NM HSD Pharmacy

2023 Policy and Billing Manual

Contents

Section 1

Overview and Purpose

The purpose of this Pharmacy Policy and Billing Manual is to provide a reference for the policies established by the New Mexico Human Services Department (HSD) related to the administration of the pharmacy benefit. The Manual was developed by the HSD Medical Assistance Division (MAD) to support a common understanding of the expectations for eligible recipients of services, providers, managed care organizations, and financial management agencies. This includes expectations for physicians, hospital administrators, pharmacies and other providers, as well as office staff and billers of providers. These individuals/groups should become familiar with the requirements for member eligibility and enrollment, prior authorization requirements, claims submissions, billing policies and procedures, and the use of modifiers.

Section 2
Definitions

NMAC is the acronym for New Mexico Administrative Code. The NMAC consists of the rules filed by state agencies.

Section 3
Provider Requirements

Provider Responsibilities and Requirements

A provider who furnishes services to a Medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules and instructions as specified in this manual, its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the Centers for Medicare and Medicaid Services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

A provider must verify that an individual is eligible for a specific Medicaid health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

Services must be provided within the scope of practice, licensure, and must be in compliance with the statutes, rules and regulations of the applicable practice act.

A pharmacy provider must discuss all matters with the Medicaid Eligible Member or their personal representative that, in the provider's professional judgment, are significant. Pharmacy counseling services are subject to the standards for counseling established under the state Pharmacy Practice Act. Counseling must be furnished unless declined by the Medicaid Eligible Member or their authorized representative. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act.

A pharmacy provider must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs. [8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1-1-14]

A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor.

Participating providers must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in practice address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or

may have occurred prior to any sale, merger, consolidation, dissolution, or other disposition of the provider or person.

The Patient Protection and Affordable Care Act (PPACA) requires attending, ordering, referring, rendering, and prescribing providers to be enrolled in the Medicaid program. This is required in order to meet PPACA program integrity requirements designed to ensure all attended, prescribed, ordered, referred, or rendered services, items, and admissions for Medicaid beneficiaries originate from properly-licensed providers who have not been excluded from Medicare or Medicaid.

Providers must be enrolled as Medicaid providers before submitting claims to the New Mexico Medicaid Fiscal Agent [ALTERNATIVE LANGUAGE: MAD claims processing contract] to be reimbursed for covered services rendered to Medicaid recipients. The MAD Benefits and Reimbursement Bureau is responsible for enrolling Medicaid fee-for-service providers through a provider participation agreement (PPA), with the exception of intermediate care facilities, personal care agencies, nursing home facilities (enrolled by the MAD Program Planning Bureau), and presumptive eligibility determiners (enrolled by MAD Client Services Bureau.)

MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material.

Section 4
Eligible Providers

Eligible providers include:

1. Pharmacies licensed by the New Mexico pharmacy board;
2. Clinics licensed for outpatient dispensing by the New Mexico pharmacy board;
3. Institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;
4. Family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico pharmacy board;
5. Prescribers with prescriptive authority who are enrolled as an active New Mexico Medicaid provider;
6. Indian Health Service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and
7. Mail order pharmacies licensed to dispense in New Mexico.

List of Community Pharmacies

Section 5
Eligible Members

Pharmacy Services

MAD pays for medically necessary health services furnished to Medicaid Eligible Members, including covered pharmacy services and practitioner administered drugs [42 CFR Section 440.120(a)].

Individuals become eligible for New Mexico's Medicaid Program, when they meet the specific criteria for one of the Medicaid eligibility categories. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on Medicaid eligibility requirements.

A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services. A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or contracting with a magnetic swipe card vendor.

An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

For more information on member eligibility please read the Eligibility Pamphlet.

The NMAC rule numbers can also be looked up on the NM Administrative Code website.

Section 6

Covered and Non-Covered Services

Covered Services

NM Medicaid covers medically necessary prescription drugs and some over the-counter drugs, subject to the limitations and restrictions delineated below.

Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. [Placeholder for PDL link]

Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

1. **Over-the-counter requirements**: For a Medicaid Eligible Member 21 years of age and older not in an institution, coverage of over-the counter items is limited to insulin, diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculosides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over-the-counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provision listed below. Otherwise, the Medicaid Eligible Member 21 years and older, or their authorized representative is responsible for purchasing or obtaining an over-the-counter item. Prior authorization for coverage of other over-the-counter products may be requested when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.

2. **Generic-first coverage requirements**: When drugs are provided through a preferred drug list, drugs are subject to generic-first coverage provisions, when therapeutically equivalent. The Medicaid Eligible Member must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition. The generic-first provisions do not apply to Indian Health Service (IHS) facilities and PL 93-638 tribally operated hospitals and clinics. The following categories of drug items would be exempt from the generic-first requirements:[Link to approved formulary list to be added]

    A. Anti-asthmatic and other respiratory drugs

B. Anticoagulants

C. Anticonvulsants

D. Antipsychotics and antidepressants

E. Cancer chemotherapy items

F. Thyroid hormone

Brand name drug items may be covered upon approval by MAD, or its designee, including HSD contracted managed care organization (MCO), based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items.[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1-1-14]

3. **Legal requirements**: All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to their practice and ethics.

4. **Rebate requirements**: MAD pays only for the drugs of pharmaceutical manufacturers that have entered into, and have in effect, a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a Medicaid Eligible Member.

5. **Prescribing:** A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a Medicaid Eligible Member. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify their Medicaid Eligible Members that they cannot prescribe drug items for them.[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1-1-14]

Non-Covered Services or Service Restrictions

Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

MAD does not cover the following specific pharmacy items:

1. Medication supplied by state mental hospitals to a Medicaid Eligible Member on convalescent leave from the center;

2. Methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);

3. Personal care items such as non-prescription shampoos, soaps;

4. Cosmetic items, such as Retin-A for aging skin, Rogaine for hair loss;

5. Drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;
6. Fertility drugs;
7. Antitubercular drug items available from the New Mexico Department of Health (DOH) or the United States public health service;
8. Drug items used to treat sexual dysfunction;
9. Compounded drug items which lack an ingredient approved by the FDA for the indication for which the drug is intended;
10. Compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and
11. Cough and cold preparations for a Medicaid Eligible Member under the age of four.

Over-the-counter drug limitations: MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a Medicaid Eligible Member who resides in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the Medicaid Eligible Member or billed to MAD, or a HSD contracted managed care organization, by a provider:

1. Diabetic testing supplies and equipment;
2. Aspirin and acetaminophen;
3. Routine ointments, lotions and creams, and rubbing alcohol; and
4. Other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

Medicare Part D limitations: MAD does not cover drug items for a Medicaid Eligible Member who is eligible for Medicare Part D when the drug item or class of drug meets the federal definition of a Medicare Part D covered drug. MAD does not cover any copayment due from the Medicaid Eligible Member towards a claim paid by Medicare Part D nor any Medicare Part D covered drug or class of drug where the Medicaid Eligible Member has a gap in Medicare Part D coverage due to a Medicare coverage limit. Items or drug classes specifically excluded by Medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a Medicaid Eligible Member who is not dually-eligible. [8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1-1-14]

More information on fee schedules is available here.

Section 7
Authorization

Prior Authorization and Utilization Review

All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. The Uniform Prior Authorization Form may be downloaded at https://comagine.org/sites/default/files/resources/nm-uniform-prior-authorization-form.pdf.

Procedures or services may also require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. It is the provider's responsibility to contact MAD or its designee, and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

Prior authorization of services does not guarantee that individuals are eligible for MAD services. A dental provider must verify that an individual is eligible for Medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

A provider who disagrees with prior authorization denials or other review decisions can request a re-review and a reconsideration. See Provider Appeals and Member Appeals.

Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the generic-first coverage provisions, applicable therapeutic requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

1. Prior authorization: MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

2. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the Medicaid Eligible Member has other health insurance.

3. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

4. Drug utilization review: The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of

prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the Medicaid Eligible Member's service providers or governmental entities legally authorized to receive such information.

- Prospective drug use review: Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions, clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

- Counseling: Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each Medicaid Eligible Member or their authorized representative receiving services who presents a new prescription, unless the Medicaid Eligible Member or their authorized representative refuses such counsel. Pharmacists must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a Medicaid Eligible Member access to a toll-free number. [8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1-1-14]

Prescriptions and Refills

1. Dispensing frequencies: MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same Medicaid Eligible Member.

    - The limitation is established individually for each drug.

    - Maintenance drugs are subject to a maximum of three times in 90 days with a 14-calendar day grace period to allow for necessary early refills.

    - Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.

- The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.
- Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

2. Refill requirements: Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the Medicaid Eligible Member has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.
3. Quantities dispensed: Maintenance drugs are those on the MAD-approved maintenance drug list.

For a Medicaid Eligible Member with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.

Prescriptions for non-maintenance drugs are limited to 34-day supplies.

Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the Medicaid Eligible Member has been established.

Controlled substances may not be refilled until 75 percent of the drug has been used based on the days' supply of the previous prescription unless the prescriber has been notified and given approval. Products containing opioids may not be refilled until 90 percent of the drug has been used and are subject to a 90 morphine milligram equivalent (MME) limitation and an initial seven day supply of medication limit is in place for an opioid naïve Member. Members with certain conditions may be granted an exception to this requirement through the prior authorization process. Eligible conditions include, but are not limited to, cancer, hospice or palliative care, sickle cell disease (SCD), and residents in a long term care facility or facility where such drugs are dispensed to a resident.

A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale (POS) system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

Pharmacy providers may dispense up to a 90-day supply for maintenance medications upon confirmation that at least two consecutive monthly fills are on record; medication quantity can be reduced to a 30-day supply when this cannot be confirmed.

Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill. MAD considers prescription splitting to be fraudulent.

Coverage may be limited by the end date of the Medicaid Eligible Member's span of eligibility at the time of dispensing.

Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

Controlled substances may have specific controls on the quantities dispensed.

4. Unit dose packaging: MAD does not pay additional for unit dose packaging.

5. Prevention of abuse: Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the Medicaid Eligible Member of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the Medicaid Eligible Member's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

6. Mail service pharmacy: MAD may provide a mail service pharmacy for Medicaid Eligible Member use.

The mail service pharmacy is available as an option to all Medicaid Eligible Members.

Retail pharmacies may mail, ship or deliver prescriptions to all Medicaid Eligible Members consistent with applicable state and federal statutes, rules and regulations.

[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1-1-14]

Paper Prescription Requirements

Paper prescriptions must be written on tamper resistant prescription pads. Faxed or telephoned prescriptions, as well as e-prescribing methods are considered tamper resistant and are not affected by these requirements. A pharmacy may fill a prescription on an emergency basis but must verify or obtain a tamper resistant version of the prescription within 72 hours.

The tamper resistant requirement does not apply to the following:

- Pharmacy claims paid by a Medicaid MCO or when the payment for prescriptions is included in an all-inclusive payment for an inpatient hospital stay.
- Nursing homes when a prescription is ordered by a practitioner in a patient's medical chart which the medical staff then phones the order directly to a pharmacy. It does apply if an order is transcribed to a written prescription and is then taken to the pharmacy.
- Refills for an individual who has become eligible for Medicaid since the initial filling or previous refill. However, the requirements do apply if the individual receives Medicaid eligibility retroactively. In these cases, for any refills occurring on or after the Medicaid eligibility is established, the pharmacy must obtain a new, tamper-resistant prescription, obtain verbal confirmation of the prescription from the prescriber, or may obtain the prescription from the prescriber by facsimile or e-prescription.

Characteristics of Tamper Resistant Prescriptions

One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form: pantograph screen displays background graphic (e.g., VOID) when copied; holograms on the face of the prescription

One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription: uniform background color in a standard background ink, such as blue or green, that shows when erasures or modification have been attempted; chemical void preventing alteration by chemical washing; exposure to ink solvent (e.g., Acetone) will cause “void” patterns to appear or cause a heavily stained appearance.

One or more industry-recognized features designed to prevent the use of counterfeit prescription forms: paper with words or symbols that are only seen when turned at an angle or paper that uses water marks; anti-copy coin-activated will display security message when rubbed with a coin (on reverse of prescription); watermark with vendor-specified wording or design in background.

Other Pharmacy Requirements

Retention and storage of the original prescription, electronic prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years.

If the prescriber certifies that a specific brand is medically necessary, by handwriting “brand medically necessary” or “brand necessary” on the face of the prescription, the allowed ingredient cost is the estimated acquisition cost (EAC) of the brand drug. The documentation of the provider's handwritten certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512.

“Brand necessary” prescriptions may be subject to prior authorization. Any claim for which “brand necessary” is claimed must be supported with documentation in the prescriber’s medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

Section 8
Billing and Claims Requirements

To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA, an agreement with a HSD contracted MCO and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. The Provider Enrollment Application may be accessed at https://nmmedicaid.portal.conduent.com/webportal/enrollOnline.

When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the Medicaid eligible member.[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1-1-14]

Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD. [8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1-1-14]

Pharmacy Overview

NMHSD has contracted with Conduent State Healthcare, LLC to maintain a Pharmacy Benefits Management System (PBMS) with the capability to process electronic point of sale transactions. The PBMS' services include:

1. Online real-time adjudication of pharmacy claims.
2. Payment to pharmacies for adjudicated pharmacy claims.
3. Implementation of pharmacy program benefits and limitations.
4. Administration of various prior authorization, clinical, drug utilization, and administrative edits.

Providers must be enrolled as a New Mexico Medicaid Provider. In-state pharmacies, IHS or Tribal 638 pharmacies, out-of-state pharmacies, or Rural Health Clinical pharmacies may review the enrollment application requirements at https://nmmedicaid.portal.conduent.com/static/PDFs/ProvEnrollPacket/ProvTypeSpec.xlsx.

Once enrolled, providers may submit real-time POS claims or batch claims to the PBMS. Providers may contact [Insert] for instructions and guidance on submitting claims to the PBMS.

Providers should reference the current National Council for Prescription Drug Programs (NCPDP) Payer Specification Sheet for specific pharmacy billing requirements (e.g., BIN, PCN, etc.). The most NCPDP Payer Specification Sheet is available at [Insert].

Providers may contact the Conduent Pharmacy Help Desk at 1-800-365-4944 (Option 3) for technical billing assistance.

Point-Of-Sale Pharmacy Billing

A pharmacy billing for services provided by pharmacists with prescriptive authority will bill using the following:

5. The pharmacist's national provider identifier (NPI) in the prescriber NPI field with the National Drug Code (NDC) for the prescribed product;
6. A valid quantity dispensed and appropriate days' supply;
7. The corresponding preventative medicine counseling and/or intervention service performed.

This would be approximately a 15-minute session billed at the updated Medicare reimbursement methodology. Counseling sessions are not limited to 15 minutes, and providers should apply the appropriate quantity to reflect time spent as accurately as they are able to in 15-minute increments. Reimbursement will include the calculated cost of the prescribed drug, a $10.30 professional dispensing fee and a submitted patient assessment clinical service payment at the most current Medicare based reimbursement fee schedule. The clinical service payment is intended to reimburse the pharmacy for the pharmacist prescribing and preventive medication evaluation and counseling of the determined drug therapy provided. [Link to fee schedule]

When a counseling session is provided at a pharmacy without dispensing a drug, the Preventive Medicine Counseling can be billed on a CMS-1500 under pharmacy provider type 416 with the procedure code for medication therapy management services by a pharmacist for assessments and interventions (Procedure Code 99605 New Patient or 99606 Established Patient) up to the initial 15 minutes and each additional 15 minutes (Procedure Code 99607).

NOTE: As of 03/01/2021, Indian Health Service providers will be reimbursed at the All-Inclusive Rate (AIR). The provider may reflect the services provided on the claim; however, additional payment will not be made for prescribing, counseling and/or drug administration.

For prescriptive authority billing, the pharmacy must populate the following NCPDP fields.

Field #	NCPDP Field Name
405-D5	Days' Supply
407-D7	Product Service ID

Field #	NCPDP Field Name
409-D9	Ingredient Cost Submitted
412-DC	Dispensing Fee Submitted
420-DK	Submission Clarification Code
438-E3	Incentive Amount Submitted
440-ES	Professional Service Code
473-7E	Code Counter Value

National Drug Code Billing Requirements

The federal Deficit Reduction Act of 2005 requires Medicaid providers to report an NDC (currently 11-digits and subject to updates/changes by the FDA) on the CMS1500, UB04 claims, and 837 electronic transactions when billing for injectable drugs and all other drug items administered in practitioners' offices, outpatient clinics, hospitals, and other clinical settings. Providers are required to include the appropriate NDC and other essential information on the claim when billing for drug items or claims may be denied or subject to recoupment.

Understanding the NDC

The NDC code found on the prescription drug label must be included on the CMS1500, UB04 claims, and 837 electronic transactions. The NDC is a unique product identifier assigned to each drug consisting of 11 digits with hyphens separating the number into three segments in a 5-4-2 or "12345-1234-12" format.

There will be times that a manufacturer will print the NDC on a drug label omitting a leading zero in one of the segments. This will require a leading zero "0" to be added to the segment where required digits are omitted when submitting a claim with no hyphens. The manufacturer NDC can be displayed in other formats other than a 5-4-2 digit format, and they can be in a 4-4-2 or "1234-1234-12" format, or a 5-3-2 or "12345-123-12" format, or a 5-4-1 or "12345-1234-1" format.

When a manufacturer does not display an NDC in a 5-4-2 digit format, a leading zero "0" must be inserted into the segment that is not complete with the 5-4-2 format. The following are examples:

NDC 12345-1234-12 is complete and it is reported as 12345123412

NDC 1234-1234-12 requires a leading zero "0" in the first segment in order to be in a 5-4-2-digit format, to become 01234-1234-12 reported as 01234123412

NDC 12345-123-12 requires a leading zero "0" in the second segment in order to be in a 5-4-2-digit format, to become 12345-0123-12 reported as 12345012312

NDC 12345-1234-1 requires a leading zero “0” in the third segment in order to be in the 5-4-2- digit format, to become 12345-1234-01 reported as 12345123401

NDC Requirement

All administered drug items require a valid NDC code to be entered for each line billed as Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes. These include various drug items, chemotherapy, injectable insulins, immune globulins, human albumin, and plasma products.

The same requirement applies to providers billing revenue codes on UB04 claims. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the claim is an outpatient hospital, emergency room facility, dialysis facility, or other outpatient facility which uses UB04 claims submission. When HCPCS or CPT codes are used for all administered drug items, the NDC code must be reported:

Pharmacy revenue codes 0250, 0251, 0252, and 0254

Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635, and 0636

Providers paid encounter rates such as a Federally Qualified Health Center (FQHC), an IHS or tribal compact facility or bundled rates such as drugs included in a dialysis cap charge do not need to supply an NDC drug identifier because they are not reimbursed utilizing one of the revenue codes listed above.

Instructions for Billing Drug Items Administered in Provider Offices, Outpatient Clinics and Hospitals

Due to the required reporting of NDC identifiers for administered drug items, providers are required to fill in the top and bottom rows of a claim line ensuring all spaces and characters are filled in accurately to identify the NDC of the drug item. All claims which do not have a valid NDC code for physician administered drug items will be denied by Medicaid’s Fiscal Agent. The requirement for reporting NDC codes on all professional claims for physician administered or dispensed drugs may have exceptions for certain claims submitted by Indian Health Service facilities, Federally Qualified Health Centers, Rural Health Clinics, Rural Health Clinic Hospital Based facilities, general acute care hospitals and hospital rehab, and renal dialysis facilities. Providers can resubmit a denied claim with an Adjustment Request Form with the corrected CMS-1500, UB-04 or Dental claim form. Instructions can be found on the New Mexico Medicaid Portal website.

CMS1500 Form

Begin entering the NDC in the shaded area of box 24A when an NDC code is required for an administered drug item starting with a 2-digit qualifier “N4” followed by the 11-digit NDC code in the shaded area above the Dates of Service followed by 3 spaces, followed by one of the 2-digit Unit of Measure code and the number of units with up to three decimal places.

The four (4) units of measure qualifiers are:

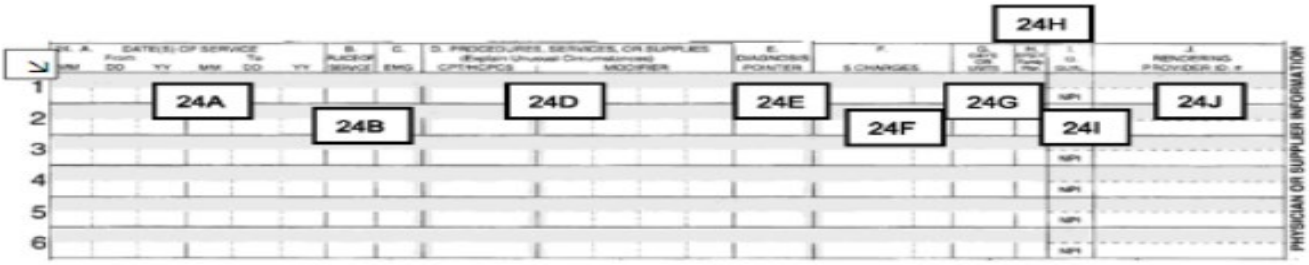
F2 - International Unit

GR - Gram

ML - Milliliter

UN - Units

Enter the NDC in the shaded area of box 24A shown below:



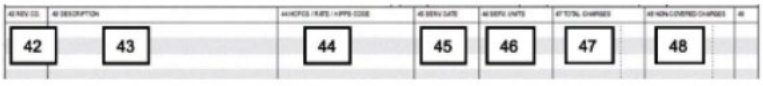
Detailed claim form instructions can be found on the New Mexico Medicaid Portal website. Information can be found on the website for item numbers 24A-J on requirements to identify the services performed.

In addition to entering an NDC, a valid HCPCS or CPT code must be entered in the non-shaded area of 24D. The unit of service for the HCPCS or CPT code is also required. Units for injections must be billed consistent with the HCPCS or CPT description of the code. For example, J0610 “Injection, Calcium Gluconate, per 10ml” is billed as 1 unit up to 10 ml dosages.

UB04 Form

A valid NDC must be entered in box 43, currently labeled as “description” and a 4-digit revenue code must be entered in form locator 42 and a HCPCS or CPT code must be entered in form locator 44.

Beginning at the left side of form locator 43, enter the 2-digit qualifier “N4” immediately followed by the 11-digit NDC. Example: NDC code 00054352763 will be entered as N400054352763



Claim form instructions can be found on the New Mexico Medicaid Portal website. Information can be found on the website for item numbers 42 - 48 on requirements to identify the services performed.

837 P and 837 I

All NDC codes must be reported in the following fields in the 837 formats:

Loop 2410

Seg LIN

Field LIN02: use the qualifier “N4”

Field LIN03: enter a valid 11-digit NDC code

340B Billing Requirements

Physician and Clinic Billing for Drugs Obtained Under the 340B Drug Pricing Program

Enactment of the Veterans Health Care Act of 1992, Public Law 102-585, resulted in the 340B Drug Pricing Program which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, including federally qualified health centers and health center program look-alikes, qualified disproportionate share hospitals, some state and local government clinics, family planning projects, and other types of clinics.

Oversight of the 340B program is the responsibility of the Health Resources and Services Administration (HRSA). Under this program, pharmaceutical manufacturers agree to charge at or below statutorily defined prices, known as 340B ceiling prices, for purchase by qualified entities. When pharmaceutical manufacturers have their drug products available at the discounted 340B rate, state Medicaid programs cannot invoice the manufacturer for drug rebates on these drug items purchased.

Therefore, MAD requires all pharmacies, physicians, regional health centers, family planning organizations, state government and other clinics that bill for drug items under 340B drug pricing agreements to:

1. Carve out of Medicaid and not submit claims for pharmaceutical items acquired through the 340B drug program, OR
2. Carve into Medicaid and submit claims for Medicaid recipients for pharmaceutical items acquired through the 340B program, and bill drug items utilizing the manufacturer assigned NDC identifier with the actual acquisition cost obtained through the 340B program using one of the following methods:

CMS1500 Claims: All pharmaceuticals acquired at 340B rates must be entered using the HCPCS code in form locator 24C followed by the modifier “UD”.

UB04 Claims: All pharmaceuticals acquired at 340B rates with the following pharmacy revenue codes 0250, 0251, 0252, 0254, 0631, 0632, 0633, 0634, 0635, and 0636 must have the HCPCS or CPT code immediately followed by the modifier UD in form locator 44. Example: HCPCS J0135 will be entered as J0135UD.

CMS mandates that Medicare providers report either the “JG” (drug or biological acquired with 340B drug pricing program discount) or TB (drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) modifiers, and are accepted by Medicaid; however, the “UD” modifier must also be included to identify 340B Medicaid claims.

Pharmacy POS Claims: New Mexico Medicaid requires all Fee-For-Service (FFS) pharmacies to identify claims billed at 340B pricing by providing modifier “08” in the “basis of cost determination” field 423-DN, submission of the 340B actual acquisition cost in the “ingredient cost submitted” field 409-D9 plus the $10.30 FFS professional dispensing fee in field 430-DU.

Billing 340b Modifiers under the Hospital Outpatient Prospective Payment System (OPPS)

Medicare Part B 340B-Acquired Drug Claims

All 340B hospitals are required to use modifiers to identify Medicare Part B 340B-acquired drugs billed under the OPPS.

CMS established two new HCPCS Level II modifiers to identify 340B-acquired drugs. Providers are required to report either modifier “JG” or “TB” on OPPS claims.

JG – Drug or biological acquired with 340B drug pricing program discount

TB – Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.

When applicable, hospital providers are required to report either modifier “JG” or “TB” on OPPS claims. Though modifier “TB” is an informational modifier, reporting is mandatory for applicable providers.

The New Mexico Medicaid program does require the use of modifiers (i.e., “UD” or 8) to identify 340B-acquired pharmaceutical stock.

Physician Administered Drug Claims and Encounters

Those providers who buy their pharmaceutical stock from 340B participating manufacturers are required to properly identify CMS-1500 and UB claims submitted using this stock for either fee-for-service or managed care claims/encounters. New Mexico Medicaid requires all physicians, regional health centers, family planning organizations, and other clinics that bill for physician administered drug items obtained under 340B drug pricing agreements to submit the UD modifier (340B drug pricing program discount) when filing a claim/encounter that used physician administered drugs from their discounted 340B stock.

Pharmacy Claims and Encounters

New Mexico Medicaid requires all pharmacies to submit actual acquisition costs under the 340B program in the “ingredient cost” in field 409-D9, complete the “gross amount due” with appropriate dispensing fee in field 430-DU, and identify the claim/encounter by providing “8” in the “basis of cost” field 423-DN.

Questions on this topic may be directed to the Conduent Provider Relations Helpdesk at 1-800-299-7304, option 6.

Provider NPI Requirements

The prescriber's NPI must be included on the pharmacy claim form.

Pharmacy claims will reject if they are not submitted with the prescriber NPI and with the appropriate prescriber ID qualifier (01).

Pharmacies may obtain NPIs directly from CMS through a query-only database, known as the NPI Registry. NPIs are also available from CMS as a downloadable file.

There may be some prescribers who are technically not required to obtain NPI numbers, such as a physician who never bills for any of their services. This should be a rare occurrence. However, if a prescriber tells the pharmacy that they are not required to have an NPI number because the provider is "not a covered entity" under HIPAA, please contact the Medical Assistance Division for instructions on how to file the claim electronically.

Questions regarding billing for pharmacist services can be directed to the Medical Assistance Division at MADInfo.HSD@state.nm.us. Questions regarding submission of pharmacy POS claims can be directed to Conduent's Pharmacy Helpdesk at 1-800-365-4944, option 3.

Section 9
Reimbursement

Reimbursement Methodology

1. For FFS point of sale prescription claims, the estimated ingredient cost will not exceed the lowest of:
    A. National Average Drug Acquisition Cost (NADAC) – NDB or NDG
    B. Affordable Care Act Federal Upper Limit (FUL)
    C. Wholesale Acquisition Cost (WAC) + 6%
    D. Submitted Usual and Customary (U&C)
2. For FFS medical pharmacy claims, the estimated ingredient cost will not exceed the lowest of:
    A. National Average Drug Acquisition Cost (NADAC) – NDB or NDG
    B. Wholesale Acquisition Cost (WAC) + 6%

Methodology Comment

Usual and customary charge:

The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

"Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

Usual and customary charges must reflect discounts given to a Medicaid Eligible Member for certain reasons, such as age or NF resident, when a Medicaid Eligible Member meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-Medicaid Eligible Member.

Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

Medicare reimbursement: Reimbursement may be limited to Medicare reimbursement limits where the total of the Medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in this Section Subsection A of this rule.

Practitioner administered drug items are reimbursed according to the MAD fee schedule.

Pharmacy price reductions: If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non-Medicaid Eligible Member, the provider must similarly reduce its charge to MAD for the prescription.

No claims for free products: If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a Medicaid Eligible Member.

Solutions: Solutions, such as saline for nebulizers, IV solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

Non-drug items: Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies; see 8.310.2 NMAC.

Reimbursement for Pharmacist Services

New Mexico law allows pharmacists to be certified to prescribe in areas such as hormonal contraception, tobacco cessation, immunizations, Naloxone drug therapy, tuberculosis testing (serum prescribing, administration and follow up reading are included as a single submission), and Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP) therapy, in accordance with the written protocols approved by the New Mexico Board of Pharmacy (NMBOP). Pharmacists with prescriptive authority often work in a retail setting and do not provide services under the supervision or direction of a physician. However, prescriptive authority shall be limited to those drugs, TB tests and vaccines delineated within currently approved and future NMBOP written prescriptive authority drug therapy protocols.

Pharmaceutical Service Reimbursement to Parity

The following information covers parity of reimbursement for all services provided by a Pharmacist Clinician (Ph.C.) and a Pharmacist with prescriptive authority who issues drug items billed through POS, or as HCPCS or CPT codes to the New Mexico Medicaid programs in an office, clinic, pharmacy, hospital, or any outpatient hospital setting.

Ph.C. Billing Requirements

Ph.C.s are not licensed for independent practice and cannot be paid directly. Reimbursement is made to the supervising provider or entity under which the extender works. See NMAC 8.310.3.11, Section C, 4, link below. Ph.C.s must enroll with the New Mexico Medicaid program. The purpose for required enrollment is so the Ph.C. can be identified as the rendering provider on the billing form.

Reimbursement for Pharmacist Clinicians (Ph.C.)

Reimbursement shall be paid to the Pharmacist Clinician or entity at the same rate that is paid to a licensed physician, physician assistant (PA), or advanced nurse practitioner (NP) for the same service. The Ph.C.'s NPI State of New Mexico Medical Assistance Program Manual Supplement is entered in the area designated for the Rendering Provider NPI and the supervising physician's NPI is entered in the billing provider information and the Service Facility NPI can also be listed in the Service Facility Location Information.

Instructions on filing CMS-1500 and UB-04 online claims can be found on the New Mexico Medicaid Portal website.

A Ph.C. is a professional certified by the NMBOP who has the additional training and licensure to provide direct health care - often in a hospital, clinic, physician's office, or pharmacy – for a variety of acute and chronic disease states that are outlined in a prescriptive authority protocol approved by a supervising physician that is licensed by the New Mexico Medical Board. They may only furnish services within their scope of practice as defined by state law. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The HSD MAD fee schedule rates were set as of July 1, 2020 and are effective for services provided on or after that date.

Reimbursement for Services Provided by Pharmacists with Independent Prescriptive Authority

Reimbursement for services provided by a pharmacist with independent prescriptive authority shall be paid at the rate that is paid to the billing provider. The billing provider must bill using the appropriate billing form.

New Mexico law allows pharmacists to be certified to prescribe in areas such as hormonal contraception, tobacco cessation, immunizations, Naloxone drug therapy, tuberculosis testing (serum prescribing, administration and follow up reading are included as a single submission), and HIV PEP therapy, in accordance with the written protocols approved by the NMBOP. Pharmacists with prescriptive authority often work in a retail setting and do not provide services under the supervision or direction of a physician. However, prescriptive authority shall be limited to those drugs, TB tests and vaccines delineated within currently approved and future NMBOP written prescriptive authority drug therapy protocols.

Instructions on filing CMS-1500 and UB-04 online claims can be found on the New Mexico Medicaid Portal website

For POS drug claims, the payer sheet is available on the HSD website and the New Mexico Medicaid Portal.

Provider Information: HSD/MAD Forms

For POS Pharmacy Billing

A pharmacy billing for services provided by pharmacists with prescriptive authority will bill using the following:

the pharmacist's NPI in the prescriber NPI field with the NDC for the prescribed product;

a valid quantity dispensed and appropriate days' supply;

with the corresponding preventative medicine counseling and/or intervention service performed.

This would be approximately a 15-minute session billed at the updated Medicare reimbursement methodology.

Counseling sessions are not limited to 15 minutes, and providers should apply the appropriate quantity to reflect time spent as accurately as they are able to in 15-minute increments. Reimbursement will include the calculated cost of the prescribed drug, a professional dispensing fee and a submitted patient assessment clinical service payment at the most current fee schedule or the MCO's provider contracted rate equivalent to procedure code 99401 (Preventive Medicine Counseling, approximately 15 minutes) with no monthly or annual limit. The clinical service payment is intended to reimburse the pharmacy for the pharmacist prescribing and preventive medication evaluation and counseling of the determined drug therapy provided.

When a counseling session is provided at a pharmacy without dispensing a drug, the Preventive Medicine Counseling can be billed on a CMS-1500 under pharmacy provider type 416 with the procedure code for medication therapy management services by a pharmacist for assessments and interventions (Procedure Code 99605 New Patient or 99606 Established Patient) up to the initial 15 minutes and each additional 15 minutes (Procedure Code 99607).

COVID Information: Codes and Resources