

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington**

To: Pharmacists
All Prescribers
Nursing Facility Administrators
Regional Support Networks
Managed Care Organizations

Memorandum No: 08-09
Issued: March 04, 2008

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (HRSA)

For information, contact:
800.562.3022, option 2, or go to:
<http://maa.dshs.wa.gov/contact/prucontact.asp>
or visit the pharmacy web site at:
<http://maa.dshs.wa.gov/pharmacy>

Supersedes #Memo 07-07

Subject: Prescription Drug Program: Medicare Part D

Retroactive to January 1, 2008, the Health and Recovery Services Administration (HRSA) will pay up to \$5.60 per prescription for Medicare Part D copayments.

What has changed?

Retroactive to January 1, 2008, HRSA will pay up to \$5.60 for Medicare Part D copayments per prescription for clients who have a prescription benefit through Medicaid AND are eligible for Medicare Part D (dual eligible clients).

Do pharmacists need to rebill?

HRSA is **not** automatically adjusting claims. For claims eligible for the higher co-payment amount, and submitted between January 1 and January 15, 2008 **pharmacists may** reverse the claim and re-bill or submit an Adjustment Request (525-109) form [DSHS 13-715].

[Because system changes were made and dates after 1/15 will have paid correctly.]

Refer to HRSA's [General Information Booklet](#) for instructions on completing the Adjustment Request (525-109) form [DSHS 13-715]. Providers may download this form from DSHS's web site at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click *the Billing Instructions and Numbered Memorandum* link). These may be downloaded and printed.

Billing

General Instructions for Billing

- Bill HRSA your usual and customary charge using the complete 11-digit NDC from the dispensing container.
- Report the actual quantity dispensed using the appropriate metric or metric decimal quantity for the product.
- Remember that HRSA is the payer of last resort. See page I.19 for instructions on coordination of benefits. (*Claims paid inappropriately when other coverage is available may be recouped.*)
- Clients who are enrolled in an HRSA managed care plan are eligible for pharmacy services under their designated plan.
- Check the HMO column on the Medical ID Card and **bill the plan first**. (See page I.8 for more instructions on billing HRSA managed care plans.)

Important Notes:

When another insurer or an HRSA managed care plan requires authorization for a drug, perform all steps necessary to obtain the authorization.

Requiring authorization is not the same as a denial of coverage.

Tamper-Resistant Prescription Pad Requirement

Beginning April 1, 2008, all **written** prescriptions for Medicaid clients in fee-for-service (FFS) programs, including over-the-counter medications, must be on compliant, tamper-resistant pads or paper. This also applies to prescriptions when Medicaid is the primary or secondary payer.

What is the new requirement?

42 United States Code (USC) Section 1936b(i)(23) requires that the tamper-resistant paper must prevent the prescription from being changed by having at **least one** of the following characteristics:

- **No copying:** For example, pantographs that reveal the word “VOID” when copied.
- **No altering:** For example, chemical stains or an altered background reveal attempts at ink or toner removal.
- **No counterfeiting:** For example, pads have a watermark and can't be reproduced.

After **October 1, 2008**, the prescription pads must have **all three** characteristics to be considered tamper-resistant.

Information about vendors who provide prescription pads that meet the federal requirement can be found at the Washington Medicaid web site at <http://maa.dshs.wa.gov>. The Department of Social and Health Services (DSHS) does not endorse any specific vendor. DSHS does not reimburse prescribers' costs for compliant paper.

Prescriptions that are telephoned, faxed, or sent electronically to the pharmacy are exempt from this federal requirement. Pharmacists receiving non-compliant, written prescriptions are encouraged to verify the prescription with the prescriber.

How are clients enrolled in managed care affected?

- This requirement does not apply to prescriptions which are paid for by the plan for enrollees in one of the following:
 - ✓ Healthy Options (HO) Managed Care;
 - ✓ Basic Health Plus (BHP+);
 - ✓ General Assistance Unemployable-Managed Care (GAU-MC);
 - ✓ Washington Medicaid Integration Partnership (WMIP); or
 - ✓ Medicare/Medicaid Implementation Program (MMIP).
- This requirement does apply when a managed care contract excludes the drug if otherwise reimbursable under FFS.

- If a client has third-party liability (TPL) with a managed care plan for non-contracted Medicaid services, then the requirement **does** apply.

Medicare Part D Copays

This requirement applies to Medicare Part D prescriptions.

What about emergency dispensing?

Pharmacists are allowed to dispense the prescription written on non-compliant paper as long as the pharmacy receives verification from the prescriber by telephone, fax, or email within 72 hours of filling the prescription. Federal controlled substance laws must continue to be met when prescribing or dispensing Schedule II drugs.

What about Medicaid clients with retroactive certification?

To submit a claim for a Medicaid client retroactively certified for Medicaid, the following applies:

- The prescription must meet the tamper-resistant compliance requirement.
- Refills that occur after the date on which the client is determined to be eligible require a new, tamper-resistant prescription.
- If the original order is not compliant with the tamper-resistant compliance requirement, the pharmacy may either obtain a verbal, faxed, or email confirmation of the prescription from the prescriber.
- The pharmacy must reimburse the client in accordance with WAC 388-502-0160.

What are the documentation and records retention requirements?

The pharmacist must document that the prescriber was contacted by telephone, fax, or email to verify that the legitimacy of the prescription written on non-compliant paper **before** it was dispensed.

Prescription records, including documentation for non-compliant prescriptions, must be kept for six years according to WAC 388-502-0020.

Prescription Transfers Between Pharmacies

The pharmacy accepting a prescription transfer from another pharmacy only needs to obtain a telephone call or fax from the transferring pharmacy in order to confirm the authenticity of the tamper-resistant prescription.

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit initial claims and adjust prior claims in a timely manner. The following are HRSA's timeliness standards for initial claims and for resubmitted claims for the Prescription Drug Program:

- **Initial Claims**

HRSA requires providers to submit an **initial claim** to HRSA and have an Internal Control Number (ICN) assigned by HRSA within 365 days from any of the following:

- ✓ The date the provider furnishes the service to the eligible client;
- ✓ The date a final fair hearing decision is entered that impacts the particular claim;
- ✓ The date a court orders HRSA to cover the services; or
- ✓ The date DSHS certifies a client eligible under delayed¹ certification criteria.
- ✓ The date on which an HRSA contracted Managed Care plan recouped payment from the provider as a result of premium payment recoupment by HRSA.

Medicare Part B Crossover Claims: If Medicare Part B allows the claim, it is no longer billable as a Prescription Drug Program claim through the Point-of-Sale (POS) system. Claims allowed by Medicare are billable as a crossover claim on a 1500 Claim Form within six months of the date that Medicare processes the claim. If Medicare prints remark code MA07 or the phrase "claim information forwarded to Medicaid" on the EOMB, HRSA will extend the billing period for these claims to 12 months from the date of service. If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for the initial claim.

Medicare Part D Copays: Follow the same timeliness standards as non-Medicare crossover claims.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment** from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill, demand, collect, or accept payment** from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

- ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

Providers must bill known third parties for services. (See WAC 388-501-0200 for exceptions.) Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

- **Resubmitted Claims**

HRSA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within 15 months of the date the service was provided to the client. After 15 months, HRSA does not accept a prescription drug claim for resubmission, modification, or adjustment.

- **Overpayments that must be refunded to DSHS**

The 15-month period for resubmitted claims above **does not apply** to overpayments that a prescription drug provider must refund to DSHS. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. **Do not submit a claim adjustment.** Questions regarding overpayments may be directed to HRSA Cash Control at 360.725.1279.

- **Billing the Client**

HRSA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements in this section, resulting in the claim not being paid by HRSA. (See "Billing a Client," page I.4.)

2 **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment** from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

Billing for a Baby Using his/her Parent's PIC

BILLING

Hard copy billers must indicate "**Baby using parent's PIC**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "2" in the *Insurance Segment, Eligibility Clarification Code* field.

Billing a Client [Refer to WAC 388-502-0160]

Reminder

- A common billing complaint is the pharmacist misinterpreting a POS message as a denial and charging the client instead of calling HRSA for authorization. Please remember that it is the pharmacist's responsibility to call HRSA for authorization when the pharmacist receives an authorization message from the POS system.

The POS system does not solve the problem of identifying clients who are not currently on HRSA's eligibility file. For clients whose Medical ID Cards show that they are eligible, but their claims deny in the POS system for lack of eligibility, please take the following steps:

- ✓ **FAX** a copy of the client's Medical ID Card to Claims Entry at **360.586.1403**; or
- ✓ Mail in a **completed** paper claim with a photocopy of the Medical ID Card attached.

Faxed copies of Medical ID Cards will be updated within two working days in order for claims to be resubmitted. Please do not fax **claims** to this number.

See Washington Administrative Code on next page...

Refer to WAC 388-502-0160

1. A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if HRSA does not pay for the service because the provider failed to satisfy the conditions of payment in HRSA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.
2. The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.
3. A provider may bill a client only if one of the following situations apply:
 - a. The client is enrolled in medical assistance managed care and the client and provider comply with the requirements in WAC 388-538-095;
 - b. The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request.

The agreement must include each of the following elements to be valid:

- i. A statement listing the specific service to be provided;
 - ii. A statement that the service is not covered by HRSA;
 - iii. A statement that the client chooses to receive and pay for the specific service; and
 - iv. The client is not obligated to pay for the service if it is later found that the service was covered by HRSA at the time it was provided, even if HRSA did not pay the provider for the service because the provider did not satisfy HRSA's billing requirements.
- c. The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);
 - d. The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by HRSA. [Medical Assistance is not insurance.];

Prescription Drug Program

- e. The provider has documentation that the client represented himself/herself as a private pay patient and not receiving Medical Assistance when the client is already eligible for and receiving benefits under an HRSA medical program. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection 3.b. regarding the agreement to pay. However, if the patient later becomes eligible for HRSA coverage of a provided service, the provider must comply with subsection 4 of this section for that service.
- f. The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by HRSA; or
- g. The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a \$3.00 copayment may be imposed on the client by the hospital, except when:
 - i. Reasonable alternative access to care was not available;
 - ii. The "indigent person" criteria in WAC 246-453-040(1) applies;
 - iii. The client was 18 years of age or younger;
 - iv. The client was pregnant or within 60 days postpregnancy;
 - v. The client is an American Indian or Alaska Native;
 - vi. The client was enrolled in a HRSA managed care plan, including Primary Care Case Management (PCCM);
 - vii. The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
 - viii. The client receives waived services such as community options program entry system (COPEs) and community alternatives program (CAP).

4. If a client becomes eligible for a covered service that has already been provided because the client:

- a. Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:
 - i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
 - ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill HRSA for the service;

Prescription Drug Program

- b. Receives a delayed certification (see page I.2), the provider must:
 - i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
 - ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill HRSA for the service; or
- c. Receives a retroactive certification (see page I.3), the provider:
 - i. Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
 - ii. May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

Note: Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.

If eligible, the client receives a DSHS Medical ID Card dated the first of the month of application. The Medical ID Card is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

- 5. **Hospitals may not bill, demand, collect, or accept payment from a Medically Indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described in subsection 3.g. of this section.**
- 6. **A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or HRSA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.**

This includes, but is not limited to:

- a. Medical charts;
- b. Radiological or imaging films; and
- c. Laboratory or other diagnostic test results.

Hospice Clients

Clients who have elected to receive hospice benefits are identified by an “X” in the hospice area on their Medical ID Card.

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated by the designated hospice agency (be sure to call the hospice agency to find out what must be billed under hospice) and attending physician **only**.

Services **not** related to their terminal illness may be provided to clients on an FFS basis. When billing for hospice clients and the service is **not** related to the terminal illness (be sure to call the hospice agency to find out what medications are not related to the hospice diagnosis or end-of-life care needs), use the following billing procedures:

BILLING

Hard copy billers must enter “K” in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers must enter “11” in the *Patient Segment, Patient Location* field.

Do not use this procedure for dates the client is not on hospice services. Be sure to check with the hospice agency before you use the “K” or “11”.

Clients Enrolled in an HRSA Managed Care Plan

HRSA reimburses for drugs dispensed to clients enrolled in an HRSA managed care plan only when a managed care contract excludes the drug or pharmaceutical supply and the product is otherwise reimbursable under FFS. The following may be billed FFS to HRSA:

- Prescriptions written by **dentists** will be paid FFS.
- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed following abortion procedure are reimbursable on a FFS basis for clients enrolled in an HRSA managed care plan.
- Over-the-counter contraceptives, including emergency contraception for female clients over the age 18, when billed by a pharmacy that is not contracted with the clients managed care plan.
- HIV Anti-Retrovirals.
- Protease Inhibitors.

Billing for Managed Care clients

Eligible medical assistance clients enrolled in a Plan must have their prescriptions filled at a pharmacy contracted with the Managed Care Organization (MCO). If your pharmacy is non-contract, the client must be referred to an MCO-contracted pharmacy.

- Bill the Plan first, except for drugs prescribed by a Health Department.
- If the Plan denies with a conditional claim rejection, such as Plan limitations or prior authorization required, do what is necessary to be reimbursed by the Plan.
- If the Plan denies the claim and the prescriber is a Family Planning Agency or a Community Mental Health Center, or if the service is excluded from the managed care contract as described above, bill HRSA with the “2” in the *Prior Authorization Type Code* field for reimbursement if the service is a benefit under the client’s program.

Clients enrolled in a HRSA managed care plan may receive services under separate contracts from the following 3 entities:

- Community Mental Health Centers;
- Family Planning Agencies; and
- Health Departments.

The prescriptions written by the above entities must be related to the therapeutic classifications listed below. Clients may take these prescriptions to any medical assistance-participating pharmacy and are reimbursable FFS by HRSA.

Pharmacists must document the prescribing entity (i.e., community mental health center, family planning agency, or health department) on the original prescription. All other FFS rules apply to claims for the therapeutic classes listed below, including authorization requirements.

Community Mental Health Centers may prescribe mental health drugs within the following therapeutic drug classes:

- Attention Deficit Hyperactive Disorder (ADHD) drugs;
- Anti-anxiety;
- Anticonvulsants;
- Antidepressants;
- Antipsychotics;
- Central Nervous System (CNS) drugs; and
- Ancillary drugs for the treatment of side-effects.

Prescription Drug Program

Family Planning Agencies may prescribe contraceptives, drugs for sexually transmitted diseases (STD) (excluding HIV) when related to the client's family planning method, and drugs related to a sterilization procedure within the following therapeutic drug classes:

- Analgesics;
- Antibiotics;
- Anti-emetics;
- Antifungals;
- Anti-infectives;
- Anti-inflammatories; and
- Contraceptive drugs/devices.

Health Departments may prescribe drugs for STD (excluding HIV), tuberculosis, and prescription contraceptives within the following therapeutic drug classes:

- Antibiotics;
- Anti-emetics;
- Anti-infectives;
- Contraceptive drugs/devices; and
- Tuberculosis drugs.

BILLING

Hard copy billers must enter one of the following comments in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

**Prescribed by Family Planning Agency;
Prescribed by Community Mental Health Center; or
Prescribed by Health Department.**

Point-of-Sale billers must enter "2" in the *Claim Segment, Prior Authorization Type Code* field.

Family Planning Only and TAKE CHARGE Clients

Clients on the Family Planning Only or TAKE CHARGE Programs are identified by the statement “Family Planning Only” or “TAKE CHARGE” on their Medical ID Card.

Family planning agencies may prescribe the following drugs related to family planning and contraceptives within the following therapeutic drug classes to Family Planning Only or TAKE CHARGE clients:

Contraceptives and Drugs	
Contraceptives, oral, including emergency contraception	Macrolides
Contraceptives, injectables	Antibiotics, misc. other
Contraceptives, transdermal	Quinolones
Contraceptives, intravaginal	Cephalosporins – 1 st generation
Contraceptives, intravaginal, systemic	Cephalosporins – 2nd generation
Contraceptives, implantable	Cephalosporins – 3rd generation
Vaginal lubricant preparations	Absorbable Sulfonamides
Condoms	Nitrofurans Derivatives
Diaphragms/cervical caps	Antifungal Antibiotics
Intrauterine devices	Antifungal Agents
Vaginal antifungals	Anaerobic antiprotozoal – antibacterial agents
Vaginal Sulfonamides	
Vaginal Antibiotics	
Tetracyclines	

HRSA covers anti-anxiety medications before a sterilization procedure and pain medications after a sterilization procedure for Family Planning Only and TAKE CHARGE clients as follows:

Anti-anxiety Medication – Before Sterilization Procedure

Medication	Maximum Number of Doses
Diazepam	2
Alprazolam	2

Pain Medication – After Sterilization Procedure

Medication	Maximum Number of Doses
Acetaminophen with Codeine #3	12
Oxycodone HCl/Acetaminophen 5/500	12
Hydrocodone Bit/Acetaminophen	12
Oxycodone HCl/ Acetaminophen	12

BILLING

When billing for the covered preoperative anti-anxiety medications and postoperative pain medications for TAKE CHARGE or Family Planning Only clients:

Hard copy billers must enter “**Family planning sterilization medication**” in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers must enter “**6**” in the *Claim Segment, Prior Authorization Type Code* field.

Skilled Nursing Facility (SNF) Clients

Over-the-Counter (OTC) Drugs

HRSA does not reimburse for OTC drugs when the client resides in a SNF unless the drugs are on the Washington Preferred Drug List (see section L). Reimbursement for OTC drugs is included in the SNF per diem.

Medications for SNF clients on leave

SNF clients on leave should have their additional maintenance prescriptions filled for the duration of the leave. If client leaves weekly, prescriptions should be filled for a one-month supply.

SNFs should determine which of the following methods will be followed when a SNF client goes on leave:

- The client may take the prescription medication home and keep it there for use during SNF absences; or
- The client may return the prescription medication to the SNF following each leave so that it may be stored for safekeeping. The prescription medication is the client’s personal property.

Both of these practices are in accordance with state pharmaceutical regulations.

BILLING

Hard copy billers must indicate “**weekend pass**” or “**take home/leave supply**” in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter “8” in the *Claim Segment, Prior Authorization Type Code* field.

Emergency Kits

The *emergency kit* is a set of limited pharmaceuticals furnished to a SNF by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each SNF’s client population and is for use during those hours when pharmacy services are unavailable.

Medications supplied from the emergency kit are the responsibility of the SNF.

SNF Unit Dose Delivery Systems [Refer to WAC 388-530-7350]

HRSA recognizes two types of **Unit Dose Delivery Systems** for SNFs:

- **True Unit Dose Delivery System**
- **Modified Unit Dose Delivery System**

Eligible unit dose providers receive the unit dose dispensing fee when dispensing in-house unit dose prescriptions. The term *in-house unit dose* applies to bulk pharmaceutical products that are packaged by the pharmacy for unit dose delivery. Providers receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to the *Reimbursement* Section of these billing instructions for HRSA Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?

[Refer to WAC 388-530-5100(1)]

To be eligible for a unit dose dispensing fee from HRSA, a pharmacy must:

1. Notify HRSA in writing of its intent to provide unit dose service;
2. Specify the type of unit dose service to be provided;
3. Identify the SNF or facilities to be served;
4. Indicate the approximate date unit dose service to the facility or facilities will commence; and
5. Sign an agreement to follow HRSA requirements for unit dose reimbursement.

For information on becoming a unit dose provider, please call Provider Enrollment at 800.562.3022, option 2 then option 5. You may also fax a written request to 360.725.2144 or mail the request to:

Health and Recovery Services Administration
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

How do pharmacies bill HRSA under a unit dose delivery system?

[Refer to WAC 388-530-5100(2), (3), and (4)]

Under a unit dose delivery system, a pharmacy must bill HRSA only for the number of drug units actually used by the HRSA client in the SNF.

It is the unit dose pharmacy provider's responsibility to coordinate with the SNFs to ensure that the unused drugs the pharmacy dispensed to the facility for distribution to an HRSA client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment form or claims reversal of the charge to HRSA for the cost of all unused drugs returned to the pharmacy from the SNF on or before the 60th day following the date the drug was dispensed. This adjustment must conform to the SNF's monthly log.

Exception:

Unit dose providers are not required to credit HRSA for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

BILLING

Hard copy billers must indicate "**In-house unit dose**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "3" in the *Claim Segment, Unit Dose Indicator* field.

Who is responsible for the cost of repackaging client's bulk medications? [Refer to WAC 388-530-5100(5)]

The cost of repackaging is the responsibility of the SNF when the repackaging is done:

- To conform with the SNF's delivery system; or
- For the SNF's convenience.

Pharmacies may not charge clients or HRSA a fee for repackaging a client's bulk medications in unit dose form.

What records do SNF pharmacies need to keep? [WAC 388-530-5100(6) and (7)]

The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each SNF served, including, but not limited to the following information:

- Facility name and address;
- Client's name and patient identification code (PIC);
- Drug name/strength;
- National Drug Code (NDC);
- Quantity and date dispensed;
- Quantity and date returned;
- Value of returned drugs or amount credited;
- Explanation for no credit given or nonreusable returns; and
- Prescription number.

Upon request, the pharmacy must submit copies of these monthly logs to HRSA. HRSA may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to HRSA? [WAC 388-530-5100(8)]

When the pharmacy submits the completed annual prescription volume survey to HRSA, it must include an updated list of SNFs served under unit dose systems.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

**A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.
(Refer to WAC 388-502-0020[2])**

What additional records do pharmacies need to keep?

[Refer to WAC 388-530-5000]

In addition to the previous record retention requirements, pharmacies must comply with the following:

Provision of Prescription Drugs

Keep any specifically required documents for the provision of prescription drugs, including but not limited to:

- Authorizing order (prescription);
- Name of person performing the service (dispensing pharmacist);
- Details of medications and/or supplies prescribed or provided including NDC, name, strength, and manufacturer;
- Drug Use Review (DUR), intervention, and outcome documentation;
- Expedited authorization (EA) documentation; and
- Proof of fill.

Proof of Delivery

- When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the item(s) delivered.
- When a provider mails an item to the client, the provider must be able to furnish proof of delivery, including a mail log.
- When a provider uses a delivery/shipping service to deliver items, the provider must be able to furnish proof of delivery and it must:
 - ✓ Include the delivery service tracking slip with the client's name or a reference to the client's package(s); the delivery service package identification number; and the delivery address.
 - ✓ Include the supplier's shipping invoice, with the client's name; the shipping service package identification number; and a detailed description(s).
- When a client or the client's authorized representative picks up the prescription, the provider must be able to furnish proof of delivery including signature, client's name, and a detailed description of the item(s) delivered.
- Make proof of delivery records available to HRSA, upon request.

Coordination of Benefits (COB)

HRSA is required by federal regulation to determine the liability of third-party resources available to HRSA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, HRSA may make reimbursement on the balance if the insurance payment is less than HRSA's allowed amount.

It is the provider's responsibility [[WAC 388-501-0200](#)] to bill HRSA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the Medical ID Card;
- The Point-of-Sale (POS) system alerts the provider to a client's insurance; or
- The provider believes insurance is available.

The Insurance Carrier List and carrier information is available on the DSHS/HRSA web site at <http://maa.dshs.wa.gov/Download/hcarrier.txt>. The information can be downloaded and printed or used as an online reference.

HRSA's billing time limit is 365 days, but an insurance carrier's time limit to bill may be different. It is the provider's responsibility to meet the insurance carrier's billing time limit prior to receiving any payment by HRSA. The provider should not bill HRSA with an *Other Coverage Code* if the claim was denied by the insurance carrier for late filings.

For questions related to insurance, contact:

Coordination of Benefits Hotline
800.562.6136
Monday through Friday
8:00 a.m. to 4:30 p.m.
or
Coordination of Benefits Program
PO Box 45565
Olympia, WA 98504-5565

Other Coverage Codes (Override Codes)

Why are Other Coverage Codes important?

The HRSA POS system alerts a provider when a client has other insurance. When a provider submits a claim through the POS system, and HRSA files indicate that a client has insurance, **HRSA will deny the claim. Then the provider must bill the client's insurance before using the Other Coverage Codes** (override codes).

The provider's weekly Remittance and Status Report (RA) shows that the claim is denied with the Explanation of Benefits (EOB) 090. The EOB states "*Please bill your claim to the insurance company as instructed. For questions call 800.562.6136.*" The insurance carrier information is printed on the RA for the provider's reference.

When may providers use one of the override codes?

The following chart lists situations in which other insurance is available, gives some direction to the provider, and explains which *Other Coverage Codes* (override codes) to enter. In all of the situations described below, the pharmacy must bill the other insurance **before** using the override code.

The chart also provides information about documentation. Pharmacy providers who submit their claims through the POS system are not required to submit third-party documents. However, the provider must have these documents available for audit purposes. **Examples of the documentation that would justify the provider's use of the override code are listed below in italics.**

Contact the COB Hotline number (800.562.6136) for any override situations that are not listed below. See Section K for values and definitions of the *Other Coverage Codes*.

Situations	Explanation/Solution	Other Coverage Code
The insurance has made payment to the pharmacy. <i>(An EOB or electronic transmission from insurance identifying the insurance paid amount.)</i>	Bill balance to DSHS.	2
Insurance allowed amount of the prescription is less than or equal to the copay. <i>(An EOB or electronic transmission from insurance identifying both the insurance allowed and co-pay amounts.)</i>	Bill DSHS.	3

Prescription Drug Program

Situations	Explanation/Solution	Other Coverage Code
The prescription must be filled by mail order. <i>(Contract verification that the prescription must be filled by mail order; or denial from insurance stating mail order.)</i>	Bill DSHS.	3
Plan only covers a new prescription. <i>(An EOB or electronic transmission from insurance showing only new prescriptions covered.)</i>	Bill refills to DSHS.	3
The insurance carrier applied the claim charges to the client's deductible. <i>(An EOB or electronic transmission from insurance identifying the claim amount was applied to the deductible.)</i>	Bill DSHS.	3
The client's insurance plan maximum annual benefit has been met. <i>(An EOB or electronic transmission from insurance identifying the annual benefit has been met.)</i>	Bill DSHS.	3
The insurance denied the medication as a noncovered drug. Clarify if denial is for noncovered or nonformulary drugs. If nonformulary, third-party payment procedures must be followed. <i>(An EOB or electronic transmission identifying the drug is noncovered or include a copy of the contract drug exclusion list)</i>	Bill DSHS.	3
The client has a discount card. <i>(Verification of discount card or denial from insurance stating "discount card".)</i>	Bill DSHS.	3
DSHS reports that the client has insurance. Insurance denied the claim as client not eligible for insurance or, insurance cannot identify the cardholder/member. <i>(An EOB or electronic transmission from insurance denying the claim for eligibility. If the primary insurer can not identify the client, call HRSA at 800.562.6136.)</i>	Bill DSHS.	7
Capitated service agreement with insurance carrier. <i>(A signed capitated service agreement.)</i>	Bill DSHS.	8
Note: For questions on the use of <i>Other Coverage Codes</i> or acceptable documentation, call COB at 800.562.6136.		

If one of the previously listed situations occurs, providers may resubmit the claim entering an *Other Coverage Code* (override code) into the POS system to bypass the edit for other insurance coverage.

Inappropriate use of override codes may result in an audit of your POS claims and recoupment of improper payments.

Note: In those instances where the primary insurance has made payment, the normal 34-day supply limit may be exceeded.

Clients with Privately Purchased HMO Insurance

A client with privately purchased health maintenance organization (HMO) insurance will have an ***HI, HO, or HM*** identifier in the insurance column on their Medical ID Card. The client is required to use the HMO facilities for pharmacy services. If services are provided that are not covered by the HMO plan, the claim may be submitted to HRSA for processing.

Situations may occur when a client is out of the HMO service area or HMO coverage is not accessible, a pharmacy provider may proceed to meet the client's immediate needs.

Billing

Pharmacy providers who submit their claims through the POS system are not required to submit insurance EOB documents. ***However, documentation must be retained and kept by the provider for audit purposes.*** [[WAC 388-502-0020](#)]

Primary Insurance Billing Exceptions

Primary insurance billing exceptions listed below are examples of third-party situations and how they are processed in the POS system. All amounts billed to the insurance and to DSHS must be usual and customary charges, except for capitated copayments.

What does the provider do if a third-party liability question arises and it is after COB hours?

Situations may occur when a client is asking to fill a prescription, a question arises and it is outside of COB's regular business hours. After making reasonable attempts to access the primary insurance coverage, proceed with filling what is necessary to meet the client's immediate needs. "Immediate needs" means pharmacists using their professional judgment to determine the quantity to dispense to best meet the client's needs in an emergency. The pharmacy must contact COB within 72 hours for billing assistance. Examples may include:

- DSHS indicates that the patient has insurance, but the coverage cannot be identified and the patient does not provide it; or
- The patient has HMO private insurance or has a closed pharmacy network.

What does the provider do if the client's coverage is prepay?

Contact COB for billing assistance if the client's coverage is prepay. Prepay means the client's identified insurance coverage policy requires the client to pay at the time of service, and the insurance reimbursement is made only to the subscriber. Do not bill the insurance and do not bill DSHS with an *Other Coverage Code*. Prepay is defined on a case-by-case basis.

How do I bill for nonformulary or noncovered drugs?

Pharmacists are required to obtain prior authorization from the insurance carrier for nonformulary drugs before providing the drugs to the client. When the denial reason is related to a nonformulary drug, the pharmacy may need to coordinate with the prescriber and/or the insurer to authorize an alternative drug or get the insurer to cover the prescription as prescribed. **Do not use an *Other Coverage Code*.** The pharmacy must meet all third-party billing requirements prior to billing HRSA.

Noncovered drugs are not to be confused with nonformulary drugs. It is the provider's responsibility to correctly determine if the drug is noncovered or nonformulary with the primary insurance carrier. Noncovered drugs may be billed to HRSA using the *Other Coverage Code 3*.

Coordination of Benefits Frequently Asked Questions (FAQ)

1. How do I find out if a client has retail prescription drug coverage and who processes the prescriptions?

Ask the client if she has insurance coverage, an insurance card, and/or Medical ID Card. If the Medical ID Card lists the insurance carrier and you do not know where to submit the claims, contact the insurance carrier. Verify there is retail prescription coverage with the insurance carrier and ask where to submit claims. When you submit a claim through the POS system and no *Other Coverage Code* has been entered, you will be notified if the client has prescription coverage.

Download the insurance carrier contact information at <http://maa.dshs.wa.gov/download/hcarrier.txt>.

2. What do I do if a client's insurance states there is no coverage or the insurance coverage has ended?

If there is no coverage or the coverage has ended, notify COB at 800.562.6136.

3. What do I do if a client's insurance plan cannot identify the client?

If the insurance carrier cannot identify the client, contact COB at 800.562.6136 to verify the cardholder identification and the plan being billed are the same as on file with COB. We will assist you with verifying the client's prescription coverage or update COB records if the client does not have coverage.

4. What do I do when the insurance column is blank on the Medical ID Card, and when I bill POS, the claim rejects to bill the primary insurance?

Although insurance carrier information is updated daily, it is possible the information was updated after the Medical ID Card was printed. The pharmacy must meet all insurance carrier billing requirements prior to billing HRSA.

5. What is discount only or mail order only coverage?

Discount only or mail order only coverage means insurance does not reimburse for any prescriptions filled at retail pharmacies.

- a. If a client has *discount only* or *mail order only* benefits, HRSA does not consider this a primary insurance. Bill HRSA.
- b. If you bill HRSA and we deny the claim to bill the insurance carrier, and you believe the client has *discount only* coverage, contact COB.

Note:

- Some clients have *mail order only* on certain prescriptions, requiring them to use mail order when they refill prescriptions on an ongoing or regular basis.
- Insurance carriers may refer to mail order as “maintenance.” For example, some plans consider mail order to be maintenance when a certain prescription is refilled more than two times. Bill the insurance carrier first. If the claim is denied by insurance to use mail order, then bill HRSA with an *Other Coverage Code 3*.

6. What do I do when the insurance states copay is 100%?

Contact the insurance carrier for claim denial or paid at zero detail. Examples of denials or paid at zero are:

- a. A prepay plan;
- b. Less than copay;
- c. Benefits are exhausted; or
- d. The maximum number of fills has been met.

7. How do I bill for after hours services?

After hours services means prescriptions filled outside of COB regular business hours. After making reasonable attempts to meet the primary insurance carrier’s billing requirements, you may proceed with filling what is necessary to meet the client’s immediate needs.

8. What is “meeting client’s immediate needs?”

Immediate needs means pharmacists are to use their professional judgment to determine the quantity to dispense to best meet the client’s needs in an emergency. Please contact COB within 72 hours for billing assistance. Examples may include:

- a. HRSA indicates the client has insurance, but you cannot identify the coverage; or
- b. The client has HMO private insurance or has a closed pharmacy network.

9. What is the service area?

Service area means the nearest pharmacy that accepts the insurance within 25 miles or 45 minutes in one direction from the client's address.

10. What do I do when POS will not accept an *Other Coverage Code*, or I do not know where to enter the *Other Coverage Code*?

Contact your pharmacy software or switch vendor.

11. What is prepay?

Prepay means the client's insurance coverage requires the client to pay at the time of service, and the insurance reimbursement is made to the subscriber. In this instance, you must call COB for billing assistance. Do not bill the insurance, and do not bill HRSA with an *Other Coverage Code*.

On September 1, 2003, pharmacists were notified in [Memorandum No. 03-55 MAA](#) that HRSA has discontinued the *Other Coverage Code* 4.

12. Why does my claim get rejection code DV (MISSING/INVALID OTHER PAYER AMOUNT PAID) or E8 (MISSING/INVALID OTHER COVERAGE CODE) when I try to bill the balance to HRSA?

If you get a rejection code DV, you have indicated that insurance made payment by entering 2 in the *Other Coverage Code* field, but the payer amount was entered as 0.00.

If you get a rejection code E8, you have entered an insurance payment, but have not entered the 2 in the *Other Coverage Code* field.

Verify the insurance carrier has made payment, and enter the amount in the *other payer* amount field. If there is no insurance payment, **do not enter a 2** in the *Other Coverage Code* field; contact the insurance carrier to find out why the payment was not made. If you have verified the insurance amount paid and the payment amount is not displayed on the POS system, please contact your software or switch vendor.

13. If I cannot get the claim to go through, is entering \$.01 in the insurance paid field allowed?

No. Enter an amount only if \$.01 or another amount is the actual amount paid by the insurance. Entering any amount paid by the insurance carrier other than the actual amount paid could be considered fraudulent.

14. When can I use Other Coverage Code 8?

HRSA allows only pharmacy providers that have a capitated service agreement with an insurance carrier to use this *Other Coverage Code*. This is limited to those pharmacy providers that make no FFS billing to the insurance carrier.

Exception: See page I.31 for billing for Medicare Part D copayments for Medicare and Medicaid dual-eligible clients.

15. How do I submit a claim to HRSA when the insurance allowed amount is less than or equal to the copay amount?

Copay is the amount that private insurance has determined the person with the private insurance coverage is expected to pay per prescription.

Note: Eligible Medicaid clients with private insurance are not expected to pay a copay. When the insurance allowed or payable amount is less than or equal to the copay amount, the insurance nonpayment reason is less than copay. Bill HRSA, after you bill the insurance. Use a 3 in the *Other Coverage Code* field.

16. Why would my claim be paid at zero or denied by insurance?

If you cannot verify the reason the claim was paid at zero, you must contact the insurance carrier and find out why the claim was paid at zero or denied. If you still have questions after contacting the insurance carrier, contact COB.

17. What is a closed pharmacy network?

Closed pharmacy network means an insurer restricting prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy not included on the exclusive list. [[WAC 388-530-7800\(3a\)](#)]

HRSA may pay for the prescription without requiring the client to use a participating network pharmacy ONLY in the following situations:

- a. When the prescription is not covered by the policy;
- b. If the client is out of the service area; or
- c. If you provided medications to meet a client's immediate need for services.

If you are not a participating pharmacy, do not bill with an *Other Coverage Code* prior to contacting COB.

18. What do I do if I am not contracted with the client's private insurance carrier?

HRSA requires clients to use pharmacy providers contracted with their private insurance carrier. Clients with managed care private insurance will have an HM, HI, or HO identifier in the insurance column on their Medical ID Card.

If the insurance carrier provides pre-pay plan coverage for noncontracted pharmacy providers, contact COB for billing assistance.

If you are not contracted and the coverage is not pre-pay, HRSA may pay for the prescription without requiring the client to use a contracted pharmacy ONLY in the following situations:

- a. When the prescription is not covered by the policy;
- b. If the client is out of the service area ; or
- c. If you provided medications to meet a client's immediate need for services.

Do not bill with an *Other Coverage Code* prior to contacting COB.

19. What do I do if a client's insurance coverage requires paper billing and our pharmacy only bills electronically?

The pharmacy must meet all third-party billing requirements prior to billing HRSA.

If the insurance coverage is a pre-pay plan for paper billers, contact COB for billing assistance. Do not bill with an *Other Coverage Code* prior to contacting COB.

20. How do I paper bill HRSA after primary insurance has been billed?

While POS billing is preferred, pharmacies who submit their claims to HRSA on paper must enter any amount paid by the primary insurance in the *insurance paid amount* field and the primary insurance processing details in the *justification/comments* section on the Pharmacy Statement [DSHS 13-714]. Download the Pharmacy Statement at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

21. If the client has a DSHS managed care plan/Healthy Options plan and private insurance, who do I bill?

If a client has both an HRSA managed care plan/Healthy Options plan **and** private insurance for the date of service, the pharmacy bills the HRSA managed care plan/Healthy Options plan. The managed care plan/Healthy Options plan then bills the primary insurance. Contact the HRSA managed care plan/Healthy Options plan or HRSA Customer Service Center at 800.562.3022 for billing assistance and information about the primary coverage.

22. If I bill the insurance carrier and the denial reason is “plan limits exceeded,” can I bill HRSA with an Other Coverage Code?

If the client’s insurance benefits have been exceeded, it is appropriate to bill HRSA with an *Other Coverage Code 3*.

The pharmacy must meet all third-party billing requirements prior to billing HRSA.

23. How do I bill if the insurance carrier requires authorization?

The primary insurance carrier requirements must be met. Contact the insurance carrier for authorization review and to determine if and how the medication is covered by the insurance plan.

24. The pharmacy did not know the client had HRSA coverage at the time of service, and the client was charged a copay at the time of service. Are we required to refund the client?

See HRSA’s [General Information Booklet](#) Section H for details on billing a HRSA client. Claims submitted to HRSA after the fill date must be completed per HRSA’s *Prescription Drug Program Billing Instructions*, and the primary insurance details must be complete and accurate.

25. The insurance carrier requires authorization. The prescriber will not provide information to the pharmacy or insurance carrier so authorization can be obtained. Can I bill HRSA directly?

The insurance carrier requirements must be met. It is not appropriate to bill HRSA with an *Other Coverage Code* unless the billing conditions of the insurance carrier have been met.

26. What are the documentation requirements? How long does documentation need to be kept?

Pharmacy providers who submit their claims through the POS system are not required to submit third-party EOB documents. However, documentation must be retained and kept by the provider for audit purposes. Documentation is to be made available to HRSA for six years from the date of service. [[WAC 388-502-0020](#)]

27. The client has insurance coverage through multiple carriers. Am I required to bill both?

It is the provider’s responsibility to seek timely reimbursement from a third-party when a client has available third-party resources. [[WAC 388-501-0200](#)]

How to bill for clients who are eligible *for both Medicare and Medicaid?*

Some Medicaid clients are also eligible for Medicare Part B or Part D benefits. Bill Medicare first. The following instructions will assist in billing for dual eligible clients.

Medicare Part B

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Part B Medicare cover some drugs and drug-related supplies. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier *first*. Medicare is the primary payer of claims.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. HRSA will pay up to Medicare's allowable or HRSA's allowable, whichever is less.

An **X** in the *Medicare* column on the client's Medical ID Card indicates Medicare eligibility.

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical ID Card in addition to QMB)

- If Medicare *and* Medicaid cover the service, HRSA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare *and not Medicaid* covers the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicaid covers the service and Medicare does not cover the service, HRSA will reimburse for the service.

Part B—Medical Insurance

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service, it may not be covered by Part B. Medicare Part B also covers a limited number of other types of drugs. (Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to www.cms.hhs.gov.)

Medicare Part B Medications (that are not covered through Part D)

After Medicare Part B has processed the claim, and if Medicare has allowed the medication(s), in most cases Medicare will forward the claim to HRSA for any supplemental Medicaid payment. When the words, "*Claim information forwarded to Medicaid*," appear on the Medicare remittance notice, it means that the claim has been forwarded to HRSA or a private insurer.

- If **Medicare Part B has paid** for a medication and the Medicare crossover claim does not appear on the HRSA Remittance and Status Report within 30 days of the Medicare statement date, bill HRSA.

You must submit the claim to HRSA within six months of the Medicare statement date. If Medicare prints remark code MA07 or the phrase “claim information forwarded to Medicaid” on the EOMB, HRSA will extend the billing period for these claims to 12 months from the date of service.

- If **Medicare Part B has denied** a medication, bill HRSA through the POS system using the appropriate DUR outcome code (see page K.5). Claims may also be billed on the Pharmacy Statement form and must have the Medicare denial letter or Explanation of Benefits (EOMB) attached. [**Note:** When Medicare denies a service that requires authorization, HRSA waives the *prior* requirement, but authorization is still required.]

Bill Medicare’s coinsurance and deductible using the 1500 Claim Form.

Medicare Part D

Benefits under Medicare Part D cover some drugs and drug-related supplies. When a client is eligible for both Medicaid *and* Medicare Part D benefits, submit claims for that client to the Medicare intermediary or carrier *first*. Medicare is the primary payer of claims.

Medicare Part D Copayments

Who is eligible to have copayments covered by the HRSA?

The client's Medical ID card must display all of the following:

- An "X" in the Medicare column;
- A "CNP" or "MNP" medical program identifier; and
- "MedicareRx."

What is the maximum HRSA pays for a Part D copayment?

For dates of service February 21, 2006, through December 31, 2006, the maximum basic Medicare Part D copayment is \$5.00.

For dates of service January 1, 2007, through December 31, 2007, the maximum basic Medicare Part D copayment is \$5.35.

Retroactive to dates of service January 1, 2008, and after, the maximum basic Medicare Part D copayment is \$5.60.

Note: Some dual-eligible clients have elected prescription coverage from Medicare-approved "creditable coverage" plans or from enhanced Medicare prescription drug plans. HRSA pays the maximum copayment amount described above for dual-eligible clients. Copayment amounts above the maximum copayment amount of \$5.60 per prescription are the client's responsibility.

How do I bill the copayment?

Enter an "8" in the *Other Coverage Code* field 308-C8 and enter only the copayment amount in either the *Other Amount Claimed Submitted* field 480-H9 or the *Gross Amount Due* field 430-DU. **Do not submit the COB/Other Payment Segment.**

Note: HRSA pays only the copayment of a paid Medicare Part D claim, in the amount indicated by the client's plan up to the maximum copayment amount.

Medicare Part D—Prescription Drug Insurance

Medicare Part D-covered drugs are:

- Biological products;
- Insulin and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze);
- Vaccines; and
- Drugs that are:
 - ✓ Available only by prescription;
 - ✓ Used and sold in the United States; and
 - ✓ Used for a medically accepted indication.

Certain drugs or classes of drugs, or their medical uses, are excluded by law from Medicare Part D coverage. These drugs or classes of drugs are listed at:

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf.

While these drugs or uses are excluded from basic Medicare Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare.

How do I bill if Medicare denies as nonformulary?

When the client is covered by Medicare Part D, Medicaid does not pay for any prescriptions that are the responsibility of Medicare Part D. Contact the prescription drug plan for authorization for nonformulary drugs. Due process under the Medicaid appeal rules such as an administrative hearing and Exception to Rule are not available to the client under this circumstance.

Helpful hyperlinks

- List of medications that HRSA will cover:
<http://maa.dshs.wa.gov/medicaredrugs/MedicareDWAStateCoverecRxFeb06.xls>
- Medicare Part D web site:
<http://www.medicare.gov/>
- HRSA Medicare web site:
<http://maa.dshs.wa.gov/MedicareDrugs/>
- SHIBA web site:
<http://www.insurance.wa.gov/consumers/medicare/medprescriptdrugs.asp>
- CMS web site:
<http://www.cms.hhs.gov/>

This page intentionally left blank.