Division of Medicaid and Medical Assistance (DMMA) Pharmacy Policy Cheat Sheet

For Complete Pharmacy Billing Manual:
http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=214

For Complete Preferred Drug List (PDL)*:
http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=940

**PDL preferred drugs are updated twice a year; please ensure your PDL is the most current version.*

- **Member Identification Numbers**
  - All numbers are numeric and 10 digits
  - Please update any numbers in your system that reflect a trailing 'M'; Numbers trailing with 'M' are not to be used.
  - If a member presents an AmeriHealth Caritas or Highmark Health Options card, you can use that Member ID number for the drug benefit. Please refer to their websites for policy.
    - AmeriHealth: 1-855-294-7048
    - Bin: 600428; PCN: 07710000
    - Highmark Health Options: 1-844-325-6253
    - Bin: 004336; PCN: MCAIDDE
  - 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**,** respond 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
    - PG Pregnancy
    - PA Drug Age
    - MC Drug Disease
    - DD Drug Interaction
  - **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.*

- **Quantity Limits**
  - *Additional quantities require prior authorization and all are tablets/capsules unless otherwise indicated:*
    - Short-Acting Opioid Analgesics: 120/30 days for acute treatment, 60/30 days for chronic treatment, 720/year
    - Benzodiazepines: 120/30 days
    - Triptans: 9/45 days
    - Anticonvulsants: 240/26 days
    - Sedative Hypnotics: 30/30 days
    - Lovenox: 10 days' supply/30 days
    - Tramadol: 240/30 days
    - Muscle Relaxants: 120/30 days
    - Pseudoephedrine: 3600mp/84 days
    - Tussionex: 120ml/84 days; 900ml/year
    - Oxycodone 15mg: 240/year
    - Oxycodone 20mg: 120/year
    - Oxycodone 30mg: 60/year
    - Depo-Provera Inj: 1 unit/84 days
    - Narcotic Cough Syrup: 240ml/30 days; 480ml/84 days
    - Rescue Nebulize Solutions: 2 boxes/30 days
  - 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. *Example*: If a prescription is billed on 7/15, the system looks back at all claims from 6/15 to 7/15.

- **Early Refills**
  - For all early refills, the member must have used 83% 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**.

- **Medicare Part D**
  - 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 (if applicable) = 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.

- **Copays**
  - Copays range from $0.50 to $3.00 based on the cost of the prescription (for Traditional Medicaid and DCTP)
  - 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:
    - Children (under the age of 21) – will always have a $0 copay
    - Pregnant women and up to 90 days after delivery (enter diagnosis code Z331 or Z379 to bypass copays) – will always have a $0 copay
    - CRDP members – will always have a $0 copay
    - Long-term care nursing facility group or the acute care hospital group – $0 copay
    - Family planning services and supplies – $0 copay
    - Hospice services – $0 copay