DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
Delaware Medical Assistance Program

Pharmacy Policy Billing Reference Guide

Pharmacy Billing Manual:
https://medicaidpublications.dhss.delaware.gov/docs/search?Command=Core_Download&EntryId=214

Preferred Drug List (PDL)*:
http://medicaidpublications.dhss.delaware.gov/docs/search?Command=Core_Download&EntryId=940
**The Preferred Drug List is updated twice a year; please ensure your PDL is the most current version.*

Member Identification Numbers

- All identification numbers are numeric and 10 digits.
- Numbers trailing with "M" are not to be used.
- If a member presents an AmeriHealth Caritas, Highmark Health Options, or Delaware First Health card, you should use that member number for the drug benefit. Please refer to their respective websites for plan-specific policies.

AmeriHealth Caritas	**Highmark Health Options**	**Delaware First Health**
1-855-294-7048 (TTY 711)	1-844-325-6253 (TTY 711)	1-877-236-1341 (TTY 711)
BIN: 600428	BIN: 004336	BIN: 003858
PCN: 07710000	PCN: MCAIDDE	PCN: DSHP

- There may be a small population of members who are ***NOT*** enrolled in a managed care program. For these members, the drug benefit will be processed under Delaware Medical Assistance Program (DMAP)/traditional Fee-for-Service (FFS) Medicaid. Members that may be included in this group:
  - Chronic Renal Disease Program (CRDP)
  - Delaware Cancer Treatment Program (DCTP)
  - FFS members

Drug Utilization Review (DUR) Alerts

When a medication denies for a DUR alert, the pharmacy responds to this DUR. When a medication is denying for multiple DURs, the ones listed below are set up with a higher priority than the rest and must be addressed first:

- DC Drug Disease Inferred
- PA Drug Age
- DD Drug Interaction
- PG Pregnancy
- MC Drug Disease

- **NOTE:** For Therapeutic Duplication, Clarification Code 5 is ***ONLY*** used when there is a change in therapy—either from one strength of a medication to another strength of that same medication or from one medication to another medication in that same drug class.
  - ***Inappropriate use of this code may result in recoupment of monies.***

Early Refill

- For all early refills, the member must have used 83% of the prescription (based on day supply) before the claim will pay.
  - For controlled substance prescriptions (Schedule II - V), members must have used 90% of the prescription (based on day supply) before the claim will pay.
- If the directions on a medication have changed, please call Pharmacy Services with the new dosing and when it was changed.
  - **NOTE:** A prescription will only hit for early refill against the same **medication and strength**.

Quantity Limits
Additional quantities require prior authorization, and all are tablets/capsules unless otherwise indicated.

Delaware uses utilization management controls to promote efficient delivery of care and to control costs. Quantity limits exist for select categories of drugs. A complete list of the select drugs with limits can be viewed in the agency's provider manual.

- Day supply: claims are to be billed with no more than 100 dosing units or a 34-day supply.
- **NOTE:** The time period is a rolling 30-day window based on the date of service being billed. There is no start/stop date. Ex: If a prescription is billed on 7/15, the system looks back at all claims from 6/15 to 7/15.

Medicare Part D (DPAP)
- BIN: 610452 PCN: PDMAPPARTD
- When billing DMMA as a "split bill" or coordination of benefits (COB) bill, the following codes must be entered into the COB segment on the claim in order for DMMA to be recognized as a secondary payer:
  - Other Payer ID Qualifier 99
  - Other Payer ID PartD
  - Rejection code 70 (if drug is excluded from Part D)

Medicare Part B
- When a member has Medicare Part B, the following classes of medications are covered by Part B:
  - Diabetic Supplies (meters, test strips, lancets, etc.)
  - Immunosuppressants
  - Nebulizer solutions
- These need to be billed to Part B first, then billed to DMAP through the Provider Portal: https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx

Pharmacy Copays
- Copays range from $0.50 to $3.00 based on the cost of the prescription (for traditional Medicaid and DCTP members).
- There is a $15 copay cap per calendar month; so, once the member pays $15 in copays, all remaining copays will be zero ($0) for the remainder of the month.
- The following are exceptions to the above copay guidelines. They will always have a $0 copay:
  - Children (under the age of 21 years)
  - Pregnant women and up to 12 months postpartum
    - Enter diagnosis code Z33.1 or Z37.9 to bypass copay requirement.
  - CRDP members
  - Long-term care nursing facility group or the acute care hospital group
  - Family planning services and supplies
  - Hospice services
  - Naloxone opioid overdose rescue medications
  - Smoking cessation products
  - Medication-Assisted Treatment (MAT) used for Opioid Use Disorder (OUD)
  - All immunizations that are Advisory Committee on Immunization Practice (ACIP) recommended

Contact Us
- If you have any questions about the above information, please contact the Pharmacy Services team at 1-800-999-3371; Option 0, Option 1.
- Log into the DMAP Provider Portal to submit prior authorizations, verify a member's DMAP eligibility, or send secure correspondence: https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx.