NEVADA MEDICAID AND NEVADA CHECK UP PHARMACY MANUAL

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This document is intended to be a helpful resource to OptumRx Pharmacies providing services to Nevada Medicaid and Nevada Check Up recipients. A copy of this document is posted on the Nevada Medicaid website for ease of reference. The manual is updated regularly with program changes. The most current version of the manual can be found by following the links on the Nevada Medicaid website (https://www.medicaid.nv.gov).

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1.0 INTRODUCTION

Effective January 1, 2012, the Point-of-Sale (POS) system required pharmacies to submit claims to OptumRx electronically in the National Council for Prescription Drug Programs (NCPDP) standardized Version 5.1 or Version D.0; lower versions would not be accepted. Effective **April 1, 2012**, NCPDP Version D.0 is the only version accepted. After submission, OptumRx will respond to the pharmacy provider with information regarding recipient eligibility, Nevada Medicaid allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable Rejection messages. ProDUR messages will be returned in the DUR response fields; other important related information will be displayed in the free form message area. It is extremely important that pharmacies display all messages exactly as returned by OptumRx.

All arrangements with switching companies should be handled directly by the pharmacy with their preferred switching company. Pharmacies must submit claims within 90 days of the date of service.

1.1 NEVADA MEDICAID PROVIDER TELEPHONE NUMBERS

Responsibility	Phone Numbers	Availability
OptumRx Technical Call Center (Pharmacy Help Desk)	866-244-8554	24/7/365
OptumRx Clinical Call Center (Prior Authorizations)	855-455-3311 855-455-3303 (fax)	24/7/365

1.2 STATE POLICY

Nevada Medicaid State policy is in Chapter 1200 of the Medicaid Services Manual (MSM). The MSM is on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov

1.3 NEVADA MEDICAID/OPTUMRX WEBSITE

Announcements, meeting dates and policy updates are posted to the Nevada Medicaid/OptumRx website as they become available. It is recommended that users visit https://www.medicaid.nv.gov weekly to view the latest information. Pharmacy information is under the "Pharmacy" menu.

1.4 SYSTEM AVAILABILITY

The POS system is available 24 hours per day 7 days a week 365 days per year except during scheduled routine maintenance. In the rare instance the POS system is down for any reason, hold your claims until online capability resumes. Announcements will be posted at https://www.medicaid.nv.gov when the POS system is not available outside of scheduled maintenance.

2.0 PROGRAM SETUP

2.1 CLAIM SUBMISSION

- NCPDP version 5.1 format was accepted for all POS submissions through **March 31, 2012.**
- NCPDP version D.0 format was accepted for all POS submissions beginning **January 1, 2012.**
- NCPDP version D.0 format is the only accepted format for all POS submissions beginning **April 1, 2012.**
- No other POS claim submission formats are accepted.

The following list provides important identification numbers for this program:

ANSI BIN #	001553
Processor Control #	NVM
Provider ID #	National Provider Identifier
Cardholder ID #	NV Medicaid Pharmacy ID Number
Prescriber ID #	National Provider Identifier
Product Code	National Drug Code (NDC)

- A group number is not needed for a Nevada Medicaid transaction.

- The Nevada Medicaid Pharmacy card will list the recipient's ID number, name and date of birth.

- This recipient information must be entered **exactly** as it appears on the card (including any hyphens, apostrophes, etc.)

- A middle initial is not mandated.
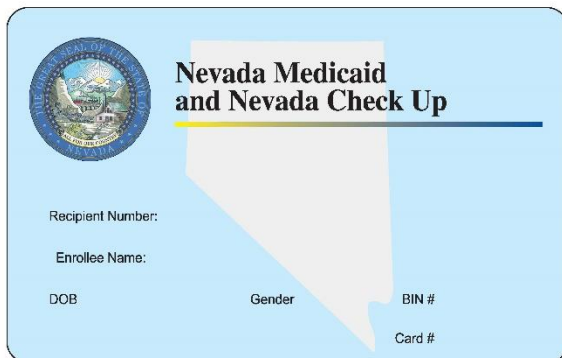
2.2 TIMELY FILING LIMITS

Most pharmacies submit point-of-sale claims at the time of dispensing; however there may be extenuating circumstances that require a claim to be submitted after being dispensed.

- For all original claims and adjustments, the timely filing limit from the date of service (DOS) is 180 days.
- For all original claims and adjustments involving other third party payers, the timely filing limit from the date of service (DOS) is 365 days.
- Claims for persons who are retroactively determined eligible for Medicaid must be received no later than 180 days after the date of eligibility determination or the date of service, whichever is later.

    - Claims that exceed the prescribed timely filing limit are denied.
        o (NCPDP EC #81/Timely Filing Exceeded).
    - Providers should contact the **OptumRx Technical Call Center** **at 1-866-244-8554** for late claim override consideration.

3.0 PROGRAM REQUIREMENTS

3.1 DISPENSING LIMITS

Days' Supply

- There is a per claim day supply maximum of 34 days*.

*Drug Agents which allow up to 100 days' supply	
Anticonvulsants	Thyroid Preparations
*Drug Agents which require 90-100 days after one-time initial fill	
Contraceptives, Topical	Antiarrhythmics
Estrogens	Progesterone
Contraceptives, Oral	Antidiabetics
Antihypertensives	Cardiac Glycosides
Antianginals	Diuretics

- If 80% of a non-controlled or 90% of a controlled medication has been utilized (the system will calculate back to the original fill date) the system will automatically allow the claim to go through. If 80% of a non-controlled or 90% of a controlled medication has not been used, the system will message back the next date the prescription may be filled.

Dose/Duration

- All claims are interrogated against the Preferred Drug List (PDL), benefit requirements and DUR criteria. A complete listing of prior authorization criteria, step therapy requirements, quantity limits, and duration of therapy edits can be found online through the DHCFP's website (http://dhcfp.nv.gov).
- All claims are interrogated for compliance with state and federal requirements.
- Prescriptions must be dispensed pursuant to the orders of a physician or legally authorized prescriber. Any subsequent refills may be dispensed not more than one year from the date the prescription was written (or earlier whenever legally dictated).

- Schedule II controlled substances (CIIs) may not be refilled; a new prescription is required for each fill.
- Controlled drugs other than CIIs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to five refills or six months, whichever comes first.
- Non-controlled drugs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to one year.

Oral Contraceptives
- Oral contraceptives can be filled up to a 12-month supply after an initial 3-month supply followed by a 9-month supply.
- Subsequent prescriptions may continue to be filled for up to 12 months.

3.2 TAMPER-RESISTANT PRESCRIPTIONS

Medicaid is mandated by federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

As of October 1, 2008, prescriptions are required to have a minimum of one feature from each of the three Centers for Medicare & Medicaid Services (CMS) categories listed below:

1) Industry-recognized feature(s) designed to prevent unauthorized copying.

Feature	Description
"Void" or "Illegal" pantograph	The word "Void" appears when the prescription is photocopied. Due to the word "Void" on faxed prescriptions, this feature requires the pharmacy to document if the prescription was faxed.
Watermarking	Special paper containing "watermarking."

2) Industry-recognized feature(s) designed to prevent erasure or modification written by the prescriber.

Feature	Description
Quantity check off boxes with refill indicator *(circle or check number of refills or "NR")*	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be 25's with the highest being "151 and over." The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. Indicates the number of refills on the prescription. Refill number must be used to be a valid prescription. Document if the prescription was faxed.

Feature	Description
Uniform non-white background color	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase or copy, the consistent background color will look altered and show the color.

3) Industry-recognized feature(s) designed to prevent use of counterfeit prescription forms.

Feature	Description
Security features and descriptions listed on prescriptions	Complete list of the security features on the prescription paper for compliance purposes.
Heat sensing imprint	By touching the imprint or design, the imprint will disappear.

NOTE: Be advised that all prescriptions paid for by Nevada Medicaid must follow these state/federal regulations.

3.3 E-PRESCRIBING

Nevada Medicaid encourages prescribers to submit electronic prescriptions. Recipient pharmacy claims history, eligibility, drug coverage data and the indication of the need for a PA are also available to prescribers who use electronic prescribing systems.

Prescribers who use electronic prescribing systems can arrange for appropriate access to this data by contacting their software vendors.

For more information, see the Nevada Medicaid website www.medicaid.nv.gov and select E-prescribing from the Provider's menu.

3.4 DISPENSING PRACTITIONERS

Nevada Medicaid reimburses practitioners to dispense medications from a remote site or satellite consultation site when the following criteria are met:

a. Must have a current Certificate of Registration through the Nevada State Board of Pharmacy. Refer to NRS 639.070 and NAC 639.390.
b. Must be enrolled with Nevada Medicaid provider enrollment as a provider type 28.
c. The dispensing practitioner's site must be located in the State of Nevada.
d. All prior authorization criteria and quantity limitation apply to dispensing practitioner claims.
e. Only provider type 28 claims will receive a dispensing fee.
f. All claims must be submitted in the NCPDP format through Medicaid's POS system.

3.5 GENERIC SUBSTITUTION POLICY

Per Nevada Revised Statute (NRS) 639.2583, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

- Is less expensive than the drug prescribed by brand name;

- Is biologically equivalent to the drug prescribed by brand name;

- Has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and

- Is of the same generic type as the drug prescribed by brand name and the least expensive of the drugs that are available to him for substitution.

Should a prescriber indicate that a branded drug is medically necessary for a recipient, the prescriber must comply with the following:

- The physician should document in the recipient's medical record the need for the brand name product in place of the generic form.

- The certification must be in the physician's own handwriting.

- Certification must be written directly on the prescription blank.

- The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions, "Dispense as written" must be noted. Not acceptable: a printed box on the prescription blank checked by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.

- A prior authorization is required to override generic substitution.

- Certification is not required if a generic is not manufactured.

- A fax copy/verbal order may be taken by the pharmacist from the physician, but the pharmacy must obtain an original printed copy and it keep on file.

3.6 MAXIMUM ALLOWABLE COST (MAC) LIST

- State Maximum Allowable Costs is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP or Fiscal Agent.

- The MAC List is updated monthly. Providers may access information regarding the OptumRx /Nevada Medicaid Maximum Allowable Cost by viewing the following link: https://www.medicaid.nv.gov/providers/rx/MACinfo.aspx.

- Providers who have questions or concerns about a particular MAC price may submit a MAC Price Research Request Form, which can be found on the Nevada website: https://www.medicaid.nv.gov/providers/rx/MACinfo.aspx.

- Providers may appeal the current SMAC for pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.
    - The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.
    - Information needed to make the decision will include NDC number, manufacturer, drug name, strength and price paid. A faxed copy of the actual invoice for the drug may be requested.
    - Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent's SMAC Coordinator for investigation and resolution.
    - If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to 1) adjust SMAC pricing for the particular claim being appealed, and 2) make changes to the SMAC pricing file.
    - Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

3.7 COVERED AND NON-COVERED DRUGS

- The Nevada Medicaid Drug program will pay for medications as outlined in Medicaid Services Manual, Chapter 1200:
    - Covered legend and non-legend pharmaceutical manufacturers must participate in the federal Medicaid Drug Rebate Program unless listed on the excluded list in Chapter 1200 of the Medicaid Services Manual.
    - Pharmaceuticals must be prescribed for a medically accepted indication.
    - Family planning items such as diaphragms, condoms, foams and jellies are a covered benefit.

- The Nevada Medicaid Drug Rebate Program will not reimburse for the following pharmaceuticals:
    - Agents used for weight loss
    - Agents used to promote fertility
    - Agents used for cosmetic purposes or hair growth
    - Yohimbine
    - Drug Efficacy Study and Implementation (DESI) list "Less than Effective Drugs"
    - Pharmaceuticals considered "Experimental" as to substance or diagnosis for which prescribed.
    - Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.
    - Agents used for impotence/erectile dysfunction

3.8 COVERED OTC DRUGS

- Over-the-counter medications are a covered Nevada Medicaid benefit subject to prior authorization:

    - Coverage is limited to two prescriptions per month within the same Standard Therapeutic Class (please see Appendix B of Chapter 1200 of the Medicaid Services Manual for a list of Standard Therapeutic Classes) without PA. Any more than two prescription requests for medications within the same therapeutic class will require PA.

    - Insulin will be exempt from any Clinical PA requirements.

3.9 RECIPIENT CO-PAY INFORMATION

- Nevada Medicaid and Nevada Check Up do not require the recipient to pay a co-pay.

3.10 PRIOR AUTHORIZATION PROCEDURES AND DIAGNOSIS CODES

Technical Call Center

The **OptumRx Technical Call Center (866) 244-8554** assists in the following circumstances on behalf of Nevada Medicaid:

Early Refills (DUR Reject 79): The Technical Call Center may assist in overriding this reject if one of the following circumstances exists:
- Dosage/Therapy change has occurred; patient is no longer taking the original dosage
- Dosage Time/Frequency Change has occurred
- 2 strengths of the same drug are used to make a strength of that medication not currently manufactured

NOTE: At this time, no other exceptions will be made.

Clinical Call Center

The **OptumRx Clinical Call Center (855) 455-3311** assists in the following authorization requests/overrides on behalf of Nevada Medicaid:

- Preferred Drug List (PDL)
- Step Therapy
- Clinical Criteria
- Dose Optimization
- Therapeutic Duplication
- Drug-Drug Interaction
- All Other Clinical Edits
- Quantity Limits

To request prior authorization for the edits listed above, the prescribing physician or the prescribing physician's agent must submit a prior authorization request. Requests may be submitted through the Electronic Prior Authorization (ePA) portal.

- OptumRx provides Electronic Prior Authorization (ePA) services through SureScripts® and CoverMyMeds®. Access the ePA through one of the following methods:
    - Select "Pharmacy Web PA Login" from the "Pharmacy" tab on the non-secure Nevada Medicaid website. (effective December 21, 2020)
    - Select "Pharmacy PA" under "Provider Services" on the secure Provider Web Portal. (effective December 21, 2020)
    - Use your organization's Electronic Medical Record (EMR) software.
    - To register and submit a prior authorization request, visit: https://professionals.optumrx.com/prior-authorization.html.

- If ePA is not an option, requests may still be faxed to (855) 455-3303 (must include the appropriate prior authorization request form) or requested by phone by calling the OptumRx Clinical Call Center at (855) 455-3311.
- Should the pharmacist have access to the applicable clinical information, they may initiate the prior authorization request.
- Ideally prior authorizations should be obtained at the time the prescription is being written. If this does not occur, the claim is denied at POS with a message that the prescriber should contact (855) 455-3311 for prior authorization consideration.
- The OptumRx Clinical Call Center responds to all prior authorization requests within 24 hours of initiation.
  - If more information is needed from the prescriber to make a determination for the prior authorization, the prescriber is contacted by the OptumRx clinical call center and additional information is requested. If the information is not received, the request will be denied.
- It is not necessary to enter a PA number when the claim is transmitted. An active PA record in the OptumRx system is all that is necessary.
- Prior authorization edits apply to all claims.

Appropriate Diagnosis for Prior Authorization Bypass

In an effort to assist prescribers and providers, prior authorization requirements can be bypassed for certain medications when specific medical conditions exist. Those specific medications and diagnoses are noted in the Nevada Medicaid Services Manual, Chapter 1200. Prescribers are encouraged to include the applicable diagnosis code on written prescriptions for inclusion on the electronic pharmacy claim. The submitted claim should include a Diagnosis Code Qualifier (field 492-WE) of "02," indicating ICD-10, as well as the appropriate Diagnosis Code (Field 424-DO).

3.11 THE PREFERRED DRUG LIST

Nevada Medicaid and Nevada Check Up utilize a Preferred Drug List (PDL). Non-preferred drugs in the listed classes require prior authorization.

The PDL can be found on the Nevada Medicaid/OptumRx website https://www.medicaid.nv.gov/providers/rx/PDL.aspx. Visit this website to ensure you have the most recent version of the PDL as it is updated periodically.

3.12 EMERGENCY SUPPLY POLICY

If the prescriber is not available and the pharmacist feels the recipient needs to receive the prescribed drug, the pharmacist should contact the Clinical Call Center at: **(855) 455-3311**. OptumRx may authorize a 96-hour emergency supply.

NOTE: An emergency situation is a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the recipient, or the continuation of immediate and severe adverse consequences to the recipient, if an outpatient drug is not dispensed when a prescription is submitted.

3.13 COORDINATION OF BENEFITS

It is important that providers be aware that Nevada Medicaid is **always the payer of last resort,** except as defined in Medicaid Services Manual Chapter 100. Each Nevada Medicaid recipient should be asked whether he/she is covered by any pharmacy insurance provider other than Medicaid. If the recipient identifies any other pharmacy payer(s), the pharmacy is required to bill all other payers prior to billing pharmacy claims to Nevada Medicaid.

- As a matter of program policy, providers must bill all other payers first and then bill Nevada Medicaid. Nevada Medicaid is always the payer of last resort.

- If the recipient shows other coverage on the date of service (DOS), the pharmacy will receive a "41" Reject Code — Submit to Primary Payer.

- The pharmacy will also receive a message with information about the recipient's TPL, including the PCN (if applicable), BIN number, Identification Number, Group Number, and telephone number to the Nevada Medicaid recipient's primary insurance plan.

- The pharmacy must then submit the claim to the primary insurance for payment.

- If other payment is received, providers must resubmit the prescription claim to Nevada Medicaid with the following information for payment consideration (see Coordination of Benefits (COB) Reference Guide below and Payer Specification Sheet in Section 7.0 for complete detailed situations):

  ☐ OTHER COVERAGE CODE (NCPDP #308-C8) = only values of "2", "3" or "4" in this field are accepted

  ☐ OTHER PAYER AMOUNT PAID field (NCPDP #431-DV) = amount received from all other payers (must be greater than $0.00)

  ☐ OTHER PAYER DATE (NCPDP #443-E8) = date payment received from other payer

- In all cases, OptumRx uses the Nevada Medicaid **"Allowed Amount"** when calculating payment. If the primary insurer has reimbursed greater than the Nevada Medicaid Allowed Amount, this may result in zero payment on the secondary claim.

Nevada Medicaid Pharmacy Coordination of Benefits Requirements

NCPDP #308-C8	When to Use	Submission Requirements / Responses
O- Not Specified	Allowed; submit when member does not have other health insurance. Submit Processed as Primary, reject 41 if TPL on member record	Claim will reject with a 41 error if member record has alternate insurance. Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be sent to Primary Insurance and then resubmitted with proper OCC and other required fields.
1- No Other Coverage	Allowed; this code value indicates that they did attempt to determine if there was other coverage but weren't able to find any	Claim will reject with a 41 error if member record has alternate insurance. Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be sent to Primary Insurance and then resubmitted with proper OCC and other required fields or call Clinical Call Center for 41 reject override.
2- Exists Payment Collected	OCC 2 is used when any positive amount of money is collected from another payer. Submit the amount collected from the primary payer (TPL), along with the date the claim was adjudicated to the primary payer (TPL) in order to override the TPL denial.	Paid claim; also requires submission of: Other Payer Amount Paid (431-DV) that is > $0 Other Payer Amount Paid Qualifier (342-HC) that is valid Patient Paid Amount Submitted (433-DX) this is => $0 Other Payer Date (443-E8) that is valid Other Payer ID (340-7C) that is valid Other Payer ID Qualifier (339-6C) that is valid Claims submitted without proper required COB fields will reject with code 13.
3- Exists Claim Not Covered	OCC 3 is used when the Nevada Medicaid recipient has other primary insurance, but the particular drug is not covered by the specific plan(s).	Requires submission of: Other Payer Date (443-E8) Other Payer ID (340-7C) Other Payer ID Qualifier (339-6C) And the reject code generated after billing the other insurer(s) in the "Other Payer Reject Code (472-6E). Claim will pay only if the following Other Payer Reject codes are submitted: 60, 61, 63, 65, 66, 67, 68, 69, 70, 3Y Claims submitted without proper required COB fields will reject with code 13.
4- Exists Payment Not Collected	OCC 4 is used when a recipient's primary insurance plan is active, but there is no payment collected from the primary insurer because the beneficiary has not met their	Paid claim; also requires submission of : Other Payer Amount Paid (431-DV) that = $0 Other Payer Amount Paid Qualifier (342-HC)

		primary payer's deductible obligation. This value should also be used if the total cost of the claim is less than the patient's primary insurance co-pay requirement and the primary insurance plan made no payment.	Patient Paid Amount Submitted (433-DX) this is > $0 Other Payer Date (443-E8) that is valid Other Payer ID (340-7C) that is valid Other Payer ID Qualifier (339-6C) Claims submitted without proper required COB fields will reject with code 13.
8- Claim Billing for a Copay	OCC 8 is used when billing a co-pay from Medicare Part D	Paid claim; also requires submission of: Other Payer Amount Paid (431-DV) that is > $0 Other Payer Amount Paid Qualifier (342-HC) that is valid Patient Paid Amount Submitted (433-DX) this is => $0 Other Payer Date (443-E8) that is valid Other Payer ID (340-7C) that is valid Other Payer ID Qualifier (339-6C) that is valid Claim submitted without proper required COB fields will reject with NCPDP code 13.

3.14 DRUGS COVERED UNDER FEE-FOR-SERVICE MEDICAID FOR RECIPIENTS WITH MEDICAID MANAGED CARE (MCO CARVE OUT)

The following drugs are covered under Fee-For-Service (FFS) Medicaid regardless of whether the recipient is covered by FFS Medicaid or has Medicaid coverage through a Medicaid Managed Care Organization (MCO). These drugs require prior authorization.

Zolgensma® (onasemnogene abeparvovec-xioi): Prior authorization is required for Zolgensma®. Provider will request clinical review for prior authorization electronically, by calling the OptumRx Call Center at 855-455-3311 or by faxing the completed Zolgensma® Prior Authorization Request Form (FA-166) to 855-455-3303. Prior Authorization form is available at https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

Upon completion of the clinical review and approval by the DHCFP and OptumRx, a PA will be applied by OptumRx to allow the claim to pay as a point-of-sale (POS) or physician-administered drug (PAD) claim.

3.15 MEDICARE PART D PLAN (PDP) AND DUAL-ELIGIBLE RECIPIENTS

Recipients eligible for both Medicare and Medicaid benefits ("dual-eligibles") will receive prescription drug coverage through a Medicare Part D Prescription Drug Plan (PDP).

All claims for dual-eligibles must be billed to the recipient's Medicare PDP prior to billing Medicaid. Submit the claim to Medicaid using standard COB processing, i.e., include all required COB processing fields. Enter the Other Coverage Code of "2" (Field 308-C8). The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount. The Part D billed Bank Identification Number (BIN) (Field 340-7C) or Part B BIN is required for processing claims for recipients that are eligible for Medicaid, Medicare Part D and Medicare Part B.

Medicare Excluded Drugs

Some drugs are not covered by the Medicare PDP. Medicare excluded drug categories are:

- OTC Medications
- Cough and Cold Medications
- Vitamin and Mineral Supplements including Prenatal Vitamins

Submit your claim to Medicaid after the Medicare PDP denies the claim as a non-covered benefit. Enter a "3" (Other coverage exists, this claim not covered) in Field 308-C8 (Other Coverage Code).

Medicaid requires a prescription for all drugs, prescribed and OTC. All current Medicaid limitations and exclusions apply to claims not covered by a recipients' Medicare PDP.

Co-Payment Claims

Medicaid will cover prescription co-payments ($1.30 for generics, $4.00 for brands) for non-institutionalized dual-eligibles who have an eligibility code of "A" or "B."

Medicaid does not cover Medicare Part D co-pays ($3.70 for generics, $9.20 for brands) for dual-eligible recipients with an eligibility code of "5" or "S."

Medicaid will not reimburse Part D co-pays for recipients in Long-Term Care (LTC) facilities as these co-pays are waived per federal Medicare regulations.

Medicaid will cover Medicare Part B co-pays for dual-eligible recipients with an eligibility code of "A," "B," "5" or "S."

Medicaid co-pay logic does not allow for the reimbursement of a dual-eligible co-pay for an amount greater than $4.00. For Medicare Part B covered drugs, the co-pay amount can and will exceed this amount in most cases. To exceed the current $4.00 co-pay maximum for Part B covered drugs for recipients with Part B and D, bill Medicare Part B as the primary payer. Medicaid can be billed as the secondary payer using standard COB billing practices. For Part B covered drugs, enter the Other Coverage Code of "2" (Field 308- C8). The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount.

Diabetic Supplies

Blood glucose testing equipment and supplies, as well as injection devices, are a Part B-covered benefit. These items are not considered Part D drugs and therefore are not a Part D benefit. After billing Medicare Part B for these items, Medicaid can be billed as the secondary payer using standard COB billing practices.

Enter the Other Coverage Code of "2" (Field 308- C8). The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount. The Part D billed Bank Identification Number (BIN) (Field 340-7C) or Part B BIN is required for processing diabetic supply claims for recipients that are eligible for Medicaid, Medicare Part D and Medicare Part B.

3.16 GENDER DYSPHORIA HORMONES

Hormones used in the treatment of individuals with Gender Dysphoria are a covered benefit for Nevada Medicaid recipients. The prescription must document the proper diagnosis of F64.1 through F64.9 (Gender Dysphoria). The gender restriction will be bypassed when the pharmacy transmits this diagnosis on the electronic claim.

3.17 FAMILY PLANNING DRUGS

You may submit claims for family planning drugs directly to Medicaid without billing a primary insurance carrier first.

3.18 HOSPICE DRUGS

As stated in MSM Chapter 3200, drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual chapter for those services.

Hospice recipients can be identified by:

- Information on the recipient's Medicaid enrollment file, *or*
- The PATIENT LOCATION code (Field 307-C7) on the inbound claim contains a code "11" (Hospice)

Prior authorization is required to bill Medicaid for a drug that is unrelated to the terminal illness.

3.19 LONG-TERM CARE CLAIMS

- Drugs that are generally included in the per diem rate are not a covered benefit. Refer to Medicaid Services Manual Chapter 500 for complete information on LTC
- Non-billable Items
  - IV Hydration therapy of standard fluids without additives (e.g. antibiotics, potassium and heparin) and supplies associated with I.V. therapy, enteral nutrition and TPN administration are part of the LTC or Nursing Facility per diem rate and may not be billed as a separate charge. The following items are not billable for recipients in an LTC facility (they are considered covered through the per diem rate).
    - Dental supplies
    - Disposable supplies
    - Emollient supplies
    - Endocrine supplies
    - Fluid and electrolyte supplies

- Metabolic, nutritional and temperature supplies
- Respiratory supplies
- Supplements (see MSM Chapter 1300)
- Urological Supplies
- Wound Care Supplies

- Billable Items
  - I.V. Drugs/TPN may be billed as a separate charge for recipients in LTC facilities
- Unit Dose Repackaging Incentive
  - An incentive plan is available to pharmacies who repackage non-unit dose products (tablets and capsules) to recipients in a LTC facility. Email Nevada.Medicaid@sxc.com for enrollment and program details.
  - Enrolled pharmacies are entitled to a per claim incentive fee of $0.43. Submit this fee in the INCENTIVE AMOUNT SUBMITTED field (438-E3). Additionally, submit a value of "3" (Pharmacy Unit Dose) in the UNIT DOSE INDICATOR field (Field 429-DT)
  - In addition, nursing facilities must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of medications.
- Drugs Indicated as Unit Dose: As indicated by Medispan, most unit dose drugs are covered for recipients in LTC facilities only. If a medication is ONLY available as in unit dose packaging, coverage will also be included for non-LTC recipients.
- Please note: Patients who reside in "Assisted Living Facilities" are not considered as "Long-Term Care" patients.

Identify claims for recipients in a LTC facility by entering "04" (Long Term/Extended Care) in Field 307-C7 (Patient Location)

3.20 340B DRUG DISCOUNT PROGRAM

The 340B Drug Discount Program is a federal program that requires drug manufacturers to provide covered outpatient drugs to certain eligible 340B-enrolled entities at significantly reduced prices. For these 340B entities, the Division of Health Care Financing and Policy (DHCFP) is prohibited from claiming drug rebates as this would subject the drug manufacturers to duplicative discounts. All drug claims submitted by a 340B pharmacy to DHCFP are excluded from the drug rebate collection process.

DHCFP utilizes the Health Resources and Services Administration's (HRSA's) Medicaid Exclusion File to identify 340B providers. Pharmacies registered as a 340B pharmacy must bill with their actual acquisition cost. If a pharmacy decides to bill DHCFP as a 340B pharmacy, ALL outpatient drugs billed to DHCFP must be billed with the pharmacy's actual acquisition cost. This applies to Medicaid Fee-for-Service and Medicaid Managed Care claims.

Please refer to: http://www.hrsa.gov/opa/ for more details.

3.21 SPECIAL RECIPIENT CONDITIONS ("LOCKED-IN" PATIENTS)

- When a recipient shows patterns of abuse/misuse of benefits, the recipient can be "Locked In" to a pharmacy.
- Patients may be locked into a designated pharmacy. Pharmacies will receive a NCPDP-50 reject if they try to fill a prescription from an unauthorized pharmacy. In the event of an emergency, OptumRx may be contacted for override consideration.
- Any Nevada Medicaid participating pharmacy has the right to accept or decline any "locked-in" Nevada Medicaid recipient only after contacting the **OptumRx Technical Help Desk** at 1-866-244-8554.

3.22 COMPOUNDS

All compounded medications require prior authorization. Refer to Nevada Medicaid Services Manual (MSM) Chapter 1200 for specific criteria at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

A $10.17 dispensing fee applies to all compound claims.

Compound Claims Processing

- All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be submitted on the claim. At least one item in the compound must be a covered drug. *If an excluded or non-PDL agent is included in the compound, the claim will reject for "invalid compound."* The pharmacy may place an "**8**" in the submission clarification code field and resubmit the claim; however, be advised that any component of a compound requiring prior authorization will necessitate an approval prior to receiving payment from The Nevada Medicaid Pharmacy Program.

Provider Instructions

- There are three segments that must be completed to submit a compound claim. Nevada Medicaid is listing the required entries by NCPDP field numbers. If you are unsure where these specific fields are located in your software please contact your software provider and give them the full Payer Specification Sheet for the Nevada Medicaid Pharmacy program that is included in this manual under Appendix B.
- On Claim Segment:
  - Enter PRODUCT CODE/NDC (NCPDP Field # 407-D7) as "00000000000" on the claim segment to identify the claim as a multi-ingredient compound.
  - Enter COMPOUND CODE (NCPDP Field # 406-D6) of "2."
  - Enter QUANTITY DISPENSED (NCPDP Field # 442-E7) for the entire product.
  - Enter INGREDIENT DRUG COST (NCPDP Field # 409-D9) of the entire product.
    - This must equal the sum of the individual ingredient drug costs submitted in the compound segment.
  - Enter GROSS AMOUNT DUE (NCPDP Field # 430-DU) for the entire product.
  - Enter USUAL AND CUSTOMARY CHARGE (NCPDP Field # 426-DQ) for entire product.

- o SUBMISSION CLARIFICATION CODE (NCPDP Field # 420-DK) = 8 (Process Compound for Approved Ingredients) allows a claim to continue processing if at least one ingredient is covered. This is only needed if the compound contains a non-covered ingredient (see section 3.14 above).

- On Compound Segment:
  - o COMPOUND DISPENSING UNIT FORM INDICATOR (NCPDP Field # 451-EG)
    Acceptable values are **ML** or **GM**
  - o COMPOUND ROUTE OF ADMINISTRATION (NCPDP Field # 452-EH)
    Example values are:
    1) 3 = Inhalation
    2) 4 = Injection
    3) 11 = Oral
    4) 13 = Otic
    5) 15 = Rectal
    6) 17 = Topical
  - o COMPOUND INGREDIENT COMPONENT COUNT (NCPDP Field # 447- EC) - must equal the number of NDCs transmitted in the compound segment (Maximum of 25)
  - o For each line item (ingredient):
    COMPOUND PRODUCT ID QUALIFIER (NCPDP Field # 488-RE), always **03 = NDC**
    COMPOUND PRODUCT ID (NCPDP Field # 489-TE), **NDC** of ingredient
    COMPOUND INGREDIENT QUANTITY (NCPDP Field # 448-ED), quantity of the individual ingredient included in the compound
    COMPOUND INGREDIENT DRUG COST (NCPDP Field # 449-EE), cost of the individual ingredient included in the compound

Important Notes

- The Claim Segment Product ID (i.e., NDC) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
- A non-blank space value is expected in the Claim Segment Product ID field for field validation. The pharmacy submits all zeroes in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected if all zeroes are not submitted as the Product ID.
- A Submission Clarification Code value of **"8"** only allows a claim to continue processing if at least one ingredient is covered. Non-rebateable ingredients will process with the submission clarification code; but only rebateable ingredients are eligible for reimbursement.
- Each multi-ingredient compound claim counts as one claim towards the **Brand** Rx fill limits, if applicable.
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- Compounds which contain an antibiotic must also contain another active ingredient. For example, an antibiotic suspension plus flavoring or an injectable antibiotic plus a fluid will not be covered as a compound.
- Coverage of Active Pharmaceutical Ingredients (APIs)
  - o An API is defined by 21 C.F.R. § 207.3(a)(4) as a bulk drug substance that "is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug." APIs may be included in

extemporaneously compounded prescriptions and may serve as the active drug component in a compounded formulation.

3.23 PARTIAL FILL FUNCTIONALITY

Partial fill functionality allows pharmacies to bill for partial quantities of a single prescription. The following rules apply:

- Partial fills must be billed via the POS system
- The dispensing fee is paid on the first fill only
- Partial fill functionality cannot be used with multi-ingredient compound claims
- Partial fills may not be transferred from one pharmacy to another
- You may not submit two partial fill transactions for the same prescription on the same day; the service date must be different for each partial fill.

The following sections list the NCPDP fields that are required to submit initial, subsequent and final claims using the partial fill functionality.

- **Initial Claims** – complete these fields on an initial partial fill claim.
  - Quantity Dispensed (Field 442-E7): Enter the actual quantity dispensed for this claim
  - Days Supply (Field 405-D5): Enter the number of days supply that was dispensed for this claim
  - Dispensing Status (Field 343-HD): Enter "P" in this field
  - Quantity Intended to be dispensed (Field 344-HF): Enter the total quantity that was prescribed
  - Days Supply Intended to be dispensed (Field 345-HG): Enter the total days supply that was prescribed
- **Subsequent Claims** – Complete these fields on a subsequent partial fill claim
  - Associated Prescription/Service Reference Number (Field 456-EN): Enter the prescription number from the initial partial fill
  - Associated Prescription/Service Date (Field 457-EP): Enter the date of service of the most recent partial fill in the series.
  - Quantity Dispensed (Field 442-E7): Enter the actual quantity dispensed for this claim.
  - Days Supply (Field 405-D5): Enter the number of days supply that was dispensed.
  - Dispensing Status (Field 343-HD): Enter "P" in this field.
  - Quantity Intended to be Dispensed (Field 344-HF): Enter the total quantity that was prescribed.
  - Days Supply Intended to be Dispensed (Field 345-HG): Enter the total days supply that was prescribed.
- **Final Claim** – Complete these fields on a final partial fill claim:
  - Associated Prescription/Service Reference Number (Field 456-EN): Enter the prescription number from the initial partial fill
  - Associated Prescription/Service Date (Field 457-EP): Enter the date of service of the most recent partial fill in the series.
  - Quantity Dispensed (Field 442-E7): Enter the actual quantity dispensed for this claim.
  - Days Supply (Field 405-D5): Enter the number of days supply dispensed
  - Dispensing Status (Field 343-HD): Enter "C" in this field

- Quantity Intended to be Dispensed (Field 344-HF): Enter the total quantity that was prescribed
- Days Supply Intended to be Dispensed (Field 345-HG): Enter the total days supply that was prescribed

3.24 INJECTABLE DRUGS

Intravenous (I.V.) therapy drugs claims must be submitted through the pharmacy POS system using the Multi-Ingredient Functionality.
- Dispensing Fees:
  - For outpatient antibiotic therapy, a daily dispensing fee of $10.17 will be applied to the claim.
  - For recipients in Long-Term Care, a daily dispensing fee of $.10.17 will be applied to the claim. This fee will be multiplied by the number of days the therapy was provided.
- Supplies
  - I.V. therapy supplies, enteral nutrition/supplies, Standard Total Parenteral Nutrition (TPN) solution and supplies are billed on CMS-1500 claim form or through the 837P electronic transaction. Medications added to TPN Solution immediately prior to administration are billed through the pharmacy POS system.
  - For coverage and limitations, see the Billing Guidelines for Provider Type 33, MSM Chapter 1200, Section 1203.2 and MSM Chapter 1300.

3.25 REFILLS

Dispense refills pursuant to the orders of the physician, but not more than one year from the date of the original prescription.

Early refills may be dispensed only when 80% of the prescription is used for non-controlled drugs and 90% for controlled drugs. Recipients must use drugs in accordance with the prescriber's orders.

3.26 VACATION FILL

To override an Early Refill denial message for a non-controlled substance (Reject Code 88) where the prescriber has authorized a vacation fill, enter '03' as the Submission Clarification Code (Field 420-DK).

3.27 REASON FOR SERVICE CODE (CONFLICT CODE)

A Reason for Service Code (Reject Code E4) defines the type of utilization conflict that was detected (Field 439).

- Professional Service codes and Result of Service codes are required for Severity Level One Conflict codes.

3.28 LOST MEDICATION

The recipient is responsible for payment to replace lost, stolen or otherwise destroyed medication even if a physician writes a new prescription for the drug. Prior authorization may be granted in a life-threatening situation for maintenance medication (refer to MSM Chapter 1200).

3.29 USE OF PHARMACY DRUG DISCOUNT CARDS BY RECIPIENTS AND RETRO-ELIGIBLE REFUNDS

Per Nevada Medicaid's Billing Manual for Nevada Medicaid and Nevada Check Up, any payment collected from a Nevada Medicaid recipient for a covered service must be returned to the recipient if they are later determined eligible for retroactive coverage that includes those dates of service. Nevada Check Up does not offer retroactive coverage. Nevada Medicaid offers up to three months of retroactive eligibility from the date in which the individual filed their application for assistance.

Drug discount cards can cause reimbursement issues for Medicaid recipients. If a recipient is pending Medicaid or becomes retro-eligible and has used a drug discount card for a drug claim, the transaction must be cancelled by the drug discount card processor in order to bill Medicaid. Pharmacies will be unable to bill Medicaid and reimburse the recipient until the initial claim using the discount drug card has been reversed. Online reversal of the claim may not be possible due to retail pharmacy company policies and system limitations. Manual reversal of the claim may or may not be possible; therefore, reimbursement cannot be guaranteed.

Pharmacies are encouraged to notify recipients using drug discount cards of this policy regarding future refunds.

3.30 ORDERING, PRESCRIBING OR REFERRING (OPR) PROVIDER REQUIREMENTS

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Refer to the Pharmacy Billing Manual Appendix B – NCPDP D.0 Payer Sheet for Pharmacy Providers for billing instructions.

Please refer to Section 5.5 of this billing manual for billing instructions for vaccine claims when submitted with a non-participating prescriber due to Ordering, Prescribing and Referring (OPR) practitioner validation.

3.31 BILLING FOR POINT-OF-SALE (POS) CLAIMS EXCEEDING $999,999.99

Due to the field size limitations from the National Council for Prescription Drug Programs (NCPDP) for fields 409-D9 (Ingredient Cost Submitted), 426-DQ (Usual and Customary Charge) and 430-DU (Gross Amount Due), claims exceeding $999,999.99 require special billing and handling. Providers must split the claims as necessary to allow the proper amount

due to be billed. The total quantity dispensed (442-E7) must be split by the provider and billed on multiple claims. A prior authorization will be necessary to allow for multiple dispenses on the same date of service. The prior authorization will also pay only a single dispensing fee, if applicable.

4.0 PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available. Because the ProDUR solution through OptumRx examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. ProDUR edits can detect the following potential problems: therapeutic duplication, early refills, high dose, drug-drug interactions, drug-inferred diagnosis interactions, drug-gender edits, and geriatric or pediatric precautions.

OptumRx recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties. If a pharmacist assesses a potential drug therapy problem, and determines that the prescription should be dispensed, the pharmacist can override the ProDUR edit at point of sale using Pharmacy Professional Service (PPS) Codes (See table below). Exceptions include ProDUR edits involving: narcotic analgesics, sedative hypnotics, benzodiazepines or skeletal muscle relaxants. ProDUR edits for these four classes require a call to the call center in order to obtain an override.

Pharmacy Professional Service Codes		
Response Field		**Response Codes**
Conflict Code	**DD**	**Drug-Drug Interaction**
	HD	**High Dose**
	TD	**Therapeutic Duplication**
	DC	**Drug-Disease**
	LD	**Low Dose**
	MN	**Insufficient Duration**
	MX	**Excessive Duration**
	PA	**Drug-Age**
Intervention Code	**M0**	**Prescriber consulted**
	P0	**Patient consulted**
	R0	**Pharmacist consulted other source**
Outcome Code	**1A**	**Filled As Is, False Positive**
	1B	**Filled Prescription As IS**
	1C	**Filled, With Different Dose**
	1D	**Filled, With Different Directions**
	1E	**Filled, With Different Quantity**
	1G	**Filled, With Prescriber Approval**

4.1 THERAPEUTIC AND CLINICAL EDITS

Therapeutic Duplication

A Therapeutic Duplication edit has been enabled for specific therapeutic classes as a safety precaution. Claims encountering this edit are denied with an NCPDP "88" Reject - TD. Additional information is shared as outlined in Section 4.3 below.

Therapeutic Duplication Alert Classes*		
ACE Inhibitors	Antipsychotics	H2RAs
ACE Inhibitors/CCB	Benzodiazepines (Anxiety)	Leukotrienes
Alpha Blockers	Benzodiazepines (Insomnia)	Statins (lipotropics)
Angiotensin Receptor Blockers	Beta Blockers	Fibrates (lipotropics)
Antiarthritics (NSAIDS, COX-II)	Bile Salt Sequestrants	Narcotic Analgesics
Antidepressants (SSRI, SNRI)	Calcium Channel Blockers	Quinolones
Antidepressants (TCAs)	PPIs	Skeletal Muscle Relaxants
Antihistamines		

*The above list may not be all inclusive and is subject to change

4.2 CALL CENTERS

The OptumRx Technical Call Center is available 24 hours per day, seven days a week. The telephone number is (866) 244-8554. Alert message information is available from the Technical Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Technical Call Center about ProDUR messages at the time of dispensing. The Technical Call Center can provide claims information on all error messages, which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Technical Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. OptumRx has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, OptumRx clinical pharmacists are available for consultation and are located at the Clinical Call Center. The telephone number is (855) 455-3311. The Clinical Call Center is available 24 hours a day, seven days a week.

4.3 PRODUR ALERT/ERROR MESSAGES

ProDUR is an integral part of the Nevada Medicaid Pharmacy Program's claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed; reviewing the available medical history; focusing on those patients at the highest severity of risk for harmful outcome; and intervening and/or counseling when appropriate.

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HR, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. 1 = Your Pharmacy 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters. Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. 1 = First Data Bank 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

5.0 PROVIDER REIMBURSEMENT

5.1 SWITCHING FEES

OptumRx does NOT charge any switching fees for any claims. Pharmacies may be charged switching fees by their individual "claims switching service." Pharmacies are encouraged to consult with their claims switching service for further details.

5.2 AMBULATORY/LTC NETWORK PHARMACY PAYMENT ALGORITHMS

Pricing for all drugs and supplies (except diabetic, family planning supplies and vaccinations) is always the "lesser of":

- National Average Drug Acquisition Cost (NADAC) + Dispensing Fee
- Wholesale Acquisition Cost (WAC) + Dispensing Fee

- Federal Upper Limit (FUL) + Dispensing Fee
- Maximum Allowable Cost (MAC) + Dispensing Fee
- Department of Justice (DOJ) – 15% + Dispensing Fee
- Gross Amount Due (Field 430-DU) (Submitted)
- Usual and Customary (Field 425-DQ) (Submitted)
- Actual Acquisition Cost (AAC) (Submitted)

Pricing for Diabetic and Family Planning Supplies is always the "Lesser of":

- Wholesale Acquisition Cost (WAC) + 8% + $1.54 Dispensing Fee
- Gross Amount Due (Field 430-DU)
- Usual and Customary (Field 425-DQ)

Actual Acquisition Cost (AAC)

For products that do not have WAC, FUL, MAC or DOJ pricing on file, a pharmacy will be prompted to submit their actual acquisition price. The pharmacy should submit the actual invoiced cost of the medication for the quantity submitted.

The Point of Sale system will return the message "PLEASE SUBMIT PHARMACY ACQUISITION PRICE AND SUBMIT PRIOR AUTH #00000000012" if no other pricing is on file for the submitted NDC. The pharmacy should submit the following:

- The calculated actual acquisition cost in the "Gross Amount Due" (430-DU) field
- The "PA Type Code" (461-EU) field should be "1"
- The "PA Number Submitted" (462-EV) field should be "00000000012"

Compounds (Other than Home I.V. antibiotics)

Each individual **ingredient is priced as above + the applicable dispense fee. The lesser of calculated amount, Usual and Customary, and Gross Amount** Due are reimbursed. There are no additional repackaging fees.

5.3 AMBULATORY/LTC NETWORK PHARMACY DISPENSING FEES

- Dispensing fee is currently $10.17 per claim.

5.4 PHYSICIAN ADMINISTERED DRUG (PAD) CLAIM PAYMENT ALGORITHMS

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity and the Healthcare Common Procedure Coding System (HCPCS) code for each claim line with a physician-administered drug. For billing specifications, see the Nevada Medicaid NDC Billing Reference (select "NDC" from the "Providers" menu, then click "Billing Reference").

Not Otherwise Classified Drugs

Correct coding requires an item be coded with the most specific code available that appropriately describes the item. Not Otherwise Classified (NOC) Healthcare Common Procedure Coding System (HCPCS) codes must only be used when a more specific HCPCS code is not available.

Providers who indicate procedure codes such as **J3490** (Unclassified drugs), **J3590** (Unclassified biologics), and **J9999** (Not otherwise classified, antineoplastic drugs) on claims for NOC drugs must also indicate the following on the claim:

- The NDC of the drug dispensed,
- The drug name,
- The NDC quantity billed, and
- The NDC unit of issue (i.e., ea, gm, or ml).

If this information is not included on the claim or if there is a more specific HCPCS procedure code for the drug, the claim could be denied.

Pricing for all drugs and supplies (except diabetic, family planning supplies and vaccinations) is always the "lesser of":

- NADAC
- WAC
- FUL
- MAC
- Department of Justice (DOJ) – 15%
- Gross Amount Due (Field 430-DU) (Submitted)
- Usual and Customary (Field 425-DQ) (Submitted)
- AAC (Submitted)

Pricing for Diabetic and Family Planning Supplies is always the "Lesser of":

- WAC + 8%
- Gross Amount Due (Field 430-DU)
- Usual and Customary (Field 425-DQ)

5.5 END STAGE RENAL DISEASE (ESRD) FACILITY AND HOSPITAL BASED ESRD CLAIMS

- ESRD facilities and outpatient hospitals are reimbursed by a bundled prospective payment system (PPS).
- Refer to the Nevada Medicaid Billing Guidelines for Provider Types 45 and 81 for information regarding PPS for ESRD facilities and outpatient hospitals.
- For a list of drugs included in the PPS, refer to the CMS Manual System, Pub 100- 04 Medicare Claims Processing, Transmittal 2134.
- Drugs administered must be billed by National Drug Code (NDC). All services (e.g., drugs and labs) administered should be billed regardless of the global (PPS) methodology. Services that are billed and included in the PPS rate will not be paid separately but will deny as included in the global rate.

5.6 PHARMACIST ADMINISTERED VACCINATIONS

Effective April 17, 2012, Nevada Medicaid and Nevada Check Up will reimburse pharmacies for administering adult and childhood vaccines.

Requirements

- The administering pharmacist must be appropriately certified by the Nevada State Board of Pharmacy.

![OPTUMRx logo]

- Records must be kept on file for auditing.
- Pharmacies are responsible for physician oversight of the program and other state licensing requirements per Nevada Board of Pharmacy Rules.
- Pharmacies must enter vaccination given in the Nevada WebIZ Website.
- Pharmacies must enroll in the Vaccines for Children Program (VFC). VFC vaccines are provided by the Nevada State Health Division for recipients who are under 19 years of age at no cost to the provider.
- The following is a list of covered vaccines:

Covered Vaccines
• **Influenza**
• **Tetanus, diphtheria, pertussis (Td/Tdap/DTaP)**
• **Varicella**
• **HPV (Male and Female) (Provided through VFC program through age 18)**
• **Zoster (only covered for recipients 50 years old and greater, not included in VFC)**
• **Measles, Mumps, Rubella (MMR)**
• **Pneumococcal**
• **Meningococcal**
• **Hepatitis A**
• **Hepatitis B**
• **Inactivated Poliovirus**
• **Haemophilus influenza type b**
• **Rotavirus**
• **COVID-19**
• **Synagis®**

Reimbursement

- **The administration fee is $7.80 if administered in the pharmacy. If dispensed and administered off site, the pharmacy will be reimbursed the standard dispensing fee.**
- All claims should be submitted through the Pharmacy Point of Sale System.
- **Pharmacies will not be reimbursed an ingredient cost for VFC Program Vaccination, but pharmacies will receive the administration fee.**
- Ingredient cost will be reimbursed using the lesser-of logic payment algorithm.

Claims Submission for Synagis®

Providers must submit requests for prior authorization for the number of required whole vials. Requests for partial vials will be rejected with messaging from the pharmacy system indicating missing or invalid quantity. Please refer to the following table for dosing allowance for calculating dosage and number of required vials.

Dosing Allowance: Synagis® is available only in 50mg and 100mg vials. Due to the potential for significant waste, the following table should be utilized to determine permitted dose (within 10% of calculated dose due to vial overfill) and vials to dispense.

Weight	Calculated Dose/Month	Allowed dose	Dispense
0 to 3.6 kg	54 mg	50 mg	One 50 mg vial
3.7 to 7.3 kg	110 mg	100 mg	One 100 mg vial
7.4 to 11.1 kg	220 mg	200 mg	Two 100 mg vials
14.7 to 18.1 kg	271 mg	250 mg	Two 100 mg vials and 50 mg vial

Claims Submission for COVID-19 Vaccinations

When submitting a claim for the COVID-19 vaccine, submission should include the NCPDP fields as depicted below. An administration fee will be paid to POS pharmacy providers that submit claims for covered COVID-19 vaccines for Nevada Medicaid Fee-for-Service (FFS) recipients within the specified product limits. The pharmacy provider's fee is $40.44 for the first, second and third administration (dose) of the vaccination. Coverage for the third dose is provided if the recipient meets criteria for medical necessity. If a pharmacy claim is submitted for a recipient's second or third vaccination dose with a National Drug Code (NDC) from a different manufacturer than was used with the first dose, the claim will be denied, requiring prior authorization.

Effective August 18, 2021, the third vaccination is applicable only to Nevada Medicaid recipients where medically necessary, meaning that the recipient is immunocompromised due to solid organ transplant or recipients that are diagnosed with conditions that are considered to have an equivalent level of immunocompromise. Examples include but are not limited to cancer, human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS) and inherited diseases that affect the immune system. The third dose is to be administered at least 28 days following the two-dose regimen of the same vaccine. This additional dose applies to immunocompromised recipients 18 years of age or older for the Moderna vaccination and ages 12 or older for the Pfizer vaccination.

NCPDP Field Name	NCPDP Field Number	First Dose	Second Dose (If Applicable)	Third Dose (If Applicable)
Professional Service Code (DUR-PPS)	440-E5	MA = Medication Administration	MA = Medication Administration	MA = Medication Administration
Day Supply	405-D5	1-Day	1-Day	1-Day
Submission Clarification Code (SCC)	420-DK	2 = Other Override	6 = Starter Dose	
Ingredient Cost Submitted	409-D9	$0.01	$0.01	$0.01
Dispensing Fee Submitted	412-DC	$0.00	$0.00	$0.00
Basis of Cost Determination	423-DN	15 = Free Product	15 = Free Product	15 = Free Product
Incentive Amount Submitted	438-E3	$40.44	$40.44	$40.44
Product / Service ID / NDC	407-D7	EUA approved NDC	EUA Approved NDC	EUA Approved NDC
Fill Number	403-D3	00	01	02

Claims Submission for Pharmacist Administered Vaccinations

- For POS claims:
  - Submit ingredient cost submitted (409-D9)
  - Submit Dispensing Fee Submitted (412-DC)
  - Submit Patient Paid Amount (433-DX)
  - It is not required, but Incentive Amount (433-E3) may be submitted
  - Submit Gross Amount Due (430-DU)
  - All other fields are the same as standard POS claims.
- Response for POS claims:
  - You will only be reimbursed what is allowed according the payment algorithm.
  - If the recipient is 18 years old or less, a zero ingredient cost (506-F6) will be returned, if the recipient is 19 years old or over, the ingredient cost will be reimbursed based on the algorithm above.
  - The administration fee will be returned in the Incentive Fee field (521-FL) for all claims for vaccinations.

Billing Instructions for Vaccine Claims when Submitted with a Non-participating Prescriber Due to Ordering, Prescribing and Referring (OPR) Practitioner Validation

Effective February 6, 2015, pharmacies submitting claims for vaccines to Nevada Medicaid and Nevada Check Up with non-participating prescribers will need to enter the following information:

- Prior Authorization Type (461-EU) = '01'
- Prior Authorization Number Submitted (462-EV) = '44444444444'

This override is applicable only when billing for vaccines.

For more information:

Visit: http://dpbh.nv.gov/Programs/Programs or http://dpbh.nv.gov/Programs/VFC/VFC_-_Home for information specific for Vaccine for Children (VFC).

All vaccines administered must be documented in Nevada's WebIZ – the Statewide Immunization Information System. Please visit: http://dpbh.nv.gov/Programs/WebIZ/WebIZ_-_Home for enrollment information.

6.0 PROVIDER EDUCATION

- Provider Educators are available to assist Nevada Medicaid providers who may have questions regarding the pharmacy program (i.e., Preferred Drug List (PDL), Point-of-sale messaging, etc).
- In addition to ensuring PDL compliance, the overall objective for provider educators is to improve provider awareness of the Nevada Medicaid pharmacy program policies and procedures.
- Provider training is available as needed or one-on-one if requested.
- Email Nevada.Medicaid@optumrx.com to request training or ask questions.

7.0 APPENDICES TO THIS MANUAL

Appendix A – Instructions for Completing the NCPDP Universal Claim Form (Ver 5.1)

Appendix B – NCPDP D.O Payer Sheet for Pharmacy Providers

Appendix C – Other Carrier Code List

[Appendix D – Quantity Limits](#) (If more than the listed quantity is needed for treatment, please call the OptumRx Clinical Call Center for a prior authorization: (855) 455-3303.)

[Appendix E – Drugs Not Requiring Whole Quantities](#) (Partial units may be billed to allow the remaining quantity to be administered to another recipient instead of wasted. This applies to outpatient retail claims billed through point of sale (POS) and physician administered drugs (PAD).)

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