Pharmacy Billing Instructions

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1.0 Introduction

The Delaware Division of Medicaid and Medical Assistance (DMMA) establishes all policies and procedures governing the Delaware Medical Assistance Program (DMAP) that includes Medicaid, The Delaware Healthy Children Program, The Chronic Renal Disease Program (CRDP), Delaware Cancer Treatment Program (DCTP) and the Delaware Prescription Assistance Program (DPAP). The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

Initially, providers should carefully read this manual to become familiar with the contents. The manual should then be referenced when completing billing documents or forms. DXC will periodically update the Billing Manual on the Delaware Medical Assistance Portal Web site.

DXC Technology (DXC) is the Delaware Medical Assistance Program Fiscal Agent. Providers are to use a designated POS software vendor for claim submission or the Delaware Medical Assistance Portal / Provider Portal for Pharmacy claims submission. Providers must contact DXC if they need assistance with claims submission using the portal at 1-800-999-3371. The Pharmacy Billing Instructions section is designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual must be used in conjunction with the General Policy and Provider Specific Policy sections. Participation in the POS program is mandatory for any pharmacy provider serving ambulatory members. The POS-DUR program will have a 100-day timely filing limit, with the exception of claims submitted to a primary insurance. These claims can be submitted up to 120 days after the date of service. Claims adjudicated via the POS system will be reimbursed with a check or by Electronic Funds Transfer (EFT) on the next financial cycle. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment. Providers are responsible for the accuracy of all data elements submitted on their claims including, but not limited to the metric quantity, days, supply, diagnosis and correct identification of the prescriber.

Delaware is part of the CMS national drug rebate program. It is vital that claims are submitted with the NDC of the product actually dispensed. Only medications that were actually dispensed should be billed. If a medication is not in stock or partially filled, the claim should not be submitted or only billed for the number of partial units dispensed.

1.1 Delaware Medical Assistance Program (DMAP) and the Delaware Healthy Children Program (DHCP)

The DMAP and the DHCP coverage is based on criteria as stated in the General Policy and the provider-specific sections of the manual.

1.2 Chronic Renal Disease Program (CRDP)

The CRDP has some coverages that are unique to the program. Eligible members will have their own benefits package that may include a co-payment and a maximum benefit limit.

1.3 Delaware Prescription Assistance Program (DPAP)

The DPAP has some requirements that are unique. Members are required to pay a co-pay for each prescription. DMMA will cover a portion of drugs covered by Part D if it is part of the deductible or coverage gap. The PDP co-payment is the member's responsibility and based on the PDP transaction information. For claims that are 100% covered by DMMA, the co-pay will be equal to 25% of the allowed amount for the prescription or $5.00, whichever is greater. There is no maximum on the amount of a co-pay.

The co-pay calculation on claims with a primary insurance payment takes the DMMA allowed amount and compares it to the sum of all other insurance payments. If the balance between DMMA's allowed amount and the total other insurance payment is less than DMMA's 25% of maximum allowed or $5.00, the co-pay will be reduced. The co-pay will be calculated to be the difference between DMMA's allowed amount and the sum of the other insurance payments or $0.00, whichever is greater.

The NCPDP response transaction will state the amount of co-pay required to be paid to the pharmacy prior to the medication being dispensed.

Eligible members are limited to a $3,000 benefit each calendar year effective July 6, 2006. If a member exceeds the maximum benefit the co-pay will be increased by the total amount that could not be covered by the program.

The DPAP cannot cover medications for Medicare covered members except as noted above unless the medication is in an excluded Medicare category such as OTC products, cough and cold products or vitamins and minerals. There are detailed billing instructions for submitting a claim that needs a coordination of benefits in the Medicare Part D Billing Instructions section of this manual.

Medication coverage will also be based on the manufacturer’s willingness to pay a rebate to the Department of Health and Social Services. Products labeled by non-participating manufacturers will not be covered.

Members who obtain other prescription benefit coverage or no longer reside in Delaware or whose income exceeds 200% of poverty will no longer be eligible for the program. Providers are cautioned to verify eligibility before dispensing any medications.

2.0 Billing Instructions

2.1 Introduction

POS-DUR on-line adjudication has eliminated paper claims. Pharmacy claims must be submitted using the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required transactions for pharmacy services. This is the NCPDP Version D.Ø transaction and code set. The Delaware Medical Assistance Programs uses NCPDP

Version D.Ø in conjunction with the approved data dictionary from July 2007 to determine the specifications and definitions for transaction creation and submission.

The provider should keep documentation of all authorization numbers to serve as a reference for on-line adjudication. The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

2.2 General Procedures

2.2.1 Providers are required to verify member eligibility and other important member information prior to rendering services. Eligibility and other important member information should be verified via the voice response system at 800-999-3371 or through the Delaware Medical Assistance Portal https://medicaid.dhss.delaware.gov/ regardless of the type of claim. The above two sources will provide either an eligibility or ineligibility response along with a verification number. For emergency situations where computer communication is inaccessible or not functioning, eligibility should always be verified via the voice response system. Providers submitting National Council for Prescription Drug Programs (NCPDP) claims that are interactive may treat the claim response as verification of eligibility, coverage and patient responsibility. In the event of a Delaware State of Emergency, the number of days that the Governor has declared an emergency will be covered as long as the member is Medicaid eligible.

2.2.2 National Provider Identifier

2.2.2.1 The prescriber ID field must include the prescribing practitioner's NPI number.

2.2.2.2 If a prescription is written by a prescriber with an NPI that has been removed from DMMA network, the claim will be denied and should not be submitted with an alternate identifier. If audited and such claims are found, monies may be recouped.

2.2.2.3 If the physician is from an emergency department in order for the prescription to be considered valid, the prescribing provider's NPI must be submitted in the prescriber ID field.

2.2.2.4 If the prescriber's NPI is not available and it is after business hours and the pharmacist considers the medication to be critical, then DMMA will honor one emergency 72 hour supply. If you experience difficulties processing this type of claim, call DXC pharmacy provider call center at 800-999-3371.

2.2.3 The NCPDP submission clarification code is to be used only for a change in therapy. Therapeutic duplication overrides using this code

should only be used if a member is being titrated off one agent. Inappropriate use of this code may result in monies being recouped.

2.2.4 Submit POS claims within 100 days of the dates of service.

2.2.5 Claims for prescriptions that are not dispensed and are returned to the pharmacy stock must be credited by reversing the claims. Medications that are returned by LTC facilities that can be issued to another resident must be credited. Reversal transactions can be submitted up to 120 days after initial submission. If there is no signature indicating it was dispensed, the claim will be deemed returned to stock.

2.2.6 Claims billed for members with a primary insurance that covers drugs, or a Medicare segment (for a Medicare covered drug), should be billed to the primary insurance prior to billing the DMAP. When billing DMAP the pharmacy will receive a reject error that states, “Bill other insurance or primary payer”. The pharmacy will enter one of the NCPDP Other Coverage Codes on the claim to let Medicaid know when (and if) the claim was submitted to the other insurance carrier. Appendix A lists the NCPDP Other Coverage Codes that are currently accepted by DMAP to allow for full payment Claims for members with Medicare Part D coverage must include a Coordination of Benefit segment that includes information received from the PDP. Refer to section 2.3.3 for Medicare Part D Billing Instructions.

2.2.7 Providers must bill Medicare Part B first for any medications or devices that are covered by the federal program, such as immunosuppressants.

2.2.8 POS Claims: Formats for claims submitted via POS will differ based on the software system in use. Certified vendors comply with NCPDP D.Ø specifications.

2.3 POS Transactions (Submitting a Claim)

A standard claim is transaction code B1, compliance with the Delaware specifications.

A claim payable response will include total amount paid as well as the claim number. Claims submitted for the DPAP program will be reduced by the amount of the co-pay. Members are expected to remit that amount prior to receiving their prescription.

A claim that is not adjudicated will contain a response status of **D** (duplicate billing) or **R** (rejected). You will also receive all of the DUR conflict information and a message further defining the problem.

Claim reversal, transaction code B2, is used to cancel a prescription that has been paid within 120 days after initial submission. DMMA expects all non-dispensed prescriptions to be credited. Reversal submission is not limited to 120 days. If the claim is found in history, DMES will process the Reversal. The DXC Help Desk cannot reverse a claim. The correct procedure for reversing a claim from both the pharmacy computer and DMAP should be well documented from the pharmacy's software vendor for the pharmacy staff to apply. The DXC Help Desk is unable to clarify problems associated with the software vendor. DMMA requirements for submission of a B2 – Reversal are below.

2.3.1 NCPDP D.Ø Layouts – Request Reversal

For NCPDP reversals, see the ***NCPDP Reversal Payer Sheet*** on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/

2.3.2 NCPDP D.Ø Layouts – Request Segments

For NCPDP layouts, see the NCPDP Payer Sheet on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/

http://www.dmap.state.de.us/information/DMES/NCPDP_Payer_Sheet.pdf.

Medicare Part D Billing Instructions

2.3.3 This section provides instructions for submitting claims related to Medicare Part D.

- **If a member has Part D, the Part D PDP must always be billed first before billing DPAP or CRDP.**
- If the Part D PDP approves the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PARTD' Other Payer ID, and an other payer amount paid must be present, even if the paid amount is $0.00.
- If the Part D PDP denies the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PARTD' Payer ID, and an Other Payer Reject Code must be present. Pharmacies should not use the NCPDP other coverage codes listed in Appendix A to mask that the claim was rejected by the PDP.
- If the claim is routed through the TrOOP Facilitator, the PCN value must be '**PDMAPPARTD** '.

2.3.4 The pharmacy is required to bill all active insurances before submitting a claim to CRDP.

- Primary coverage + Medicare Part D both pay on claim
    - If both the primary coverage and Medicare Part D coverage pay on the claim:

      The pharmacy will need to bill the claim showing two Coordination of Benefit (COB) segments with paid amounts. The NCPDP other coverage code will need to be “02”, other coverage exists payment collected.

- Primary coverage pays and Medicare Part D rejects claim
    - The pharmacy will need to submit claim with two COB segments. The first COB segment will need to show primary payer with paid amount on claim. The second COB segment will need to show Medicare Part D information with reject code. The NCPDP code will need to be “02”, other coverage exists payment collected.
- Primary coverage rejects claim and Medicare Part D pays on claim.
    - The pharmacy will need to submit the COB segment for Medicare Part D with a paid amount and the NCPDP other coverage code “03”, other coverage exists payment not collected, showing the primary coverage rejected the claim.

2.3.5 If a member is eligible for a Medicare Part D PDP and has not yet enrolled and has just become eligible for DMMA services, **LI NET (transitional enrollment)** must be billed. 1-800-783-1307

2.4 DMAC Pricing Inquiry Worksheet

Instructions

DMAC pricing is an internally calculated pricing on a small number of products considered specialty or available via special programs. The DMAC Pricing Inquiry Worksheet provides the opportunity for a pharmacy to indicate any difficulty that has been experienced in obtaining a specific drug at the price listed on the Delaware

Maximum Allowable Cost list (DMAC) provided by the Delaware Medical Assistance Program. Since DMAC pricing is only on a small number of products, any inquiry on pricing that is not related to DMAC will be returned with instructions to forward to the NADAC pricing vendor. To ensure a timely response to comments for each drug that the pharmacy is not able to purchase at the State's MAC, the pharmacy must complete the attached form and include the following:

- NDC Code for the lowest priced product available
- Drug label name
- Lowest price for which the pharmacy can obtain the drug
- Source of the product
- NDC(s) for other products that were researched
- Purchase invoice to document pricing

The form must be **faxed to DXC Pharmacy Services at (302) 454-0224**. Failure to include all of the required information will result in the inability to respond to pricing issues. Each inquiry will be researched and reviewed, and upon completion, a written response will be provided within 10 business days.

2.4.1 DMAC Pricing Inquiry Worksheet for Generic Drugs

DMAC Pricing Inquiry Worksheet for Generic Drugs

PLEASE READ BELOW BEFORE SUBMITTING

- DMAC pricing is an internally calculated pricing on a small number of products considered specialty or available via special programs.
- In order to question the DMAC price, fill out the below form and attach an invoice showing the pricing of all available products.
- Please note: National Average Drug Acquisition Cost (NADAC) and Wholesale Acquisition Cost (WAC) drug prices are managed by an external drug vendor. Updates are applied once weekly to the system when they become available. These updates occur every Friday morning. Please check the NDC lookup under interactive services to obtain the most current reimbursement rate. Since pharmacy services are point-of-sale processing, price inquiries that do warrant updates will not be priced earlier than the day they are received.

NDC	Label Name	Strength	Drug Vendor Source	Lowest Price	Date of Search

Submitted By: _____ Pharmacy: _____

Phone Number: _____ Fax Number: _____

By submission and signature of this form the provider is attesting that the Lowest Price submitted includes any discounts or reduction in cost associated with prompt payment, rebates or 'free good' programs.

(Invoice Must Be on Attached Page)

3.0 Appendix A – NCPDP Other Coverage Codes

Code	Description
01	No other coverage
02	Other coverage exists – payment collected
03	Other coverage exists – claim not covered
04	Other coverage exists – payment not collected

The exception codes should only be used for commercial plans that do not have an open network or where Medicare B has rejected the claim. Providers must bill Medicare B first for any medications or devices that are covered by the federal program. Providers may not use the NCPDP coverage codes if they do not have the ability or choose not to bill the primary carrier to use DMMA as a primary coverage.

4.0 Appendix B – DMMA Tamper-Resistant Prescription Pad Policy

Prescriptions written on or after 3/1/12 must comply with the new regulation for tamper-resistant prescription forms (*29 Del. C. section 8735 and 16 Del. C. Section 4797*). To reduce fraud, Delaware pharmacies will not dispense medications if the prescription does not contain minimum requirements, such as:

- Original dispensing date
- Name and address of patient (or institutional location)
- Name of prescriber
- DEA number of prescriber for controlled substances
- Name/strength/dosage form and quantity/route of administration for non-oral drugs
- Renewals authorized
- Patient directions for use

Starting July 1st 2011, practitioners who do not have compliant tamper-resistant prescription forms will be limited to faxed prescriptions, e-prescriptions (non-controlled only), or verbal prescriptions when permitted by federal and State law. Verbal prescriptions must be verified by a phone call to the practitioner and prescriptions on non-tamper-resistant prescription pads can be verified as valid as long as they meet all the phoned-in prescription requirements.

Phoned-in prescriptions must contain everything mentioned in the above list plus the following items, at a minimum, for validation by the pharmacist:

- Name of the person who is authorized or verified
- The prescription
- Date
- Time

The Division of Medicaid and Medical Assistance (DMMA) will recoup money if prescriptions are not compliant with the Board of Pharmacy requirements for a legal prescription.

Pharmacy Billing Manual

Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
7/1/02	2.2	Removed the word “not” from the first sentence of the third bullet.
8/1/02	2.4	Clarification was added to the required field titled Prescriber ID.
8/1/02	Added Section 2.6	Added the DMAC Pricing Inquiry Worksheet form.
2/27/04	1.0 and 2.2	Changing POS DUR timely filing limit from 14 days to 100 days.
9/8/04	2.2, 2.4 and Appendix A	Pharmacies must give the DMAP credit for reusable medications returned to the dispensing pharmacy by a long term care facility. Information added on billing a member’s primary insurance prior to billing the DMAP. Appendix A added to give the NCPDP Other Coverage Codes.
5/5/05	2.3.1 and 2.3.2	Added two new sections entitled ‘NCPDP 5.1 Layouts – Request Reversals’ and ‘NCPDP 5.1 Layouts – Request Segments’.
12/13/05	1.3 and 2.2-2.7	Electronic and paper claim submission has changed for Medicare Part D. A new section has been created for Medicare Part D billing in section 2.6. The DMAC

Revision Date	Sections Revised	Description
		pricing inquiry worksheet has been moved to section 2.7
5/25/06	1.3	Modified the process for calculating co-payments.
9/18/06	1.3	Update to Delaware Prescription Assistance Program benefit amount based on Senate Bill # 297, 143rd General Assembly (signed into State law on July 6, 2006). Also clarifying existing policy.
9/18/06	2.2, 2.3.2, 2.4, 2.6, and 3.0	Adding clarification to existing policy.
10/25/06	2.2 and Appendix A	Added the option of providing a license number instead of a DEA number when applicable. Added language directing providers to bill Medicare Part B for covered medications or devices and clarified correct use of NCPDP coverage codes.
3/10/07	2.2, and 2.4	Added instructions for the prescriber id field of the paper pharmacy claim form to include the National Provider Identifier (NPI).
3/25/07	2.3.1 and 2.3.2	Updated the NCPDP 5.1 layouts for NPI billing.
6/22/07	2.2.7, 2.3.2, 2.4 and 2.6	Clarification for billing after primary insurance. Update to data field 110-AK and clarification for billing compounds.
8/30/07	2.4, 2.6.1	Clarification has been made to the billing instructions.
10/3/07	Appendix B	Added newly mandated tamper resistant prescription pad legitimacy requirements.
11/26/07	2.4	Clarification has been made to the billing instructions for paper claims.
1/23/09	2.3.2	Updates have been made to the NCPDP Layouts. The updates are effective 3/2/09.
6/5/09	2.2.1	Clarification and instruction provided to verify eligibility in emergency situations.
8/5/11	2.7.1	Updated the DMAC Pricing Inquiry Worksheet
11/1/11	2.2.1	Removed obsolete wording
12/6/11	2.2	Guidance on NCPDP claims.
12/6/11	2.3.2	The payer sheet has been updated
1/20/12	2.3.2	The D.Ø payer sheet has been updated.
5/8/12	2.4, 3.0	Updated the completion of the Pharmacy Claim Form – instructions for completion section. Appendix A – NCPDP Other Coverage Codes removed.
5/10/12	2.1	Updated text including NCPDP Version 5.1 to Version D.Ø.

Revision Date	Sections Revised	Description
6/11/12	2.6	Updated the contact information for transitional enrollment for Part D.
6/11/12	4.0	Updated the DMMA Tamper-Resistant Prescription Pad Policy.
10/17/13	1.1, 1.3, and 2.2.2.4	Removed due to changes in existing policy.
10/17/13	2.2.1	Clarification provided to verify eligibility in emergency situations.
10/17/13	2.2.3	Clarification on therapeutic duplication overrides.
10/17/13	2.2.5	Clarification of policy for prescriptions returned to stock.
6/1/14	2.7.1	Updated the DMAC Pricing Inquiry Worksheet
12/1/14	2.3.2	The D.Ø payer sheet has been updated.
1/1/17	All	Updated manual to comply with the Delaware Medicaid Enterprise System (DMES)
1/1/2017	All	Updated manual in compliance with the Delaware Medicaid Enterprise System (DMES). The Revision table has been moved to the end of the manual.