (DME) products may be billed through the pharmacy program (see plan exceptions):

- Allergy syringes – max days supply = 100
- Asthma spacers, nebulizers, spirometers – max quantity = 1 per year
- Diabetic supplies
  - Test strips, control solution, alcohol swabs, lancets, insulin syringes – max days supply = 100
  - Monitor, lancet devices – max quantity = 1 per year
- Food thickeners – max days supply = 34
- Gloves (latex, surgical) – not cotton – max days supply = 100
- Catheters: max of 10 per day, and a max of 34 day supply at one time
- Irrigation supply – max days supply = 34
- Ostomy and urologic supplies – max days supply = 100
- Sharp containers – max quantity = 1 per year

Additional DME products may be covered under the Medicaid Medical Supplies Program. For information on enrolling as a Medical Supplies Provider, contact Conduent at 800-251-1268.

NOTE: All medical supplies used by clients residing in a nursing facility are included in the nursing facility's per diem rate and will not be reimbursed separately.

PRESCRIPTION LIMITS

NUMBER OF PRESCRIPTIONS ANNUALLY

There are no limits on the number of prescriptions a Medicaid client can receive. All prescriptions must be medically necessary.

TIMEFRAME TO FILL PRESCRIPTIONS

Schedule II-V prescriptions must be filled within six (6) months of the date the prescription was written. All other prescriptions are only valid for one year from the date written, including OTC prescriptions. Prescriptions must be renewed annually. Refills for Schedule II prescriptions are not allowed.

DISPENSING LIMITATIONS

Days supply: A prescription's days supply must equal the quantity of drug dispensed divided by the daily dose prescribed. A prescription claim will be subject to subsequent recovery and further audit proceedings if:

(i) The days supply submitted is not supported by the dosing direction as prescribed;
(ii) The dosing directions are given as "take as directed" and the pharmacist has not taken appropriate action to obtain and document on the prescription the actual dosing directions given by the practitioner;
(iii) Extra doses are being billed. The Wyoming Medicaid Pharmacy Program does not pre-emptively pay for extra doses in the anticipation of lost or wasted medication or for any other reasons; or
(iv) The dispense date submitted is not the date the pharmacy dispensed the medication to the client.

PLEASE NOTE:

- All prescriptions written with PRN dosing or use as directed must be verified with prescribing entity in order to obtain an actual dosing regimen for days supply calculation. This must be documented on the prescription hard copy.
- The days supply calculation must equal the number of doses given divided by the dosing regimen. For example, ninety (90) tablets given three (3) times a day must be billed as a thirty (30) day supply.
- Wyoming Medicaid recognizes that there are limited types of drugs (i.e. injectable drugs) where allowing for waste is therapeutically appropriate. Requests to include waste in days supply calculations will be reviewed on a case by case basis by the Division of Healthcare Financing, Pharmacy Services.
- Wyoming Medicaid must not be billed for extra tablets for an institutional fill to account for missed or lost doses.
- The quantity of medication provided to a client must exactly match the quantity billed to Medicaid.
- The quantity billed to Medicaid must meet current NCPDP standards. This includes medication in both compounded and non-compounded forms.
- The medication and NDC number billed to Medicaid must exactly match the medication and NDC number dispensed to the client.
- For questions on dispensing limitations, please call the Change Healthcare pharmacy help desk at 877-209-1264.

DISPENSING QUANTITIES

Within specific plan limitations, prescriptions should be dispensed in the maximum quantity that the prescriber's order allows. For non-maintenance medications, the maximum days supply allowed is thirty-four (34) days.

An initial fill of any narcotic is limited to a seven day supply if the client has not had a prescription filled for a narcotic within the previous forty-five days.

If plan limitations and the prescriber's orders allow, prescriptions for oral contraceptives and maintenance drugs should be dispensed in a ninety (90) day supply. A few exceptions to the ninety (90) day maximum maintenance supply include:

- Eye drops – maximum days supply = 100
- Fluoride – maximum days supply = 100
- Pediatric multivitamins – maximum days supply = 100
- Insulin products on a case-by-case basis (Please call Change Healthcare Point-of-Sale help desk at 877-209-1264)
- Covered DME products (see page 9)

There are also some medications that have a minimum day supply requirement. In this case, the pharmacy must bill for the minimum days supply requirement or greater, or the prescriber must submit a prior authorization requesting an exception.

The Division of Healthcare Financing, Pharmacy Services may allow exceptions to the dispensing quantity limitation for clinically significant disposal requirements. Request for exception must be supplied to the Division of Healthcare Financing, Pharmacy Services in writing, along with any supporting documentation necessary to determine clinical significance of request. Recovery and further audit proceedings may be possible if a prescription is not dispensed at the maximum quantity allowed by the prescription order and not previously approved by the Division of Healthcare Financing, Pharmacy Services.

MAINTENANCE MEDICATIONS

A "maintenance medication" is a medication used to treat a chronic condition over months or years. When a client has been stabilized on a dosage of a maintenance medication, the prescriber may choose to prescribe the medication for a ninety (90) day supply. When all other criteria and conditions have been met, Medicaid will reimburse for a maintenance supply for the following medications:

- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) - once the client has been maintained on the strength and dose for three (3) months or ninety (90) days
- Antiarrhythmic medications
- Antiasthmatic medications
- Anticonvulsant medications
- Antidiabetic medications
- Diuretic medications
- Hormonal medications (estrogenic, progestational, thyroid)
- Hypotensive medications
- Lipotropic/antihyperlipidemic medications
- Oral contraceptives
- Proton pump inhibitors

AUTOMATIC PRESCRIPTION FILLS

All prescription fills must be requested at the time of the fill by the Medicaid client or their representative. Medicaid does not pay for prescriptions filled based on a "cycle", "push", or "auto" filling policy. Any prescriptions filled without a request from a client or their representative will be subject to recovery and further audit proceedings. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery, and possible suspension or termination of the provider agreement.

ELECTRONIC PRESCRIBING

Wyoming Medicaid follows all state, federal, and NCPDP regulations, transmittal exceptions, and dispensing of all e-prescribing prescriptions. All dispense as written requests will require "*brand name medically necessary*" to be written on the prescription.

TAMPER RESISTANT PRESCRIPTION PAD REQUIREMENT

On May 25, 2007 Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law. The Center for Medicare and Medicaid Services released guidance providing baseline requirements to States to define and implement tamper resistant prescription pads as required by this law. The law requires that **ALL** written, non-electronic prescriptions for Medicaid outpatient drugs must be executed on tamper resistant pads in order for them to be reimbursable by the federal government.

In addition to all current Wyoming Board of Pharmacy requirements for tamper resistant prescription forms, all prescriptions paid for by Wyoming Medicaid must meet the following requirements to help insure against tampering:

Written prescriptions:

Prescriptions must contain all three (3) of the following characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all written prescriptions must contain:

    - Some type of "void" or "illegal" pantograph that appears if the prescription is copied.
    - May also contain any of the features listed within category one (1) recommendations provided by the NCPDP or that meets the standards set forth in this category.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. THIS REQUIREMENT APPLIES ONLY TO PRESCRIPTIONS WRITTEN FOR CONTROLLED SUBSTANCES. In order to meet this requirement all written prescriptions must contain:

    - Quantity check-off boxes PLUS numeric form of quantity values OR alpha and numeric forms of quantity value.
    - Refill indicator (circle or check number of refills or "NR") PLUS numeric form of refill values OR alpha AND numeric forms of refill values.
    - May also contain any of the features listed within category two (2) recommendations provided by the NCPDP or that meets the standards set forth in this category.

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:

    - Security features and descriptions listed on the FRONT of the prescription blank.
    - May also contain any of the features listed within category three (3) recommendations provided by the NCPDP or that meets the standards set forth in this category.

Computer Printed Prescriptions:

Prescriptions must contain all three (3) of the following characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all computer printed (rather than written) prescriptions must contain:

- Same as above for this category.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. In order to meet this requirement all computer printed prescriptions must contain:

    - Same as above for this category

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all computer printed prescriptions must contain:

    - Security features and descriptions listed on the FRONT or BACK of the prescription blank.
    - May also contain any of the features listed within category three (3) recommendations provided by the NCPDP or that meets the standards set forth in this category.

In addition to the guidance outlined above, the tamper resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, or by fax; when a managed care entity pays for the prescription; or in most situations when drugs are provided in designated institutional and clinical settings. The guidance also allows emergency fills with a non-compliant written prescription as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within seventy-two (72) hours.

Audits of pharmacies may be performed by the Division of Healthcare Financing, Program Integrity Unit to ensure that the above requirement is being followed. For questions regarding this policy, the Program Integrity Unit may be contacted at 307-777-7531.

MANDATORY GENERIC PROGRAM

For covered brand name drugs with an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since brand name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. Medicaid does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. The program also requires that brand name medications with A-rated generic equivalents will only be reimbursed if there is a documented allergy or adverse reaction to **ALL** generic versions.

Brand medication requests for drugs where a generic form is available must be submitted on a Brand Name Prior Authorization (PA) request form. Prescriptions will require "*brand name medically necessary*" to be written on the prescription in the *prescriber's handwriting*. Prescribers should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH. A copy of the MEDWATCH report must be included with the PA request. Completed information should be faxed to the Change Healthcare PA Department at 866-964-3472.

If the request for the brand medication is approved, a prior authorization will be given within twenty-four (24) to seventy-two (72) hours of receipt of the request. Both the prescriber and the pharmacy will be notified of the approval and the pharmacy will then be able to process the claim. If the request is denied, both the prescriber and the pharmacy will be notified by mail, fax or phone of the denial and the reason(s) for the denial.

MANDATORY GENERIC PROGRAM EXCEPTIONS

The following medications are exempt from the mandatory generic requirements:

- Coumadin
- Depakene
- Dilantin
- Lanoxin (including Lanoxicaps)
- Levothroid
- Levoxyl
- Mysoline
- Synthroid
- Tegretol (not including XR)
- Immunosuppressants

Continued use of a brand name anticonvulsant following introduction of a generic version will be allowed if the client has an epilepsy diagnosis and has been on the brand name in the previous year. If the client has not been on the brand name within the previous year, the generic mandatory policy will be enforced (requiring efficacy trial of generic or documentation of adverse effect from generic formulation).

The Medicaid Preferred Drug List (PDL) may require the use of a brand medication over a generic medication if the brand medication is less costly to the Medicaid program. In general, branded generics are considered to be generics by the Medicaid program.

The Brand Name Drug Request and the FDA MedWatch Forms may be found at http://wymedicaid.org.

DISPENSE AS WRITTEN

Due to the Mandatory Generic Program, the PDL, and the PA process, dispense as written (DAW) codes are not necessary on prescription claims. Dispense as written codes included in claims will be ignored by the POS system.

However, if the claim is for a medication where the brand is preferred over the generic and a DAW code is necessary for the pharmacy software system to process a brand name medication, then a "5" is recommended in the DAW field.

A handwritten notification of "*brand name medically necessary*" in the *prescriber's handwriting* on or attached to the hard copy is still required. Documentation for a positive "brand name medically necessary" on telephone prescriptions must be on file within thirty (30) days of prescription origination.

Documentation for a positive "DAW" for nursing facility client prescription claims must consist of a letter on file in the pharmacy, signed by the prescriber, for each prescription where a "brand name medically necessary" was affixed to the claim.

EMERGENCY SUPPLY

In the event of an emergency the pharmacy is authorized to dispense up to a seventy-two (72) hour emergency supply. An emergency supply may only be used twice for each drug per 30 days. A dispensing fee and copay will not apply. Please refer to the payer sheet for instructions for PA code type and PA number field. Use of the emergency supply for non-emergency situations or to override the PA process will result in recovery of claim payment and further audit proceedings. Emergency supply overrides can not be used for controlled substances or by Indian Health Services (IHS), tribal, or urban Indian pharmacies".

A six (6) day emergency fill at the initiation of therapy with Suboxone films or buprenorphine/naloxone tablets is allowed. Once a claim for Suboxone films or buprenorphine/naloxone tablets has been processed, emergency supplies will only process one year after a client's last prescription fill of Suboxone films or buprenorphine/naloxone tablets.

SIGNATURE LOG

The Division of Healthcare Financing, Pharmacy Services requires that each pharmacy keep a dated log that maintains a record of when a client or a client's representative picks up, or takes delivery of, every prescription paid for by Wyoming Medicaid. All signatures must be original at the time each prescription is dispensed; electronic or other methods of reproducing past signatures are not acceptable. The signature log can be either manual or electronic and should comply with all Health Insurance Portability and Accountability Act (HIPAA) and State and Federal regulations. This requirement applies to prescriptions dispensed at the provider's physical site, as well as those delivered off-site to the client's residence or other setting.

It is each provider's responsibility to verify the person receiving services is the same person listed on the Medicaid identification card. If necessary, providers should request additional materials such as a driver's license to confirm identification. It is illegal for anyone other than the person named on the Medicaid identification card to obtain or attempt to obtain services by using the card. Providers who suspect misuse of a card should report the occurrence to Change Healthcare at 877-209-1264.

Prescriptions that are mailed to clients shall be recorded in a dated log that must contain the prescription number, date of fill, client's name and address that the prescription is mailed to as well as the name of the person mailing or delivering the mail to the mail carrier. If a single prescription to be mailed has a dollar amount paid by Medicaid exceeding $500.00, a receipt that indicates that the prescription was mailed must be obtained and attached to the log. These requirements also apply to clients living in nursing and/or institutional facilities.

Pharmacies that dispense medications to facilities should require verification of delivered prescription inventory at the time the signature is collected in order to ensure disputed medication deliveries will not be the responsibility of the pharmacy.

MEDICATION RETURNED TO STOCK

If a client has not picked up or refused a medication within twelve (12) days of the date it was filled, Wyoming Medicaid requires that the claim be reversed and returned to stock.

RETURNING MEDICATIONS FROM NURSING FACILITIES

According to the Deficit Reduction Act (DRA) of 2005, states are to insure that when redistribution is permitted, any facility utilizing unit dosed prescriptions must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuation of the prescription. Therefore, the Wyoming Medicaid Pharmacy program requires nursing facilities to return any unused medications to the pharmacy that dispensed the medication as long as the requirements under Chapter 2, Section 15 of the State of Wyoming Pharmacy Act Rules and Regulations are met. Where it is appropriate to restock and resell these medications, recovery actions will apply if the medications are not properly credited to Wyoming Medicaid. In those circumstances that Wyoming State Pharmacy law does not allow for restocking and reselling of medications (for example, in a closed door pharmacy without a retail outlet) the medications do not need to be credited to Wyoming Medicaid, but should be donated to a medication donation outlet whenever possible, in the unopened unit dose packaging in which they were dispensed. Otherwise, the medications should be properly destroyed. In either situation, a record of medications donated or destroyed must be kept containing, at a minimum, the date of donation or destruction; the prescription number; the number of tablets destroyed or donated; the name of the donation outlet or the location where the medications were destroyed. Recovery is possible if this information is not recorded.

MEDICATIONS DISPENSED TO A CLIENT RESIDING IN A FACILITY

All medications dispensed to clients residing in a residential facility are the property of the client. Medications must be sent with the client upon discharge, unless the client is being temporarily transferred to a hospital. If the possibility exists that the client may return to the facility, be transferred to another facility, or return home upon discharge from the hospital, the client's medication is to be retained or sent with the client or their representative at the time of transfer. Overrides for early refills will be subject to review based on this requirement.

SHORT DAY SUPPLY PRESCRIPTION FILLS

Wyoming Medicaid requires pharmacies to fill at least a fourteen (14) day supply with each fill unless otherwise supported by the prescription. A pharmacy should not fill less than a fourteen (14) day supply unless the prescription has been written specifically for less than fourteen (14) days or the shorter day supply has been approved through the prior authorization process. Claims that do not meet this requirement will be subject to recovery and further audit proceedings.

340B

Wyoming Medicaid does not allow contract pharmacies to "carve in" Wyoming Medicaid clients.

EMERGENCY BOXES

Wyoming Medicaid does not allow separate billing for emergency box fills at a facility. If a client is given medication that was supplied by an emergency box ***and*** the pharmacy will also process a claim for the remainder of the prescription, the entire amount, including the quantity supplied by the emergency box, should be billed as one claim. Separate claims for the emergency box and the remainder of the prescription being filled at the pharmacy will not be allowed.

MEDICATION DONATION PROGRAM

In 2005, the Drug Donation Program Act was passed by the Wyoming Legislature allowing unused medications to be donated to participating donation sites in order to be dispensed to individuals who cannot afford their medications. The Division of Healthcare Financing, Pharmacy Services coordinates this program. For more information please refer to http://www.health.wyo.gov/healthcarefin/MedicationDonation/.

Medication Donation Program
Hathaway Building, Lower Level
2300 Capitol Avenue
Cheyenne, WY 82002

855-257-5041

SECTION 3. DRUG UTILIZATION REVIEW

Under the Omnibus Budget Reconciliation Act of 1990, each state is required to establish a drug utilization review program for covered outpatient drugs for Medicaid clients. This is to assure that prescriptions are appropriate, medically necessary and are not likely to result in adverse effects.

PROSPECTIVE DRUG UTILIZATION REVIEW

CLIENT COUNSELING REQUIREMENTS

The Wyoming State Board of Pharmacy details specific client counseling regulations in the Pharmacy Act Rules and Regulations, Chapter 9, Section 5. Information covered during counseling should be determined by the pharmacist's professional judgment.

New prescriptions are covered by the counseling provision. Mail order prescription outlets must offer counseling and provide a toll free telephone number.

POINT-OF-SALE DRUG UTILIZATION REVIEW

Prescriptions will be screened for drug therapy problems before they are filled or at the point-of-sale. Pharmacists or their designee must offer to counsel clients (unless counseling is refused) on the following items:

- Name and description of the medication
- Dosage form, dosage, route of administration and duration of therapy
- Special directions, precautions for preparation, administration and use of the medication
- Common severe side effects, adverse effects or interactions and therapeutic contraindications
- Proper storage, refill information
- Actions in case of a missed dose

Pharmacists must also make a reasonable effort to maintain client profiles.

No Wyoming Medicaid pharmacy provider may, by either policy or procedure, bypass the POS review engine. Prescriptions may not be dispensed to the client until the Point-of-Sale procedure is complete. Exceptions to this are only allowed when a paper claim is necessary (see pages 30-35), or emergency situations occur. Payment of claims not processed through the POS system before the medication is dispensed to the client will be subject to recovery and further audit proceedings.

REFILL-TOO-SOON

- Scheduled drugs II-V require 90% of the days supply to be used before a refill or new claim for the same medication will be allowed. For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on all subsequent claims, and the 90% refill tolerance will be calculated on that accumulated total.

- All other medications require 80% of the days supply be used before a refill or new claim for the same medication will be allowed. For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on all subsequent claims, and the 80% refill tolerance will be calculated on that accumulated total.

Pharmacies with denied claims for Refill Too Soon (RTS) (NCPDP reject code 79) may use a Submission Clarification Code (SCC) = 5 to override an increase in dose from the previous fill on non-controlled medications or will need to call the Change Healthcare POS help desk at 877-209-1264 to obtain an override for controlled substances. If the criteria are met for a lost or stolen prescription, the PA Call Center will enter the override. Change Healthcare will inform the pharmacy if the override is allowed and the override has been entered. The pharmacy can then resubmit the denied claim. **Override requests for vacations will be denied.** A maximum of one (1) Refill Too Soon override is allowed for a lost or stolen prescription, per client per year (365 day lookback period).

Note: Trying to obtain overrides for reasons other than dosage change or lost prescription may be subject to recovery and further audit proceedings.

DRUG/MEDICAL SUPPLY QUANTITY LIMITS

Medications with quantity limits are limited to a specified number of units per month. Please note there is no grace period for day supply with these edits. Please refer to the Dosage Limitation Chart at http://wymedicaid.org.

RETROSPECTIVE DRUG UTILIZATION REVIEW

Drug claims data will be reviewed periodically, using predetermined standards, to monitor for therapeutic appropriateness. Retrospective drug utilization review (DUR) also includes educational programs conducted through the Medicaid DUR Program and Pharmacy and Therapeutics (P&T) Committee, and interventions to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

Screening of claims will occur quarterly. Screening will be based on predetermined criteria and involve monitoring the following:

- Therapeutic appropriateness, over and under utilization, appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage or duration of therapy and clinical abuse or misuse

The predetermination standards must be consistent with the peer reviewed medical literature, as well as:

- *AMA Drug Evaluations*
- *USP Drug Information*
- *American Hospital Formulary Service Drug Information*
- *Drug Information System*

PREFERRED DRUG LIST

The Wyoming Medicaid Pharmacy Program's preferred drug(s) are chosen following a systematic process that begins with review of comparative safety and efficacy based on published literature. The P&T Committee will make a recommendation indicating whether the evidence shows that all medications in a class are clinically equivalent or not. The Division of Healthcare Financing, Pharmacy Services takes this recommendation, reviews cost information and chooses the preferred drug(s). Once the preferred drug(s) are chosen, the P&T Committee determines prior authorization criteria for all non-preferred drugs. Additional classes will be added as the evidence is reviewed by the P&T Committee. For more information regarding the preferred drug list, including preferred drugs and additional classes, refer to http://wymedicaid.org. For more information regarding the P&T Committee please refer to http://www.uwyo.edu/DUR.

PRIOR AUTHORIZATION

PRIOR AUTHORIZATION PROCESS

The prior authorization process assures that the approved service is medically necessary and considered to be a benefit of the Medicaid program. All claims, including those for PA, must meet claim submission requirements before payment can be made (i.e. proper prior authorization request form, client eligibility, approval, timely filing, etc.).

Following introduction to the market, new drugs and new formulations of existing drugs, and new indications that are covered through the pharmacy services program will require prior authorization until published literature is available through standard literature review processes. The drug will be considered at the next scheduled P&T Committee meeting, and its coverage status will be reviewed at that time. Exceptions to this rule will be handled on a case by case basis.

The prior authorization process is primarily done electronically through the POS system. As a pharmacy claim is processed, the POS system checks the claim against clinical rules based on prescription, diagnostic, and therapeutic histories. If the clinical rules are met, the claim will pay. If not met, the claim will deny and a PA form must be completed and signed by the prescriber. Point-of-sale prior authorizations reduce the number of paper prior authorization requests due to the system's ability to check both prescription and medical claims information. High cost prescription claims may require PA approval prior to dispensing.

If a claim is approved, notification will be sent to the provider and pharmacy. PA approval will include documentation of the approved **quantity** and **days supply**. Claims that are submitted for a larger quantity than the approved PA will be denied. Claims that are submitted for a **shorter days supply than the approved PA** (without prescription direction support) may be subject to recovery and further audit proceedings.

In all cases, the quantity and days supply submitted on the claim must be supported by the dosing directions on the prescription. See the "Dispensing Limitations" section on page 10 of this manual for additional considerations in calculating days supply. If a change in dosing directions necessitates a change to the PA, please contact Change Healthcare.

Prior authorization questions may be addressed to:

Change Healthcare
Prior Authorization Department
PO Box 21719
Cheyenne, WY 82003
Phone: 877-207-1126
Fax: 866-964-3472

PRIOR AUTHORIZATION APPEALS PROCESS

If a PA is denied, in accordance with Chapter 10 of the Medicaid Rules, clients or the prescriber may request reconsideration of the decision to deny the request for prior authorization within twenty (20) days of the receipt of the notice of denial. The request for reconsideration shall be made in accordance with the reconsideration provisions of Chapter 3 of the Medicaid Rules. Prescribers must include any additional supporting documentation along with the request for reconsideration. Please send the submission to:

Change Healthcare
Prior Authorization Department
PO Box 21719
Cheyenne, WY 82003
Fax: 866-964-3472

Once the Division of Healthcare Financing, Pharmacy Services issues its decision, clients or the prescriber may request a contested case hearing in writing, as set forth in Chapter One of the Wyoming Medicaid Rules. According to Wyoming Medicaid Rules, Chapter (3), Section 14(g), the failure to request reconsideration in a timely manner prevents appeal. Fax or mail the letter to:

Wyoming Department of Health
Division of Healthcare Financing, Pharmacy Services
6101 Yellowstone Ave., Suite 210
Cheyenne, WY 82002
Fax: 307-777-6964

BACKDATED PRIOR AUTHORIZATION REQUESTS

Requests for backdating PAs should be submitted to Change Healthcare on the prior authorization form and should include the date that the PA should be backdated to, as well as the reason for the backdate. All requests will be reviewed and approved or denied by the Division of Healthcare Financing, Pharmacy Services.

SAMPLES

Providing samples to Wyoming Medicaid clients as a method to avoid the prior authorization (PA) process ***will not be allowed.*** Though a client may be stabilized on a medication obtained through samples it is no guarantee that a PA request for sampled medication will be approved. A trial and failure of preferred agents ***can and will be required.***

MEDICAID LOCK-IN PROGRAM

The Medicaid Pharmacy Lock-In Program limits certain Medicaid clients to receiving prescription services from a single designated pharmacy provider. Any Wyoming Medicaid client who receives controlled substance prescriptions from multiple prescribers and utilizes multiple pharmacies within a designated time period is a candidate for the Lock-In Program.

When a pharmacy is chosen to be a client's designated Lock-In provider, notification is sent to that pharmacy with all important client identifying information. If a Lock-In client attempts to fill a prescription at a pharmacy other than their Lock-In pharmacy, the claim will be denied with an electronic response of " CARE NOT AUTHORIZED BY PRIMARY PHARMACY - Pharmacy Participant Restriction - contact help desk at 877-209-1264."

Pharmacies have the right to refuse Lock-In provider status for any client. The client may be counseled to contact the Medicaid Pharmacy Case Manager at 307-777-8773 in order to obtain a new provider designation form to complete.

Expectations of a Medicaid designated Lock-In pharmacy:

- Medicaid pharmacy providers should be aware of the Pharmacy Lock-In Program and the criteria for client lock-in status as stated above. The entire pharmacy staff should be notified of current Lock-In clients.
- Review and monitor all drug interactions, allergies, duplicate therapy, and seeking of medications from multiple prescribers. Be aware that the client is locked in when "refill too soon" or "therapeutic duplication" edits occur. Cash payment for controlled substances should serve as an alert and require further review. Gather additional information which may include, but is not limited to, asking the client for more information and/or contacting the prescriber. Document findings and outcomes. The Wyoming Board of Pharmacy will be contacted when early refills and cash payment are allowed without appropriate clinical care and documentation.

When doctor shopping for controlled substances is suspected, please contact the Medicaid Pharmacy Case Manager at **307-777-8773**. The Wyoming Online Prescription Database (WORx) is online with 24/7 access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy. Register at worxpdmp.com to view client profiles with **all** scheduled II through IV prescriptions the client has received. The Wyoming Board of Pharmacy can be reached at **307-634-9636** to answer questions about WORx.

EMERGENCY LOCK-IN PRESCRIPTIONS

If the dispensing pharmacist feels that in his/her professional judgment a prescription should be filled and they are not the Lock-In provider, they may submit a hand-billed claim to Change Healthcare for review. Overrides may be approved for true emergencies (auto accidents, sudden illness, etc.).

FRAUD

Any Wyoming Medicaid client suspected of controlled substance abuse, diversion, or doctor shopping should be referred to the Medicaid Pharmacy Case Manager. Please call the Pharmacy Case Manager at 307-777-8773 for referrals, or fax referrals to 307-777-6964. Referral forms can be found at http://www.health.wyo.gov/healthcarefin/medicaid/pharmacy-services/ppi/

PLEASE REPORT! To report any and all fraudulent activity with Wyoming Medicaid, please call **855-846-2563.**

HOSPICE LOCK-IN PROGRAM

Medication for clients in the Hospice Lock-In program should be billed directly to the hospice provider. The hospice provider will directly reimburse the pharmacy for prescriptions that are deemed "related to the hospice condition" by the hospice provider.

Medications that are deemed "not related to the hospice condition" by the hospice provider should be billed to the Wyoming Medicaid program. The pharmacy or hospice provider must contact the Change Healthcare pharmacy help desk to request an electronic override at 877-209-1264. The hospice provider must submit documentation that states that the medications are not related to the client's terminal illness and will not be covered by the hospice provider, before the override will be given.

Once the override is in the claims system, the pharmacy provider will be notified by Change Healthcare and the pharmacy provider should bill the hospice claim as any other Medicaid pharmacy claim. All Medicaid rules, edits and limitations will apply. No co-payments apply to hospice claims.

SECTION 4. REIMBURSEMENT & CO-PAYMENTS

TIMELY FILING FOR CLAIMS SUBMISSION

Timely filing for correct pharmacy claims must occur within one (1) year from the date the medication was dispensed or services rendered. The Division of Healthcare Financing, Pharmacy Services must approve any requests to file claims beyond the one year limit.

CLIENT CO-PAYMENT RESPONSIBILITIES

Payment for pharmaceutical services should be arranged at the time services are given. A provider may not deny pharmaceutical services to a client because of the client's inability to make the copayment, except when a client regularly refuses to make copayments. A client who refuses to make a copayment two or more times has "regularly refused" to make copayments for purposes of this section. Co-payment amounts are specific to each plan (see pages 39-51).

CO-PAYMENT EXEMPTIONS

- Clients under age 21
- CHIP Clients covered under plan 390
- Nursing facility residents
- Pregnant women
- American Indians and Alaska Natives
- Family planning services
- Emergency services
- Hospice services
- Vaccines

For pregnant women, place a "2" or a "4" in the PA Type Code Field (Field 461-EU) and a "4" in the PA number field (Field 462-EV) to denote "Exemption from Copay" when submitting a prescription via POS or on the Universal Claim Form.

For American Indians and Alaska Natives, place a "4" in the PA Type Code Field (Field 461-EU) and a "6" in the PA number field (Field 462-EV) to denote "Exemption from Copay" when submitting a prescription via POS or on the Universal Claim Form.

An audit will be conducted on a regular basis to verify the accurate use of the co-payment override codes for pregnancy, American Indians, and Alaska Natives. If the codes are used incorrectly, the claim may be subject to recovery and further audit proceedings.

CLAIM REIMBURSEMENT RATES

Medicaid reimbursement for covered services is based on a variety of payment methodologies depending on the service provided:

- Federal Upper Limit (FUL)/Federal Maximum Allowable Cost (FMAC)
- Gross Amount Due (GAD)
- Ingredient Cost Submitted
- National Average Drug Acquisition Cost (NADAC)
- State Maximum Allowable Cost (SMAC)
- Usual & Customary Rate (U&C)
- Wholesale Acquisition Cost (WAC)

- Estimated Acquisition Cost (EAC) = Average Wholesale Price (AWP) minus 11%

Questions regarding reimbursements should be directed to the Change Healthcare Point-of-Sale Help Desk at:

Change Healthcare
Provider Relations Unit
PO Box 21719
Cheyenne, WY 82003
877-209-1264

REIMBURSEMENT ALGORITHM

The following reimbursement algorithm applies to all legend drugs, diabetic supplies, medical supplies and OTC medications for all Medicaid Plans:

Pharmacy providers will be reimbursed the lesser of:

- NADAC + dispensing fee of $10.65,
- SMAC + dispensing fee of $10.65,
- FUL + dispensing fee of $10.65,
- Ingredient Cost Submitted + dispensing fee of $10.65,
- GAD, or
- U&C

IF NADAC is not available, the WAC + dispensing fee of $10.65 should be used for the lesser of evaluation, **IF** WAC is not available, then EAC (AWP minus 11%) + dispensing fee of $10.65 should be used for the lesser of evaluation.

The only exception to this will be for IHS pharmacies. The IHS pharmacy reimbursement for all legend drugs, diabetic supplies, medical supplies, and OTC medications for all Medicaid Plans will be based on the All Inclusive Rate (AIR).

FEDERAL UPPER LIMIT PRICING

The Federal Upper Limit pertains to multi-source generic drug products. Federal Upper Limit pricing is also referred to as Federal Maximum Allowable Costs. This is the maximum allowable cost per unit that will be reimbursed for federally funded Medicare and Medicaid programs. Federal Upper Limit prices are determined by the Centers for Medicare and Medicaid: https://www.medicaid.gov/medicaid/prescription-drugs/federal-upper-limits/index.html

STATE MAXIMUM ALLOWABLE COST DRUGS

The State Maximum Allowable Cost pertains to both multi-source generic and single source drug products. A SMAC price is the maximum allowable cost per unit that will be reimbursed for Wyoming Medicaid prescriptions. State Maximum Allowable Cost prices are determined by the Division of Healthcare Financing, Pharmacy Services. If a SMAC price is found to be less than a provider's actual purchase price, the provider can submit their invoice and claims data for prescriptions reimbursed below cost to the Wyoming SMAC Help Desk via fax at 877-308-6931. Change Healthcare will submit to the Division of Healthcare Financing, Pharmacy Services any adjustment to the current SMAC for state approval. To obtain a SMAC Review form, refer to http://www.wymedicaid.org/smac and submit as instructed. Drugs with a SMAC can be found at http://www.wymedicaid.org/smac

BRANDED GENERIC DRUGS

With a few exceptions, branded generic medications pay the same as generic claims and collect generic co-payment. If pharmacies observe otherwise, please contact the Change Healthcare provider help desk at 877-209-1264.

Pharmacies are required to send a fax or email with the NDC detail and the reason for the request. Change Healthcare will verify that the NDC is a branded generic and will request a change in the POS if warranted. Once complete, the Change Healthcare help desk staff will notify the pharmacy and let them know they can reverse and resubmit the claim to obtain the appropriate co-payment. Change Healthcare does not have the ability to alter specific claim co-payments.

POINT-OF-SALE BILLING

The Point-of-Sale drug claims system allows pharmacists to send claims to Medicaid via telecommunications networks as they are filling prescriptions for Medicaid clients, and to have those claims adjudicated on-line or in real time. The following on-line processing functions are performed:

- Verify client eligibility
- Verify claim data validity
- Perform on-line duplicate services detection and drug capitations
- Verify coverage of the drug due to formulary restrictions, DESI status, obsolete dates and rebate closures
- Price the claim, determine co-payment amounts, and pharmacy reimbursement amounts
- Provide prospective DUR, the detection of conflicts prior to filling the prescriptions
- Complete prior authorizations
- Allow pharmacy overrides

When a prescription is filled, the pharmacy enters the prescription data into the internal system through a personal computer, a terminal, or some other point-of-sale device. The pharmacy system then formats and sends the Medicaid claim to the POS drug claims system for adjudication. Medicaid uses the current NCPDP standard claim format and all pharmacies need to be compliant with this format.

The POS drug claims system interfaces with individual pharmacies through switch vendors who provide telecommunications. The switch vendors route POS claims from the pharmacies to claim processors. The response is sent back to the pharmacy via the switch vendor. With the exception of limited maintenance periods, the POS claims system is available twenty-four (24) hours a day, seven (7) days a week.

The signed POS business agreement must be on file with Change Healthcare before providers will be allowed to submit claims by POS. Pharmacies are responsible for their own telecommunications "switch" costs through their regular POS vendor. For a copy of the Wyoming Medicaid payer sheet, please refer to http://www.wymedicaid.org/sheets-info.

If a pharmacy bypasses the POS before filling a claim, Wyoming Medicaid will not be liable for any claims that do not meet DUR or eligibility criteria, or are not commensurate with the Preferred Drug List.

MANUAL CLAIM REVERSAL

When a pharmacy has reversed a claim, but the reversal is not being recognized by Wyoming Medicaid, the pharmacy may contact the Change Healthcare pharmacy help desk to request a manual reversal. Please note this is only for cases when an initial reversal has been completed by the pharmacy and the reversal was not effectively transmitted to Wyoming Medicaid. All reversals must be first attempted by the pharmacy before a manual reversal can be completed by the Change Healthcare pharmacy help desk. When a

manual reversal has been requested, a manual claim reversal request form will be faxed to the pharmacy. The pharmacy must fill out the form completely and fax it back to the Change Healthcare pharmacy help desk. Once the form has been received by the Change Healthcare the claim will be reversed and the pharmacy will be notified of the reversal.

INCARCERATED CLIENTS

Per Chapter 26, Section 6 of the Wyoming Medicaid Rules, the following services will not be covered by Wyoming Medicaid:

(e) Services furnished to an individual who is an inmate of a public institution, or an individual that is in the custody of a state, local, or federal law enforcement agency;

(f) Services provided to an individual in emergency detention.

This does not pertain to children in the custody of the Department of Family Services who are placed in juvenile detention centers. If there are any questions as to whether a claim should be billed to Wyoming Medicaid for a client please call the Change Healthcare pharmacy help desk at 877-207-1126.

USE OF DISCOUNT CARDS

Medicaid clients who present discount cards at the pharmacy MAY NOT use those discount cards in conjunction with their Medicaid benefits. Discount cards cannot be used on any prescriptions that are paid for in whole or in part by any government program regardless of the presence or absence of such a statement on the card itself. Claims that have been "split-billed" in this fashion are subject to subsequent recovery and possible future audit proceedings.

DATE OF DEATH/BIRTH

Per Wyoming Medicaid guidelines, a provider may not be paid for claims provided after the client's date of death. Claims billed after the client's date of death will be subject to subsequent recovery and possible future audit proceedings. Similarly, a provider may not be paid for claims billed before the client's date of birth. Claims billed before the client's date of birth will be subject to subsequent recovery and possible future audit proceedings.

NATIONAL PROVIDER IDENTIFIER AND DRUG ENFORCEMENT AGENCY REQUIREMENTS

All Wyoming Medicaid pharmacy claims require the pharmacy provider's National Provider Identifier (NPI) number and the prescriber's NPI number. Pharmacy claims will not be reimbursed by Wyoming Medicaid if both NPI numbers are not on the pharmacy claim. The prescriber's NPI must be enrolled with Wyoming Medicaid for the pharmacy claim to be allowed to process.

Invalid prescriber NPIs may not be substituted with the submitting pharmacy's NPI and the pharmacy should ensure that the correct prescriber's NPI is being submitted on the claim. Those claims may be subject to recovery and further audit proceedings. Schedule II-V prescriptions also require a prescriber DEA number be on the prescriber's file. Pharmacies should submit a prescriber's NPI number and the POS will verify the prescriber's DEA on file. Pharmacies cannot submit provider DEA numbers via the POS.

To assist pharmacies in obtaining a prescriber's NPI number, the Centers for Medicare and Medicaid Services provides a website that is accessible to both pharmacies and providers. There is not a charge to use the NPI registry. NPI searches can be conducted by entering the prescriber's name. The website is: https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.

When a Wyoming Medicaid pharmacy provider prescribes and administers immunizations, the billed claim must be submitted with the prescribing pharmacist's NPI and that pharmacist must have enrolled that NPI as a prescriber for the claim to be allowed to process. The "dispensing provider" should be the pharmacy's NPI.

Pharmacists interested in enrolling with Wyoming Medicaid should contact Conduent at 800-251-1268 or complete online enrollment at https://wymedicaid.portal.conduent.com/wy/general/providerEnrollmentHome.do

EXCLUSION OF INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICAID

The Health and Human Services Office of the Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicaid, Medicare, Children's Health Insurance Program (CHIP) and all federal healthcare programs based on the authority contained in sections of the Social Security Act, including Sections 1128, 1128A and 1156.

When the HHS-OIG has excluded a provider, Medicaid and CHIP are generally prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities. This includes payment for administrative and management services not directly related to patient care, such as salaries and fringe benefits. Other examples include services performed by nurses, technicians, pharmacists, pharmacy technicians, administrative staff, ambulance drivers, dispatchers, delivery drivers, social workers, billing agents, accountants, utilization reviewers, contractors, manufacturers and suppliers.

The Centers for Medicare and Medicaid will make no payments to states for any amount expended for items or services furnished under the plan by an individual or entity while being excluded from participation. Any such payments constitute an overpayment and are subject to recoupment.

Providers participating in federal programs are obligated to screen all employees and contractors to determine whether any of them have been excluded. This screening should take place upon hiring of a new staff person and monthly thereafter on all staff to check for any new additions to the exclusion list. If any exclusionary information is discovered, it should be reported to Conduent immediately. Contact information is provided below.

The following website provides current information on excluded parties: https://oig.hhs.gov/exclusions/index.asp. Search by name and verify the match by social security number or tax identification number. This is also a downloadable database that can be maintained by the provider. This option does not have the social security or tax identification number match.

An exclusion list from Medicaid and Kid Care CHIP in Wyoming is on the Wyoming Department of Health website at http://www.health.wyo.gov/healthcarefin/apply/

Report any exclusionary information for Medicaid to:

Conduent Provider Relations
PO Box 667
Cheyenne, WY 82003
800-251-1268

If you have any questions regarding this information, please contact the Medicaid Program Integrity Manager at 307-777-8037.

REIMBURSEMENT FOR COPYING OF RECORDS

The Division of Healthcare Financing, Medicaid Program periodically reviews records for quality assurance and ongoing utilization management. Providers are required to furnish, upon request, medical and financial records involving services provided to all Wyoming Medicaid clients. Effective July 1, 2012, the Division of Healthcare Financing will no longer reimburse providers for any cost associated with the copying of records when the agency or its agent requests records.

TEST CLAIMS

Pharmacies are not allowed to test claims to determine reimbursement rates, eligibility, and/or coverage. In addition, pharmacies should not reverse paid claims at a later date and resubmit those claims to determine if the reimbursement is higher. Wyoming Medicaid will not override any claims that have been rebilled for this purpose. Pharmacies that are transmitting test claims could be subject to recovery and further audit proceedings. To determine client eligibility and medication coverage, please call the Change Healthcare pharmacy help desk at 877-209-1264.

COMPOUND DRUGS CLAIMS

Compound prescriptions are covered if the main active ingredient or ingredients are drugs covered by Medicaid.

Due to NCPDP Standards, each NDC number in a compound can be billed by a pharmacy up to 25 lines. All ingredients of the compound will go through PDL, PA and DUR edits. If the NDC number is not covered, the claim will deny. A pharmacy can resubmit the claim with a submission clarification code of 8, and only the covered ingredients will pay. For help billing compound claims correctly please refer to the Compound Training Sheet at http://www.wymedicaid.org/. Claims billed incorrectly will be subject to subsequent recovery and possible future audit proceedings.

Reimbursement is based on the lesser of pricing logic (see page 25) of each drug and a single $10.65 dispensing fee. There is no additional compensation for compounding. See Section 5 for compound co-payments.

BILLING NEWBORN CHILDRENS' CLAIMS

Pharmacies are not allowed to bill claims for a newborn child to the mother's ID number. All claims, including seventy-two (72) hour emergency supplies, must be billed to the child's ID number. Payment will only be made if the newborn is found eligible and all other conditions for Medicaid Pharmacy services are met.

PAPER CLAIMS

Medicaid requires all pharmacy claims to be submitted electronically though the Point-of-Sale system. Medicaid will **only** accept a claim submitted on paper when:

- A client becomes eligible for Medicaid after receiving services (retroactive Medicaid); **AND**
- The provider's software system cannot support a claim with a previous date of service; **OR**
- The claim is a pharmacy Lock-In client who has gone to another pharmacy for an emergency (see pages 21-22); **OR**
- Prior approval has been given by the Division of Healthcare Financing, Pharmacy Services.

If submitting on paper, use the Universal Claim Form when requesting payment for drugs and pharmaceutical products authorized under the Medicaid program. If the Universal Claim Form is not used, the claim will be returned. Examples of the claim form are depicted in this section as Exhibit 1. Step-by-step instructions for completing the form follow in this module.

BASIC RULES FOR PAPER CLAIMS SUBMISSIONS

- Always use the Universal Claim Form;
- Use one claim form for each client; and
- Be sure the information on the form is legible.

BEFORE YOU BEGIN

- Is the client eligible for Medicaid on the date of service? (Refer to Change Healthcare at 877-209-1264 or Conduent at 800-251-1269)
- Do you have a copy of the client's proof of eligibility?
- Does Medicaid cover the service?
- Have you checked to make sure the client does not have other insurance?

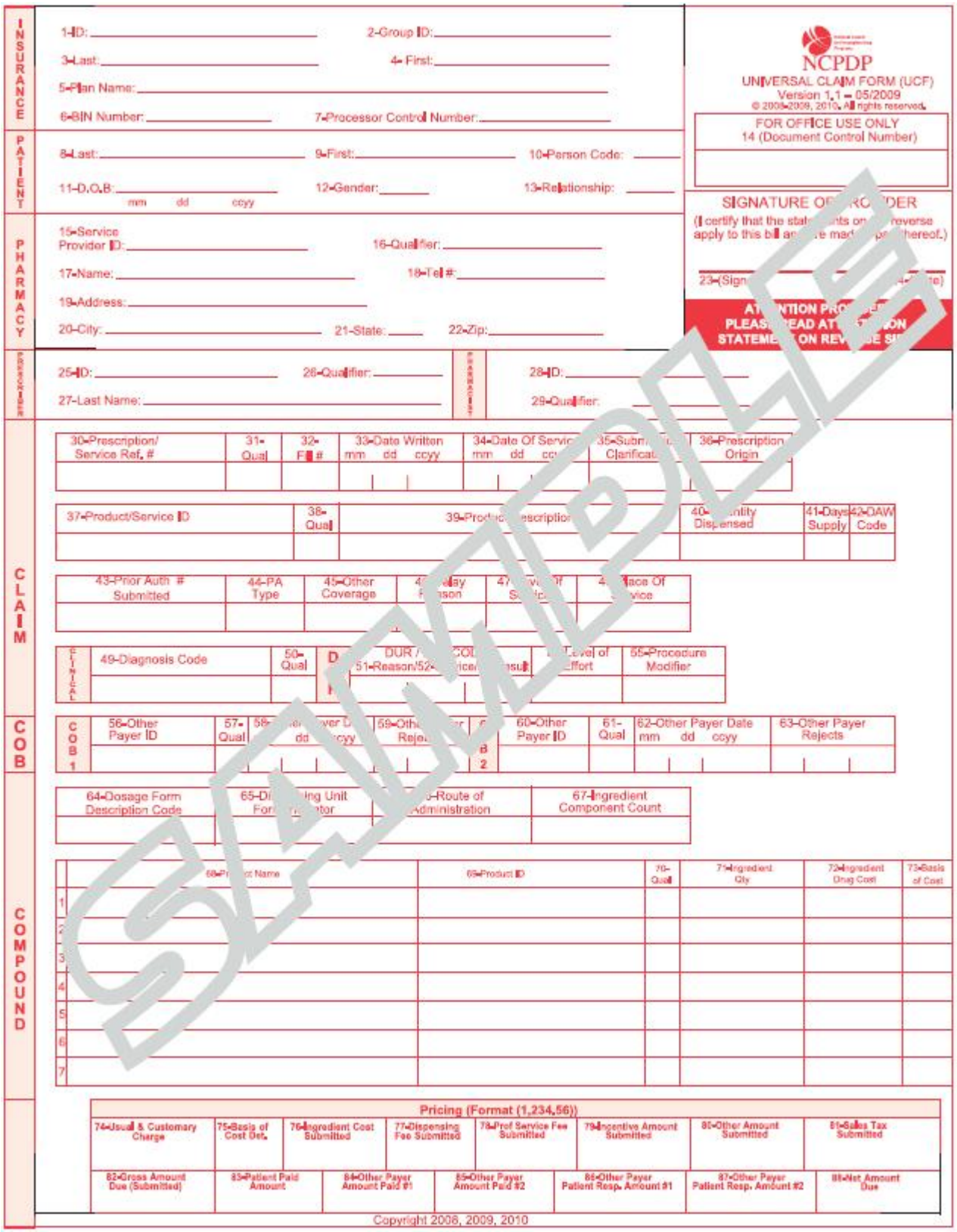
BILLING ADDRESS

Wyoming Medicaid pharmacies should send paper claims to the following address:

Change Healthcare
Provider Relations Unit
PO Box 21719
Cheyenne, WY 82003

If the response to all of the above questions is favorable, fill out the claim form following the instructions in this module.

EXHIBIT 1 – UNIVERSAL CLAIM FORM



HOW TO COMPLETE A UNIVERSAL CLAIM FORM

Claim Item	**Title**	**Req'd**	**Action**
1	Identifier (ID)	X	Enter the ten (10) digit Medicaid client ID number for the specific client whom the prescription is written.
6	BIN	X	014293
7	PCN	X	WYOPOP
8	Last	X	Enter the last name of the actual client receiving the service.
9	First	X	Enter the first name of the actual client receiving the service.
11	Date of Birth (DOB)	X	Enter the date of birth of the actual client receiving the service.
12	Gender	X	Enter the gender of the actual client receiving the service.
15	Service Provider ID	X	Enter the ID assigned to a pharmacy or provider.
16	Service Provider ID Qualifier	X	Only the NPI is supported, enter the qualifier Ø1 = NPI.
17	Pharmacy Name	X	Enter the name of the pharmacy dispensing the prescription.
19	Pharmacy Address	X	Enter the street address where the pharmacy is located.
20	Pharmacy City	X	Enter the city where the pharmacy is located.
21	Pharmacy State	X	Enter the state where the pharmacy is located.
22	Pharmacy Zip Code	X	Enter the zip code where the pharmacy is located.
23	Sign	X	The provider that completed the form must sign here.

Claim Item	**Title**	**Req'd**	**Action**
24	Date	X	The provider must enter the date the form was completed.
25	Prescriber ID	X	Enter the ID assigned to the prescriber. .
26	Prescriber ID Qualifier	X	Only the NPI is supported, enter the qualifier Ø1 = NPI.
30	Prescription/Service Reference Number	X	Enter the reference number assigned by the provider for the dispensed drug/product.
31	Prescription/Service Reference Number Qualifier	X	Enter the qualifier of 1 = Rx Billing.
32	Fill Number	X	Enter the code indicating whether the prescription is an original or a refill, Ø = Original Dispensing, 1 to 99 = Refill Number.
33	Date Written	X	In numeric format, enter the month, day, and year the prescription was written.
34	Date of Service	X	In numeric format, enter the month, day, and year the prescription was submitted.
37	Product/Service ID	X	Enter the identification number assigned to the product that was prescribed.
38	Product/Service ID Qualifier	X	Enter the qualifier of ØØ = Compound, Ø1 = UPC, Ø2 = HRI, or Ø3 = NDC
40	Quantity Dispensed	X	Enter the quantity dispensed expressed in metric decimal units.
41	Days Supply	X	Enter the estimated number of days the prescription will last.

Claim Item	**Title**	**Req'd**	**Action**
43	Prior Authorization Number Submitted	X	Enter the number submitted by the provider to identify the prior authorization. When submitting medical certification or copay exemption for pregnancy = 4, American Indian = 6, or emergency supply = 8.
44	Prior Authorization Type Code	X	This is the code to clarify the 'Prior Authorization Number Submitted'. The code of 2 should be entered when submitting medical certification for pregnancy or emergency fill or when submitting reason for exemption from copay.
45	Other Coverage Code	X	This code indicates whether or not the patient has other insurance coverage. Enter the code of 1 = No other coverage, 3 = Other coverage billed - claim not covered, or 8 = Claim is billing for patient financial responsibility only. If '3' is submitted, Other Payer reject code must be submitted (See #59). If '8' is submitted, Other Payer-Patient responsibility amount must be submitted (See #86, 87).
56 (60)	Other Payer ID	X	ID assigned to the other payer.
57 (61)	Other Payer ID Qualifier	X	Enter the qualifier of Ø1 = National Payer ID or Ø3 = BIN.
58 (62)	Other Payer Date	X	In numeric format, enter the month, day, and year the payment or denial of the claim was submitted to the other payer.
59 (63)	Other Payer Reject Code	X	Enter the reject codes received by Other Payer. Required when the Other Payer has denied payment for billing, designated by Other Coverage Code of '3'.
64	Compound Dosage Form Description Code	X	Enter the dosage form of the complete compound mixture, for example: 01 = capsule, 02 = ointment, 03 = cream, etc.
65	Compound Dispensing Unit Form Indicator	X	Enter the unit of measure that corresponds with the complete compound mixture, for example: 1 = each, 2 = grams, 3 = milliliters.

Claim Item	**Title**	**Req'd**	**Action**
67	Compound Ingredient Component Count	X	Count of compound product IDs (both active and inactive) in the compound mixture submitted.
69	Compound Product ID	X	Product identification of an ingredient used in a compound.
70	Compound Product ID Qualifier	X	Enter the qualifier of Ø1 = UPC, Ø2 = HRI, or Ø3 = NDC.
71	Compound Ingredient Quantity	X	Enter the amount expressed in metric decimal units of the product included in the compound mixture.
72	Compound Drug Ingredient Cost	X	Enter the ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity'.
73	Compound Basis of Cost Determination	X	Enter the code indicating the method by which the drug cost of an ingredient used in a compound was calculated.
74	Usual and Customary Charge	X	Enter the amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
75	Basis of Cost Determination	X	Enter the code indicating the method by which the 'Ingredient Cost Submitted' was calculated.
76	Ingredient Cost Submitted	X	Enter the submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due'.
77	Dispensing Fee Submitted	X	Enter the dispensing fee submitted by the pharmacy. This amount is included in the 'Gross Amount Due'.
79	Incentive Amount Submitted	X	Enter the amount that represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due'
80	Other Amount Submitted	X	Enter the amount representing the additional incurred costs for a dispensed prescription or service.

Claim Item	**Title**	**Req'd**	**Action**
82	Gross Amount Due (Submitted)	X	Enter the total price claimed from all sources.
83	Patient Paid Amount	X	Amount the pharmacy received from the patient for the prescription dispensed.
86 (87)	Other Payer-Patient Responsibility Amount	X	Enter the patient's cost share from a previous payer.

THIRD PARTY LIABILITY BILLING INSTRUCTIONS

When payment is received from insurance, enter the insurance payment in the "Other Payer Amount Paid" field and submit the claim to Medicaid. Medicaid will apply the lesser of logic against the client's insurance out-of-pocket responsibility amount in pricing the claim. Medicaid co-payment should be collected from the client if applicable. If a claim is denied by Medicaid because the client has other insurance that may be billed by the pharmacy and the client cannot supply a card with the insurance information, contact Change Healthcare provider help desk at 877-209-1264.

Below is a list of valid NCPDP other coverage codes for Wyoming Medicaid. Please refer to the payer sheet available at wymedicaid.org:

00 = other coverage information is not specified by the client. Zero is the default value (i.e., use when the client has no other coverage).

01 = no other coverage information available. This value must only be submitted AFTER the provider has exhausted all means of determining pharmacy benefit coverage and no other coverage was identified. This value MUST NOT be used as a default (i.e., use when the client shows as having third party liability (TPL) but indicated they no longer receive this coverage).

02 = other coverage exists (Other payer amount paid < $1 requires an override, other payer patient responsibility amount < $0 will reject)

03 = other coverage was billed but claim was not paid because the service is not covered by other insurance (other insurance reject code must = 70 and OPAP must be > $0 for OCC of 03 to be used).

04 = other coverage was billed, but no payment was received (ex: 100% deductible)

An audit will be conducted on a regular basis to verify the accurate use of the above other coverage codes. If other coverage codes reported on claims are inaccurate, claims may be subject to recovery and further audit proceedings.

If a claim is for a medication where the brand is preferred over the generic (denoted by an asterisk on the PDL) and the primary insurance only covers the generic then the generic may be dispensed and the remainder of the cost billed to Medicaid.

SECTION 5. PLAN INFORMATION

Plan 190		Overrides/Exceptions/Comments
Eligibility		
Wyoming Regular Medicaid Clients		Full Medicaid Prescription Coverage.
Co-payments*		
Generics	$0.65	Standard Co-payment exceptions
Preferred Brands	$3.65	
Non-Preferred Brands	$3.65	
Compounds	$3.65	For Both Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	90 days	Exceptions allowed on certain medications (see page 11)
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	Yes	Limited Coverage (see page 9)

Plan 191		Overrides/Exceptions/Comments
Eligibility		
Wyoming Medicaid Nursing Home Clients		Clients that are living in a nursing home setting or facility.
Co-payments		
Generics	$0	Standard Co-payment exceptions
Preferred Brands	$0	
Non-Preferred Brands	$0	
Compounds	$0	For Both Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	90 days	Exceptions allowed on certain medications (see page 11)
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	
Over-the-Counter Drugs (OTC)	No	
Durable Medical Equipment (DME)	No	

Plan 193		Overrides/Exceptions/Comments
Eligibility		
Long Term Care Waiver Clients (LTC)		Clients that receive services through the LTC waiver and Home and Community-based Services (HCB).
Co-payments*		
Generics	$0.65	
Preferred Brands	$3.65	
Non-Preferred Brands	$3.65	
Compounds	$3.65	For Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	90 days	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	Yes	Limited Coverage (see page 9)

Plan 195		Overrides/Exceptions/Comments
Eligibility		
Children's Special Health (CSH)		Clients are eligible based on their illness or disease
Co-payments		
Generics	$0	
Preferred Brands	$0	
Non-Preferred Brands	$0	
Compounds	$0	For Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	30 days	
Maintenance	No	
DUR Edits		
Prior Authorizations (PA)	No	
Preferred Drug List (PDL)	No	
Quantity Edits	No	
Covered Services		
Legend Drugs	Yes	Limited Coverage
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	Yes	Limited Coverage (see page 9)

Plan 198		Overrides/Exceptions/Comments
Eligibility		
Family Planning (FP)		Clients that are from the ages 19-45 years and choose to use preventative birth control
Co-payments		
Generics	$0	
Preferred Brands	$0	
Non-Preferred Brands	$0	
Compounds	$0	For Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	N/A	Prescriptions are limited to a 90 day supply, with the exception of implants and intramuscular injections, which are limited to one (1) service per ninety (90) days supply.
Maintenance	N/A	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	Limited to Contraceptive Products
Over-the-Counter Drugs (OTC)	Yes	Limited to Contraceptive Products
Durable Medical Equipment (DME)	No	

Plan 390		Overrides/Exceptions/Comments
Eligibility		
Wyoming CHIP (without copay)		Approved children in households with income at or below 100% FPL, or Native American or Alaskan American
Co-payments		
Generics	$0	
Preferred Brands	$0	
Non-Preferred Brands	$0	
Compounds	$0	For Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 Days	
Maintenance	90 Days	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	No	Limited Coverage (see page 9)

Plan 391		Overrides/Exceptions/Comments
Eligibility		
Wyoming CHIP (copay)		Approved children in households with income between 101% and 200% FPL.
Co-payments		
Generics	$0.65	
Preferred Brands	$3.65	
Non-Preferred Brands	$3.65	
Compounds	$3.65	For Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	90 days	Exceptions allowed on certain medications (see page 11)
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (See page 8)
Durable Medical Equipment (DME)	No	Limited Coverage (See page 9)

MEDICARE PART D/MEDICAID DUAL ELIGIBLE CLIENTS

If a client has coverage under one of the plans listed below then dual eligibility exists. There are only three (3) plans that a dual eligible client would have coverage under. Drug coverage for current plans will remain the same.

- **Plan 290**: Regular dual eligible clients (clients eligible for Medicaid and Medicare Part D drug coverage)
- **Plan 291**: Nursing home dual eligible clients (clients eligible for Medicaid nursing home benefits and Medicare Part D)
- **Plan 293**: LTC Waiver dual eligible clients (clients eligible for Medicaid LTC Waiver benefits and Medicare Part D)

MEDICARE PART D/MEDICAID DUAL ELIGIBLE CLIENT LIMITATIONS

The Code of Federal Regulations prohibits Medicaid from paying for most prescription drugs for clients who are eligible for Medicare Part D, regardless of the client's actual enrollment in a Part D plan. The Division of Healthcare Financing, Pharmacy Services covers only those drugs that are exempt from coverage by Medicare Part D prescription drug plans. These drugs include over-the-counter (OTC) products currently covered by Wyoming Medicaid. Medicaid will not cover drugs that are excluded from a prescription drug plan's formulary so any issues concerning a dual eligible client's drug coverage need to be directed to the client's Medicare prescription drug plan.

Pharmacies should bill Medicare eligible clients for OTC products currently covered by Wyoming Medicaid in the same way they bill for non-dual Medicaid clients; through POS with the client's Medicaid identification number. Copays will still apply. OTC medications are not covered for dual eligible nursing home clients because OTC medications are included in nursing home per diem rates.

The Wyoming Medicaid Pharmacy program will cost avoid TPL claims for Medicare Part D plans. According to CMS "the Medicaid program by law is intended to be the payer of last resort" and therefore, when claims are billed to a client who is eligible for both Medicare Part D and Medicaid, due diligence must be used to bill the claim to Medicare Part D first. For dual eligible clients the Medicaid formulary is limited. For any questions regarding this policy, the Change Healthcare help desk can be contacted at 877-209-1264.

Plan 290		Overrides/Exceptions/Comments
Eligibility		
Wyoming Regular Dual Eligible Clients		Clients eligible for Medicaid and Medicare Part D drug coverage
Co-payments*		
Generics	$0.65	
Preferred Brands	$3.65	
Non-Preferred Brands	$3.65	
Compounds	$3.65	For Both Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Lowest Price Advertised	Yes	Lesser of Logic
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	No	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	Dual eligible limitations (see page 46)
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	Yes	Limited to syringes

Plan 291		Overrides/Exceptions/Comments
Eligibility		
Wyoming Nursing Home Dual Eligible Clients		Nursing home clients eligible for Medicaid nursing home benefits and Medicare Part D drug coverage
Co-payments		
Generics	$0	
Preferred Brands	$0	
Non-Preferred Brands	$0	
Compounds	$0	For Both Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	No	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	Dual eligible limitations (see page 46)
Over-the-Counter Drugs (OTC)	No	
Durable Medical Equipment (DME)	No	

Plan 293		Overrides/Exceptions/Comments
Eligibility		
Wyoming Long Term Care Waiver Dual Eligible Clients		Clients eligible for Medicaid LTC Waiver benefits and Medicare Part D drug coverage
Co-payments*		
Generics	$0.65	
Preferred Brands	$3.65	
Non-Preferred Brands	$3.65	
Compounds	$3.65	For Both Brand and Generic Drugs
Reimbursement Rates		
Average Wholesale Price (AWP)-11%	Yes	Lesser of Logic
Federal Upper Limit (FUL/FMAC)	Yes	Lesser of Logic
Gross Amount Due (GAD)	Yes	Lesser of Logic
State Maximum Allowable Cost (SMAC)	Yes	Lesser of Logic
Ingredient Cost Submitted	Yes	Lesser of Logic
Usual & Customary	Yes	Lesser of Logic
National Average Drug Acquisition Cost (NADAC)	Yes	Lesser of Logic
Wholesale Acquisition Cost	Yes	Lesser of Logic
All Inclusive Rate (AIR)	Yes	Only for IHS pharmacies
Maximum Day Supply Limits		
Non-Maintenance	34 days	
Maintenance	No	
DUR Edits		
Prior Authorizations (PA)	Yes	
Preferred Drug List (PDL)	Yes	
Quantity Edits	Yes	
Covered Services		
Legend Drugs	Yes	Dual eligible limitations (see page 46)
Over-the-Counter Drugs (OTC)	Yes	Limited Coverage (see page 8)
Durable Medical Equipment (DME)	Yes	Limited to syringes

SECTION 6. APPENDIX

ACRONYMS

- ADD Attention Deficit Disorder
- ADHD Attention Deficit Hyperactivity Disorder
- AIDS Acquired Immune Deficiency Syndrome
- AWP Average Wholesale Price
- BIN Benefit Identification Number
- CHC Change Healthcare
- CMS Centers for Medicaid and Medicare Services
- CHIP Children's Health Insurance Program
- CSH Children's Special Health
- DAW Dispense as Written
- DEA Drug Enforcement Agency
- DESI Drug Efficacy Study Implementation
- DME Durable Medical Equipment
- DOB Date of Birth
- DRA Deficit Reduction Act
- DUR Drug Utilization Review
- FDA Food and Drug Administration
- FMAC Federal Maximum Allowable Cost
- FP Family Planning
- FUL Federal Upper Limit
- GAD Gross Amount Due
- HCB Home and Community-based Services
- HHS Health and Human Services
- HHS-OIG Health and Human Services Office of the Inspector General
- HIPAA Health Insurance Portability and Accountability Act
- ID Identifier
- IHS Indian Health Services
- IV Intravenous
- LTC Long Term Care
- NADAC National Average Drug Acquisition Cost
- NCPDP National Council for Prescription Drug Programs
- NDC National Drug Code
- NPI National Provider Identifier
- NSAID Non-steroidal Anti-inflammatory Drug
- OBRA '90 Omnibus Budget Reconciliation Act of 1990
- OTC Over-the-Counter
- P&T Pharmacy and Therapeutics
- PA Prior Authorization
- PCN Processor Control Number
- PDL Preferred Drug List
- PDMP Prescription Drug Monitoring Program
- POS Point-of-Sale
- PPI Proton Pump Inhibitor
- RTS Refill Too Soon
- SMAC State Maximum Allowable Cost
- TPL Third Party Liability
- U&C Usual and Customary

- WAC Wholesale Acquisition Cost
- WIC Women, Infants, and Children
- WMSA Wyoming Medicaid Service Area

FORMS

Please refer to http://www.wymedicaid.org/.

PREFERRED DRUG LIST (PDL)/ADDITIONAL THERAPEUTIC CRITERIA CHART/DOSAGE LIMITATION CHART

Please refer to http://www.wymedicaid.org/.