Pharmacy Outpatient Prescribed Drugs Provider Manual



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Chapter III. Provider-Specific Policies

A. General Pharmacy Guidelines

I. Iowa Medicaid Pharmacy Processing Information

The pharmacy processing information for Iowa Medicaid is:

ID: Member's Medicaid ID #
BIN: 011933
PCN: IAPOP
Effective Date: 12/01/2026

2. Iowa Medicaid Pharmacy Homepage

This manual gives general information about Medicaid outpatient prescribed drug coverage and billing policies. For access to pharmacy resources for Iowa Medicaid Providers, visit the Iowa Medicaid Pharmacy webpage: hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy

2. General Letters

A record of past and current General Letters outlining the content changes to this chapter are available online at: Medicaid Provider General Letters.

3. Entities Involved in Developing Medicaid Drug Policies

a. Drug Utilization Review Commission

The Iowa Medicaid Drug Utilization Review (DUR) Commission was established pursuant to Iowa Code section 249A.24. The DUR Commission is a quality assurance body of ten members that seeks to improve the quality of pharmacy services and ensures rational, cost-effective medication therapy for Medicaid members in Iowa.

This Commission meets four times a year in a public forum. The Commission discusses potential medications or therapeutic classes where prior authorization may be beneficial and discusses existing criteria to determine if the criteria continue to be therapeutically valid.

For more information about the DUR Commission, visit: www.iadur.org.

b. Pharmaceutical and Therapeutics Committee

The Pharmaceutical and Therapeutics (P&T) Committee was established pursuant to Iowa Code section 249A.20A. The P&T Committee has nine members appointed by the Governor for a two-year term. The Committee meets three times a year in a public forum.

The P&T Committee is charged with developing and providing ongoing review of the Preferred Drug List (PDL). The PDL is a list of drugs recommended to the Iowa Department of Health & Human Services by the Iowa Medicaid P&T Committee that have been identified as being therapeutically equivalent within a drug class and generally cost-effective to the Medicaid program.

Equivalent products are those that meet therapeutic equivalence standards as published in the federal Food and Drug Administration document, **Approved Prescription Drug Products with Therapeutic Equivalence Evaluations**.

The P&T Committee's focus is maximizing the initial utilization of the most cost-effective clinical choices available. All drug manufacturers have been given the opportunity to state the therapeutic benefit of their drugs and to reduce the net cost to the state through a supplemental rebate program.

The Committee has reviewed each product within a therapeutic class for:

- Pharmacology,
- Indications,
- Comparative clinical trials,
- Adverse effects and safety, and
- Relative cost of each product.

Comparing products within the same class helps identify the most clinically and cost-effective product in each class.

By first considering the therapeutics and then the cost, the P&T Committee ultimately decides which drugs to recommend to the Iowa Medicaid program as "preferred."

The P&T Committee holds public meetings with public notice of its agenda and opportunity for public comment.

For more information about the P&T Committee, visit: www.iowamedicaidpdl.com.

4. Pharmacies Eligible to Participate

To be eligible to participate in the Iowa Medicaid program, a pharmacy must be licensed by its state Board of Pharmacy. Pharmacies must enroll with Iowa Medicaid as a participating provider before dispensing medications to Iowa Medicaid members.

a. Licensure

Participating pharmacies must be licensed in the state of Iowa or duly licensed in another state.

b. Survey Participation

As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information, dispensing cost information, and any other information deemed necessary by the Department to assist in monitoring and revising reimbursement rates pursuant to 441 IAC 79.1(8) or for the efficient operation of the pharmacy benefit.

- A pharmacy shall produce and submit all requested information in the manner and format requested by the Department or its designee at no cost to the Department or its designee.
- A pharmacy shall submit information to the Department or its designee within the time frame indicated following receipt of a request for information unless the Department or its designee grants an extension upon written request of the pharmacy.
- Any dispensing or acquisition cost information submitted to the Department that specifically identifies a pharmacy's individual costs shall be held confidential.

5. Pharmacist Responsibilities

a. Prospective Drug Utilization Review

Following a prospective drug use review pursuant to rule 657 Iowa Administrative Code 8.21(155A), pharmacists shall review patient drug therapy at the point of sale to screen for potential drug therapy problems, such as:

- Therapeutic duplication,
- Drug-disease contraindications,
- Drug-drug interactions,
- Incorrect drug dosage or duration,

- Drug-allergy interactions, and
- Clinical abuse or misuse.

b. Dispensing Requirements

Pharmacists are required to:

- Dispense drugs in accordance with cost and quantity requirements established by state law.
- Dispense the **least costly item** in stock that meets the order of the doctor or other practitioner, as shown on the prescription.
- Bill once every three months for a three-month supply for any medication on the Mandatory **90-Day Supply Prescription List**. The first two fills of medications may be filled at a 30-day supply, for a total of 60 days, before the 90-day supply is required.
  - The following populations will be excluded from the 90-day supply requirement:
    - Beneficiaries residing in long term care facilities and residential programs.
    - Beneficiaries who are identified as medically needy.
- Bill once each month for a one-month supply of medication for any medication not listed on the **Mandatory 90-Day Supply Prescription List.**
  - Excluding contraceptives which may be billed for up to a three-month supply.
- Develop and implement policies and procedures for delivery of prescriptions in accordance with state law, including:
  - Establishment of effective controls against diversion of prescription drugs, as required by Iowa Code § 155A.15(2)(i);
  - Policies and procedures regarding shipment or other delivery to ensure accountability, safe delivery, and compliance with temperature requirements, as required by 657 Iowa Administrative Code 8.15(2); and
  - Maintain a record documenting receipt and delivery of the covered outpatient prescribed drug to the Medicaid member or the member's representative, as required by 441 IAC 79.3(1)"a"(2) and 79.3(2)"c"(3).
- Ensure only medications prescribed to that member are billed using the member's identification (ID) number. If medications are needed to treat remaining family members, each prescription must be billed accordingly to each family member's Medicaid ID number.

- **NOTE:** Automatic refills are permitted. Member participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis. Pharmacy requirements are in 441 Iowa Administrative Code 78.2(6).

c. Patient Counseling

Pharmacists must offer to discuss with each Medicaid member or the member's caregiver presenting a prescription those matters that, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

- The name and description of the drug;
- The dosage form, dose, administration route and duration of therapy;
- The intended use of the drug, if known, and expected action;
- Directions and precautions for preparation, administration, and use;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur;
- Techniques for self-monitoring drug therapy;
- Proper storage;
- Prescription refill information, including the approximate date when a refill will be allowed (generally, 90 percent of the prescription is used);
- Actions to be taken in the event of a missed dose; and
- Comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug.

Patient counseling is required in accordance with federal law at 42 USC Section 1396r(g)(2)(A)(ii)(I) and state rules at 657 Iowa Administrative Code 6.14(155A).

d. Reason for Denial

The pharmacist should explain the reason for any **denial** of a requested drug or item to the member or caregiver. For example, denial could be due to one of the following:

- **Refill too soon**. Inform the member or caregiver of an approximate date the prescription can be refilled (after 90 percent of the previous supply is used).
- **Non-covered drug or item**. Explain why the drug or item is not covered and suggest alternatives to the member, caregiver, or practitioner.

- **Prior authorization requirement**. Explain the prior authorization process and requirements to the member or caregiver.

  When a patient presents a prescription for a non-preferred drug at a pharmacy and it is denied, contact the prescriber and ask if the prescriber wishes to choose a preferred drug.

  - If the prescriber wishes to change to a preferred drug, the prescriber may dictate the new prescription order.
  - If the prescriber views that the non-preferred drug is medically necessary, the prescriber must obtain a prior authorization.

e. Special Circumstances

To enter a request for an early refill due to any of the circumstances listed below the pharmacist must contact the Iowa Medicaid Pharmacy Point of Sale (POS) Unit at (515) 256-4608 (local calls) or (877) 463-7671 for fee for service claims. The request will be reviewed to determine if an override can be given to allow payment.

- Non-controlled medications that are lost, stolen, or destroyed after delivery to the member are limited to a one-time override allowance per 12-month period.
- Requests exceeding the one-time override allowance for non-controlled medications that are lost, stolen, or destroyed after delivery to the member may be considered with additional documentation. Such requests involving stolen medications must include a copy of a police report.
- Override of refill too soon will not be allowed for controlled substances and/or tramadol containing products that are lost, stolen, or destroyed after delivery to the member.
- Override of refill limits will not be allowed for members residing in a long-term care (LTC) facility.
- Prescription drugs that are not received by the member because they are lost or stolen in transit, before actual delivery to the member, or that are received in damaged or unusable condition will not be replaced through override of refill too soon. The original claim for the drug that was not properly delivered to the member should be reversed and a new claim for a replacement can then be submitted.

- **Quantity Limits.** For more information regarding medications with quantity limits, visit the Billing/Quantity Limits section on the PDL website at www.iowamedicaidpdl.com.

  If adherence to the quantity limit is not possible, the prescriber should complete form **470-4556, Quantity Limit Override** or form **470-5038, Request for Fifteen Day Initial Prescription Supply Override**, and fax it to (800) 574-2515. The clinical staff will review the information submitted and determine if an override can be given to allow payment.

f. Appeals and Exception to Policy

If a member or caregiver is dissatisfied with the denial of a medication request, refer them to their HHS worker for assistance in filing an appeal or requesting an exception to policy. A provider may also request an appeal or exception to policy.

For more information on the appeals and exception to policy process, visit: www.iowamedicaidpdl.com.

6. Drug Utilization Review

The drug utilization review (DUR) process was established to fulfill a federal requirement established by the federal Omnibus Budget Reconciliation Act of 1990. Iowa Medicaid has implemented both required DUR types:

- **Prospective drug utilization review** occurs when the pharmacist does the review of patient drug therapy at the point of sale. See Pharmacist Responsibilities.
- Retrospective drug utilization review occurs when the review takes place after the point of sale. This program provides ongoing periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs.

B. Coverage of Services

Payment will be made for legend and nonprescription drugs when prescribed by a practitioner who is legally qualified to prescribe the drug, subject to the limitations described in this manual.

Legend drugs are drugs that bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."

1. Prescription Requirements

Prescription records are required for all drugs as specified in Iowa pharmacy and drug laws, including Iowa Code sections 124.308, 126, 155A.27, and 155A.29.

For Medicaid purposes, prescriptions are required for nonprescription drugs and are subject to the same provisions. This includes the record-keeping requirements on refills. Prescriptions must be maintained on file in such a manner that they will be readily available for audit by the Department.

Prescriptions executed in writing (non-electronic) for prescription drugs must be presented on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

a. Prescriber Qualifications

Payment is made for drugs prescribed by a legally qualified enrolled practitioner within their scope of practice as indicated by law and in policies established by the Department.

b. Prescriber Guidelines

Prescribers should review the therapy of their Medicaid patients for utilization of non-preferred drugs and, wherever medically appropriate, change patients to preferred drugs. New therapy should be initiated on a preferred drug unless a non-preferred drug is medically necessary.

When a non-preferred drug is medically necessary, the prescriber should request a prior authorization. See Prior Authorization Requirements for information on criteria for prior authorization and procedures.

In writing prescriptions, when it is not therapeutically contraindicated, the prescriber should prescribe a quantity of prescription medication not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed for up to a three-month quantity**.** Medications listed on the **Mandatory 90-Day Supply Prescription List** must be prescribed in three-month quantities. The first two fills of medications on the mandatory list may be prescribed at a 30-day supply, for a total of 60 days, before the 90-day supply is required.

2. Drugs Excluded from Coverage

Medicaid payment will **not** be made for:

- Drugs used for anorexia, weight gain or weight loss.
- Drugs used for cosmetic purposes or hair growth.
- Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed in section B.7.
- Drugs used for fertility purposes or for sexual or erectile dysfunction.
- Drugs prescribed for a use other than the drug's medically accepted indication.
  - **Medically accepted indication** is any use for a covered outpatient drug which is approved under the federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Social Security Act.
- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services (CMS).
  - **Less than effective drugs**, also known as DESI, are drugs that:
    - The Food and Drug Administration (FDA) has withdrawn the approval of the drug application for safety or efficacy reasons because of the drug efficacy study implementation (DESI) review; or
    - The secretary of the U.S. Department of Health and Human Services has issued a notice of a hearing under section 505(e) of the federal Food, Drug, and Cosmetic Act on a proposed order to withdraw approval of the drug application because the secretary has determined that the drug is less than effective for some or all the conditions of use prescribed, recommended, or suggested in the drug's labeling.

- Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement.
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

3. Drugs for Medicare Eligibles

Prescription drugs for Medicaid members who also qualify for Medicare (referred to as "dual eligibles") are paid through Medicare Part D effective January 1, 2006. Medicaid does not cover any drugs covered under Medicare Part D for these members including for any Part D eligible individual who is not enrolled in a Part D plan.

Iowa Medicaid covers drugs in the following categories for dual eligible members:

- Barbiturates (except when used in the treatment of epilepsy, cancer, or chronic mental health disorder diagnoses).
- Over-the-counter drugs (To view a list of covered OTC drugs, visit: www.iowamedicaidpdl.com).
- Prescription vitamin and minerals, except prenatal vitamins and fluoride preparations.

Iowa Medicaid will only accept secondary claims for these drugs. Medicaid should be listed as the secondary insurance for all dual eligibles. All claims should be submitted first to the primary insurance (Medicare Part D PDP).

Iowa Medicaid will **not** pay for any Medicare Part B drugs, such as:

- Oral immunosuppressant drugs
- Inhalation drugs when used with a nebulizer
- Oral chemotherapy drugs
- Oral anti-emetic drugs
- Blood clotting factors
- Epoetin

A drug for which coverage is available to a dual eligible under Medicare Part A or Part B must be billed to Medicare Part A or Part B.

4. Preferred or Recommended Drugs

A **preferred drug** is a drug that provides medical equivalency to the Medicaid member in a cost-effective manner (by virtue of OBRA '90 and Supplemental Rebate) and does not require a prior authorization.

A **preferred drug with conditions** is a preferred drug agent but the patient must meet medical criteria and guidelines that coincide with current prior authorization criteria. This is designated as "P" on the Preferred Drug List and has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List (PDL).

A **recommended drug** is a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will result in a cost savings to the Medicaid program.

Drug products designated on the Preferred Drug List as "P" (preferred) or "R" (recommended) do not require prior authorization unless the drug has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List.

To view the Preferred Drug List, visit: www.iowamedicaidpdl.com

5. Non-Preferred or Non-Recommended Drugs

A **non-preferred drug** is a drug that requires prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines. A non-preferred drug is designated with an "N" on the Preferred Drug List.

Drug products within a therapeutic class that are not selected as preferred will be denied for payment unless the prescriber obtains prior authorization.

Payment for drugs requiring a prior authorization will be made only when:

- The drugs are prescribed for treatment of one or more conditions set forth, and
- The Iowa Medicaid prior authorization criteria have been met, and
- Approval is obtained through the prior authorization process.

A **non-recommended drug** refers to a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will be more costly to the Medicaid program. The drug does not require a prior authorization unless a number is in the comments column to indicate a prior authorization is required. A non-recommended drug is designated with an "NR" on the Preferred Drug List. To view the Preferred Drug List, visit: www.iowamedicaidpdl.com.

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug, except when noted in policy, and reimbursement will be made.

6. Newly Released Drugs

a. New Drug Entities

New drug entities (including new generic drugs) and new drug product dosage forms of existing drug entities will be identified weekly and immediately be coded as "Non-preferred – Prior authorization required" until presented at the next scheduled P&T Committee meeting. If the drug category requires step therapy, the step therapy requirements must also be met, treating the new drug as a non-preferred step 3 drug.

These prior authorization and step therapy restrictions will continue through the review process, including while committee recommendations are being made, and lasting until HHS makes a final determination.

The 72-hour emergency supply may not be available for medications intended for a short duration therapy.

b. Exceptions to the Non-preferred Default Policy for New PDL Drugs

There are two potential exceptions to the non-preferred default policy for new PDL drugs:

- If the FDA classifies a new medication as a priority drug, the state may indicate that such a drug is preferred until the P&T Committee reviews the drug at its next scheduled meeting.
- The state may decide to designate a new drug as "draft preferred" and provide immediate access and increased therapeutic choice to physicians until the P&T Committee reviews the drug at its next scheduled meeting if:
  - A new drug is therapeutically equivalent or superior to existing preferred or non-preferred choices, and
  - Is as safe or safer than existing preferred or non-preferred choices, and
  - The net cost, adjusted for all rebates, is less expensive than all existing preferred choices.

c. Existing PDL Drugs with Supplemental Rebates

Drug rebates are payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services or with the individual state.

Although the state discourages supplemental rebate offers on existing PDL drugs between annual bidding periods, it may entertain such bids and may accept them if they:

- Are determined to represent significant additional savings, or
- Would replace a delinquent manufacturer's product or a preferred drug that is being pulled from the marketplace or significantly restricted by the FDA.

This interim preferred status will remain in effect until the P&T Committee reviews the drug at its next scheduled meeting.

Supplemental rebates will be invoiced only for approved drugs under contract. Draft preferred drugs with supplemental rebates will not be invoiced until approved by the Committee and accepted by the state. At that time, the supplemental rebates will be invoiced back to the effective date of the agreement, which is the date the drug began to benefit from preferred status.

7. Nonprescription or Over-the-Counter Drugs

Nonprescription or **Over-the-Counter (OTC)** refers to a drug that may be lawfully sold without a prescription, however Iowa Medicaid requires a prescription for covered OTC drugs. These drugs are subject to prior authorization requirements as specified in the preferred drug list. The drugs are identified on the Nonprescription (OTC) Prescribed List by Therapeutic Category located on the PDL website (www.iowamedicaidpdl.com) under the Preferred Drug Lists tab.

Nonprescription drugs cannot be billed to Iowa Medicaid POS for members residing in Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), and Psychiatric Medical Institutions for Children (PMIC) facilities. These are considered "stock items" and are to be included in the facility's Medicaid cost report and reimbursed through per diem calculations.

The only exclusions to this policy are as follows:

- For OTC insulin, bill a dual eligible member's Medicare Part D plan, or for a Medicaid only member, bill Medicaid as a POS claim.

- For pseudoephedrine, for both dual eligible and Medicaid only members, bill Medicaid as a POS claim because these agents are classified as controlled substances in Iowa.

Select nonprescription drugs are covered although the manufacturers have not entered into a rebate agreement with CMS. Payment will be made in the same manner as for prescription drugs.

Nonprescription vitamins and minerals may also be payable under conditions specified under the Prior Authorization Requirements section on the PDL website.

8. Medical Supplies

Pharmacies that dispense medical equipment and supplies should follow the **Medical Equipment and Supply Dealer Provider Manual**.

C. Prior Authorization Requirements

1. Prior Authorization Criteria

To view the current prior authorization criteria chart, visit: www.iowamedicaidpdl.com

2. Submitting a Prior Authorization Request

A **Prior Authorization (PA)** is the process of obtaining approval for a drug before the drug is provided to a member and acts as a precondition for provider reimbursement.

Prior Authorization requests must be submitted using the applicable **Request for Prior Authorization** form, and all information must be provided, as noted in each subsection. The enrolled prescriber is responsible for requesting prior authorizations, not the pharmacy. Prior authorization forms may be obtained:

- From the Iowa Medicaid PDL website: www.iowamedicaidpdl.com, or
- By calling the drug prior authorization help desk at (515) 256-4607 (local calls) or (877) 776-1567. (Requests for prior authorizations will **not** be taken at this number.)

The Iowa Medicaid Drug Prior Authorization Unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Compendium of drug information means one of the following:

- The American Hospital Formulary Service Drug Information (AHFS);
- The United States Pharmacopeia Drug Information (USP-DI) (or its successor publications); or
- DRUGDEX Information System.

The Grandfather Clause creates an exemption based on previously existing circumstances. The P&T Committee considers select therapeutic classes for grandfathering existing drug regimens. For claims processing, “drug history” means the most recent 90-day period. If a patient has a history with a specific drug within these classes, the prescriber is not required to obtain prior authorization even if the drug has a nonpreferred status on the Preferred Drug List.

Completed drug prior authorization requests can be submitted in **any of the following ways:**

- Fax (Primary Method): The prescriber can submit via Fax to the Iowa Medicaid Drug Prior Authorization Unit at (800) 574-2515.
- Pharmacy Provider Portal: This is a web-based tool that allows prescribers to create and submit a web prior authorization. Prescribers may contact the Iowa Medicaid Prior Authorization Help Desk at (515) 256-4607 (local calls) or (877) 776-1567 for additional information.
- Mail: The prescriber can mail the prior authorization request to: Iowa Medicaid, Pharmacy Medical PA, 1305 East Walnut Street, Des Moines, Iowa, 50319.

Regular working hours for the provider help desk are Monday through Friday, 8:00 a.m. to 5:00 p.m.

State-recognized holidays are as follows:

- New Year’s Day
- Martin Luther King Jr’s birthday
- Memorial Day
- Independence Day
- Labor Day
- Veterans’ Day
- Thanksgiving Day
- The Friday following Thanksgiving
- Christmas Day

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction standard for prior authorization requests (278 transaction). However, there is no standard for submitting additional documentation electronically.

If you submit a prior authorization request electronically, any additional documentation must be submitted using the following steps:

1. Complete the **Prior Authorization Attachment Control Form, Form 470-3970**. To access this form, visit: Iowa Medicaid Provider Forms.

   The 'Attachment Control Number' is the same number submitted on the electronic prior authorization request. Iowa Medicaid will accept up to 20 characters (letters or digits) for this field.

2. Staple the additional documentation to the **Prior Authorization Attachment Control Form** if physically mailing in the request. Via fax, please include the additional documentation as subsequent pages to the **Prior Authorization Attachment Control Form**.
3. Submit to Iowa Medicaid using the address or fax number on the form.
4. Once received, it will be manually matched up with the electronic prior authorization using the attachment control number and then processed.

3. Prior Authorization Form Instructions

Each category of prior authorization uses a specific request form to reflect the criteria for approval. The following instructions refer to items common to **all** requests for prior authorization.

IA MEDICAID MEMBER ID #: Copy this number directly from the member's **Medical Assistance Eligibility Card**. This number must be eight positions in length (seven numeric digits and one alphabetical character).

PATIENT NAME: Provide the first and last name of the member. Use the **Medical Assistance Eligibility Card** for verification.

DATE OF BIRTH (DOB): Copy the member's date of birth directly from the **Medical Assistance Eligibility Card**. Use two digits for each: month, day, year (i.e., 04/11/67).

PATIENT ADDRESS: Enter the member's home address.

PRESCRIBER NUMBER: Enter the national provider identifier (NPI) of the prescribing practitioner.

PRESCRIBER NAME: Enter the name of the enrolled prescribing practitioner.

PRESCRIBER PHONE NUMBER: Enter the prescribing practitioner's office phone number.

PRESCRIBER ADDRESS: Enter the prescribing practitioner's office address.

PRESCRIBER FAX NUMBER: Enter the prescribing practitioner's office FAX number.

PHARMACY NAME: Enter the name of the pharmacy where the prescription will be filled.

PHARMACY ADDRESS: Enter the address of the pharmacy.

PHARMACY PHONE NUMBER: Enter the phone number of the pharmacy.

PHARMACY NPI: Enter the pharmacy national provider identifier (NPI) number.

NDC: If available, enter the National Drug Code (NDC) of the product being requested.

DRUG NAME: Provide the complete drug name of the product being requested.

STRENGTH: Enter the strength of the drug being requested.

DOSAGE INSTRUCTIONS: Enter the instructions for use for the requested product.

QUANTITY: Enter the quantity on the prescription (cannot exceed a one-month supply unless the medication is a contraceptive or listed on the Mandatory 90-Day Supply Prescription List).

DAYS' SUPPLY: Enter the number of days' supply requested (cannot exceed a one-month supply unless the medication is a contraceptive or listed on the Mandatory 90-Day Supply Prescription List).

LENGTH OF THERAPY ON PRESCRIPTION (DATE RANGE): Provide an estimate of the duration of therapy. The prior authorization period granted will be subject to adjustment by the reviewer according to established criteria and individual consideration.

DIAGNOSIS: Enter the patient's diagnosis relevant to the requested product.

PREVIOUS THERAPY: Enter drug names, strengths, dosage instructions, and exact date ranges of other medications that have previously been tried and failed by patient.

PERTINENT LAB DATA: Enter any laboratory 909 data that may affect the outcome of this request.

OTHER MEDICAL CONDITIONS TO CONSIDER: Enter any other medical conditions the patient has that may help the Prior Authorization Unit make a decision.

POSSIBLE DRUG INTERACTIONS/CONFLICTING DRUG THERAPIES: If the patient is taking any other medications that may negatively affect the requested product, list them here.

PRESCRIBER SIGNATURE: The prescriber must sign the form, and the signature must match the prescriber's name listed at the top of the request form.

DATE OF SUBMISSION: Enter the date the prior authorization request was submitted.

4. Prior Authorization Response

The pharmacist reviewer will make a decision and respond within 24 hours of the request. In evaluating requests for prior authorization, the reviewer will consider the drug from the standpoint of published criteria only.

If a prior authorization request is denied, a letter of denial will be faxed to both the prescriber and the pharmacy. A letter of denial will be mailed to the member.

Upon approval of a prior authorization request, a letter of approval will be faxed to the prescriber and the pharmacy indicating the prior authorization number and dates of authorization.

NOTE: When approval of a request is granted, this does not indicate validity of the prescription, nor does it indicate that the member continues to be eligible for Medicaid. If you are not billing on the point of sale system, it is your responsibility to establish that the member continues to be eligible for Medicaid, either by:

- Calling the eligibility verification system (ELVS) at (515) 323-9639 (local calls) or (800) 338-7752; or
- Checking the Iowa Medicaid web portal at www.edissweb.com

D. Basis of Payment for Drugs

The amount of payment for drugs is based on several factors, in accordance with 441 IAC 79.1(8) and upper limits in 42 CFR 447.500 to 447.520.

340B Actual Acquisition Cost (340B AAC) is the net cost of a drug paid by a pharmacy for drugs purchased through the 340B drug pricing program. A drug's 340B AAC includes discounts, rebates, chargebacks, and other adjustments to the price of the drug, but excludes dispensing fees.

Average Actual Acquisition Cost (average AAC) is defined as retail pharmacies' average prices paid to acquire drug products.

- Average AAC is determined by the Department based on a survey of invoice prices paid by Iowa Medicaid retail & community pharmacies.
- Surveys are conducted at least once every six months, or more often at the Department's discretion.
- The average AAC is calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the Department is published on the Iowa Medicaid pharmacy rate-setting website at www.myersandstauffer.com/client-portal/iowa/.
- If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span is used.

Federal upper limit (FUL) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services (CMS), as described in 42 CFR 447.514.

For drugs with no established FUL, the Department determines the allowable average AAC in accordance with the provisions of federal drug regulation 42 CFR 447.512. This basis of payment is also applicable to compounded prescriptions.

Wholesale Acquisition Cost (WAC) represents the cost reported to Medi-Span by a manufacturer (updated in several ways) at which wholesalers purchase drug products from that manufacturer.

A **professional dispensing fee** is added to the ingredient cost to cover the pharmacist's professional services and costs associated with transferring the drug to a Medicaid member. The dispensing fee is set based on cost of dispensing surveys of Iowa Medicaid participating pharmacies.

A one-time professional dispensing fee will be reimbursed per one-month or three-month period, accounting for the refill tolerance of 90% consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by Medi-Span and maintenance nonprescription drugs.

1. Reimbursement Effective April 1, 2017

The Iowa Medicaid program relies on information published by **Medi-Span** to classify drugs as brand or generic.

To submit a Rate Review Request, visit the Iowa Medicaid pharmacy rate-setting website at www.myersandstauffer.com/client-portal/iowa/.

a. Generic and Nonprescription Drugs

Reimbursement for covered **generic** prescription drugs and for covered **nonprescription** drugs shall be the lowest of the following, as of the date of dispensing:

- Average actual acquisition cost (average AAC) plus the professional dispensing fee, or
- The federal upper limit (FUL) plus the professional dispensing fee, or
- The total submitted charge (represented by the lower of gross amount due as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee), or
- The provider's usual and customary charge to the public.

b. Brand-Name Drugs

Reimbursement for covered **brand-name** prescription drugs shall be the lowest of the following, as of the date of dispensing:

- Average AAC plus the professional dispensing fee, or
- The total submitted charge (represented by the lower of gross amount due as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee), or
- The provider's usual and customary charge to the public.

c. 340B Purchased Drugs

Reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

- The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee, or
- The average AAC plus the professional dispensing fee, or
- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee, or
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the public.

d. Federal Supply Schedule (FSS) Drugs

Reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

- The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee, or
- The average AAC plus the professional dispensing fee, or
- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee, or
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the public.

e. Nominal Price (NP) Drugs

Reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 will be the lowest of:

- The provider's actual acquisition cost (not to exceed the NP price), submitted in the ingredient cost field, plus the professional dispensing fee, or
- The average AAC plus the professional dispensing fee, or

- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee, or
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the public.

f. Indian Health Facilities

Indian health facility pharmacies are paid a special daily rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. The pharmacies should bill at their usual and customary charge. Pharmacy claims will be paid at one pharmacy encounter rate payment per date of service.

Indian Health Service (IHS) providers are also excluded from the 90-day supply requirement.

2. Drugs Subject to Federal Upper Limit (FUL)

a. FUL Development

The Centers for Medicare and Medicaid Services (CMS) establishes federal upper limits (FUL) for reimbursement for multiple-source drugs. These reimbursement levels are updated periodically and are available on the CMS web page at www.medicaid.gov/medicaid/prescription-drugs/federal-upper-limits/index.html.

b. Reimbursement for FUL Drugs

For the drug groups on the Preferred Drug List where brand-name products are preferred over generic products, the FUL rate will continue to apply when the generic version of the drug is dispensed.

However, the payment for preferred brand name products (which no longer require prior authorization before dispensing) equals the lower of the average AAC or the submitted charges, as opposed to the FUL rate.

Non-preferred brand products require prior authorization before dispensing. If authorized, payment equals the lower of the average AAC or the submitted charges, as opposed to the FUL rate with a prior authorization. The DAW=1 is no longer required for brand reimbursement.

Prior authorization is required for selected brand-name drugs as determined by the Department for which there is an available "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration (FDA).

For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed form **470-4119, Request for Prior Authorization: Selected Brand Name Drugs**, shall be considered as evidence of treatment failure.

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list. Prior authorization **is not required** for brand name drugs that have been designated by the Department as **preferred** under the Iowa Medicaid Preferred Drug List (PDL).

3. Reimbursement for Unit-Dose Packaging

Additional reimbursement of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist. Unit-dose reimbursements are permitted only for patients with Plan 300 eligibility.

Claim the additional reimbursement by placing a "3" in the "Unit Dose Indicator" field (field 429-DT) for electronic claims, as explained under Point of Sale Claim Submission, or a "09" in the Basis Cost (field 80) on the paper claim form, as explained under Paper Claim Submission. The additional reimbursement will be automatically added, possibly resulting in reimbursement that is higher than the submitted charge.

Credits: Payment may be made only for unit-dose-packaged drugs that are **consumed** by the patient. Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the Medicaid program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the drug cost component.

In accordance with state and federal law, proper crediting to Iowa Medicaid is **required** for the return of unused medications upon therapy discontinuation or a member's discharge, transfer, or death.

Both the long-term-care pharmacy and the nursing facility are subject to financial review by the state to ensure that medications are being returned to the pharmacy when permitted by state and federal law and proper credits are applied to the Iowa Medicaid program.

4. Reimbursement for Vaccinations

All vaccines are reimbursed through the medical benefit, not the pharmacy benefit. Pharmacists ordering and administering vaccines must be enrolled and bill consistent with Informational Letter No. 2232 and any future updates. Updates may be sent via Informational Letters or posted to the Iowa Medicaid Pharmacy webpage.

Informational Letters can be found on our Iowa HHS website at https://secureapp.dhs.state.ia.us/IMPA/Information/Bulletins.aspx.

The Iowa Medicaid Pharmacy webpage is located at https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy.

E. Billing System

Iowa Medicaid provides for on-line, real-time processing of Medicaid pharmacy claims. Through electronic submission, a provider can submit claims more accurately and receive Medicaid payments sooner than if submitted by paper claims.

Point of sale transactions are handled by the Iowa Medicaid Pharmacy Point of Sale (POS) Unit. The Pharmacy POS Unit will handle the overrides for prospective drug utilization review edits such as high dose, therapeutic duplication, refill too soon, excessive days' supply, dose consolidation, duplicate claim, or immunosuppressant drugs. To contact the Pharmacy POS Help Desk, call (877) 463-7671 or locally at (515) 256-4608.

1. Point of Sale Claim Submission

For more information on POS claim submission, refer to the 'Payer Sheet' on the www.iowamedicaidpdl.com webpage under the Billing Information tab.

The Affordable Care Act (ACA) requires that providers who prescribe or are indicated as a referring provider on a Medicaid claim must be enrolled as a participating provider in the program. Pharmacy claims submitted with a National Provider Identifier (NPI) that is not enrolled with the Iowa Medicaid program will be denied. Providers may contact Provider Services at (800) 338-7909 or (515) 256-4609 (local) for questions regarding provider enrollment.

Iowa Medicaid eliminated the procedure of paying pharmacy claims and then billing the primary insurance company on behalf of the members ("pay and chase") effective January 16, 2007, except for children under age 21 and pregnant women.

- **For members under age 21**, pharmacy claims may be processed through the Pharmacy POS System with Iowa Medicaid as the primary insurer.
- **For members who are pregnant**, pharmacy claims may be processed through the Pharmacy POS System with Iowa Medicaid as the primary insurer. To get a $0.00 copayment, enter code "2" in the pregnancy indicator code field (NCPDP field 3352C).

  For **all other** Medicaid members with other prescription insurance, the other prescription insurance is primary, and Medicaid is secondary. Ask the member for their primary prescription insurance card for that payer's claim processing information.

If a member has primary pharmacy insurance, submit the claim to the primary insurance first and then the copay to Medicaid last, using an "8" in the OTHER COVERAGE CODE field (field 308-C8).

- If a member has primary pharmacy insurance and the claim is not covered by the primary insurance, submit the claim to Medicaid using a "3" in the OTHER COVERAGE CODE field (field 308-C8).
- If a member has Iowa Medicaid pharmacy insurance only (or does not have the primary prescription insurance information), enter a "1" in the OTHER COVERAGE CODE field (field 308-C8).

a. Claims Rejected Due to Other Insurance Coverage

When a claim is submitted with a blank field or a zero in the OTHER COVERAGE CODE field, but the Iowa Medicaid eligibility file has third-party liability (TPL) information, the Medicaid claim will be denied and you will receive a rejection code of 41, "Submit to Primary Payer."

The Pharmacy POS System will give the policy number and the type of coverage. Most times the insurance company name is given. However, for the less common companies, a code is given in place of the name.

If necessary, you may contact Iowa Medicaid Provider Services for the name and address of the health insurance company.

After billing the other company, resubmit the claim with one of the following codes in the OTHER COVERAGE CODE field:

- Use code **1** if the member states that there is no other insurance coverage. If the claim has already been rejected with a reject code of 41 "Submit to Primary Payer," Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information. See Section b. Correction of Insurance Information below.
- Use code **3** if other coverage does exist but the drug is not covered under the primary insurance plan.
- Use code **8** when payment is not collected. Example: The primary third-party insurance is 100 percent major medical.

b. Correction of Insurance Information

The Department makes every attempt to keep current data regarding other insurance Medicaid members may have. However, if the primary insurance is no longer valid or has changed, the Department's records need to be corrected. The pharmacy can facilitate this in one of three ways:

- Instruct the member to notify Iowa Medicaid ; or
- Complete the **Insurance Questionnaire Form 470-2826**, and FAX to Revenue Collections at (515) 725-1352; or
- Notify the Department by e-mailing revcoll@hhs.iowa.gov or by calling (515) 256-4619 (local) or (866) 810-1206. The minimum information necessary for insurance carriers to verify the other insurance coverage is the following:
  - Member last name
  - Member first name
  - State identification number or social security number
  - Date of birth
  - Policy number
  - Full insurance company name

  For example, if the company is Blue Cross/Blue Shield, include which state the policy is from, as most every state has a BC/BS carrier. (In Iowa, it's Wellmark.)

2. Claiming Payment for Retroactively Eligible Member

For Iowa Medicaid prescription drug claims in connection to a member whose Medicaid eligibility was determined retroactively, call the Pharmacy POS Help Desk at (515) 256-4608 (local calls) or (877) 463-7671. Please have the following information available:

- The pharmacy's national provider identifier (NPI).
- The member's Iowa Medicaid number, name, and date of birth.
- The drug's name, strength, quantity, and dates requested for reimbursement.
- The date the pharmacy was made aware the member had Medicaid coverage for the state of Iowa.

For medications payable by Iowa Medicaid, the POS staff will put in an override in the Pharmacy POS system for the pharmacy to rebill the claims for reimbursement.

3. Claim Attachment Control, Form 470-3969

If you submit a claim electronically, any additional documentation must be submitted using the following steps:

1. Complete the **Claim Attachment Control Form, 470-3969**. To access this form, visit: Iowa Medicaid Provider Forms.

   The **Attachment Control Number** is the same number submitted on the electronic claim. Iowa Medicaid will accept up to 20 characters (letters or digits) for this field.

2. Staple the additional documentation to the **Claim Attachment Control** form.
3. Submit to Iowa Medicaid using the address on the form.
4. Once received, it will be manually matched up with the electronic claim using the attachment control number and then processed.

4. Paper Claim Submission

Traditional Universal Claim forms are no longer accepted. The new universal claim forms PUCF-D01PT (VER 1.2) can be ordered by calling CommuniForm at (877) 817.3676, or online at www.ncpdp.org/Universal-Claim-Forms.aspx.

The following table contains information that will aid in the completion of the pharmacy claim form. The table follows the form by field name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional, or conditional on the individual member's situation.

Field Name/Description	Instructions
1 – CARDHOLDER ID	**MANDATORY**. Enter the member's Medicaid ID number. Copy this directly from the **Medical Assistance Eligibility Card**. It consists of seven numeric characters followed by a letter, i.e., 1234567A.
2 – GROUP ID	**NOT USED**. Leave blank.
3 – LAST	**NOT USED**. Submit information under patient segment.
4 – FIRST	**NOT USED**. Submit information under patient segment.
5 – PLAN NAME	IAMED
6 – BIN NUMBER	011933
7 – PROCESSOR CONTROL NUMBER	IAPOP
8 – CMS PART D	**OPTIONAL**.
PATIENT	
9 – PATIENT'S LAST NAME	**REQUIRED**. Must be submitted.
10 – PATIENT'S FIRST NAME	**REQUIRED**. Must be submitted.
11 – PERSON CODE	**NOT USED**.
12 – DATE OF BIRTH	**REQUIRED**. Enter the member's birth date using a two-digit entry for each of the following: month, day, and year.
13 – PATIENT GENDER CODE	**REQUIRED**. Enter the gender.
14 – RELATIONSHIP TO CARDHOLDER	**NOT USED**.
15 – PATIENT RESIDENCE	**OPTIONAL**.
PHARMACY	
16 – DOCUMENT CONTROL NUMBER	**OPTIONAL**. For office use only.
17 – SERVICE PROVIDER ID	**MANDATORY**. Enter the pharmacy's national provider identifier (NPI).
18 – SERVICE PROVIDER ID QUALIFIER	**MANDATORY**. Enter "01" for national provider identifier (NPI).
19 – PHARMACY NAME	**REQUIRED**. Enter the pharmacy's name.
20 – PHONE NUMBER	**OPTIONAL**. Entering the pharmacy's area code and phone number may expedite processing of the claim.
21 – ADDRESS	**REQUIRED**. Enter the pharmacy's street address.
22 – CITY	**REQUIRED**. Enter the pharmacy's city.
23 – STATE	**REQUIRED**. Enter the pharmacy's state.
24 – ZIP	**REQUIRED**. Enter the pharmacy's zip code.

Field Name/Description	Instructions
PRESCRIBER	
25 – SIGNATURE OF PROVIDER	**REQUIRED**. Enter the signature of the representative completing the form.
26 – DATE	**REQUIRED**. Enter the date of the completed claim.
27 – PRESCRIBER ID	**REQUIRED**. Enter the national provider identifier (NPI) of the prescribing practitioner.
28 – ID QUALIFIER	01 = NPI
29 – PRESCRIBER LAST NAME	**REQUIRED**.
PHARMACIST	
30 – PHARMACIST ID	**NOT USED**.
31 – ID QUALIFIER	**NOT USED**.
CLAIM	
32 – PRESCRIPTION SERV. REF# (RX NUMBER)	**MANDATORY**. Enter the prescription number you have assigned to the prescription being billed. This number must be **all numeric**. No alpha characters are allowed.
33 – PRESCRIPTION SERV. REF# (RX NUMBER) QUALIFIER	1 = RX BILLING
34 – FILL #	**REQUIRED**. Enter "00" for a new prescription, and 01-99 for refills.
35 – DATE WRITTEN	**REQUIRED**. Enter the date the prescription was written using two digits for the month and day, and four digits for the year. **MMDDCCYY** (e.g., 08012021 for August 1, 2021).
36 – DATE OF SERVICE	**MANDATORY**. Enter the date the prescription was filled, or the professional service was rendered using two digits for the month and day, and four digits for the year. **MMDDCCYY** (e.g., 08012021 for August 1, 2021). For long-term care settings only: use the date that coverage from a subsequent payer began following Part A expiration.
37 – SUBMISSION CLARIFICATION	**OPTIONAL**. Enter "20" if 340B claim. Enter "08" if compound claim. Enter "58" if NP claim. Enter "59" if FSS claim.
38 – PRESCRIPTION ORIGIN	**OPTIONAL**.
39 – PHARMACY SERVICE TYPE	**NOT USED**.
40 – SPECIAL PACKAGING INDICATOR	**OPTIONAL**.

Field Name/Description	Instructions
41 – PRODUCT/SERVICE ID	**MANDATORY**. Enter the national drug code (NDC) found on the drug's label. All of the numerals in the NDC, including the package size, must be current and exactly match the NDC of the product actually dispensed. Be careful to copy the NDC exactly as it appears, including leading zeros. If the product number is only three digits long, enter a leading zero. For a compound, "0" must appear in this field. List each ingredient, NDC, quantity, and charge in the COMPOUND section.
42 – PRODUCT/SERVICE ID QUALIFIER	00 = COMPOUND 03 = NDC
43 – PRODUCT DESCRIPTION	**REQUIRED**. Description of product being submitted.
44 – QUANTITY DISPENSED	**REQUIRED**. Give the number of tablets, capsules, etc. or the **metric measurement** for liquids, creams, etc. Be sure the billed quantity, when divided by the number of days' supply, is an appropriate amount for that therapeutic class of drugs. If the quantity is a fractional amount, use a decimal point.
45 – DAY SUPPLY	**REQUIRED**. Enter the number of days the prescription will last.
46 – DAW CODE (MAC OVERRIDE)	Leave blank.
47 – PRIOR AUTH # SUBMITTED	**CONDITIONAL**. Leave blank unless one of the following applies: 1 = 72-hour supply 4 = Pregnant 5 = Nursing facility vaccine 7 = Mental health drugs
48 – PA TYPE	**CONDITIONAL**. Enter code "2" if a number was entered in the "PRIOR AUTH # SUBMITTED" box. Otherwise, leave blank.

Field Name/Description	Instructions
49 – OTHER COVERAGE CODE	**CONDITIONAL**. To determine whether the member has drug coverage under other insurance, check the member's eligibility using the Eligibility Verification System (ELVS) or the Iowa Medicaid web portal. ▪ If a member has Iowa Medicaid pharmacy insurance only and no other primary insurance, leave this field blank or enter a zero. ▪ Enter code "1" if the member states there is no other insurance, but the claim has already been rejected with a reject code of 41 "Submit to Primary Payer." Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information. ▪ Enter code "3" if other coverage does exist and the drug is not covered under the primary insurance plan. NOTE: **Also allowed for Part D excluded drugs**. ▪ Enter code "8" when billing is for patient financial responsibility. Only the indicator "06 = Patient Pay Amount" will be accepted as an "other payer"-patient responsibility amount qualifier.
50 – DELAY REASON	**NOT USED**.
51 – LEVEL OF SERVICE	**NOT USED**.
52 – PLACE OF SERVICE	**OPTIONAL**.
53 – QUANTITY PRESCRIBED	**OPTIONAL**.
CLINICAL	
54 – DIAGNOSIS CODE	**NOT USED**.
55 – DIAGNOSIS CODE QUALIFIER	**NOT USED**.
DUR	
56 – DUR/PPS CODE REASON	Leave blank.
57 – DUR/PPS CODE SERVICE	Leave blank.
58 – DUR/PPS CODE RESULT	Leave blank.
59 – LEVEL OF EFFORT	Leave blank.
60 – PROCEDURE MODIFIER	Leave blank.

Field Name/Description	Instructions
COB OTHER PAYMENTS	
COB1 – PRIMARY	
61 – OTHER PAYER ID	**REQUIRED FOR COB**. Payer ID of primary payer.
62 – OTHER PAYER ID QUALIFIER	**REQUIRED FOR COB**. Primary payer.
63 – OTHER PAYER DATE	**REQUIRED FOR COB**. Primary payer. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
64 – OTHER PAYER REJECT CODES	**CONDITIONAL**. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).
COB1 – SECONDARY	
65 – OTHER PAYER ID	**REQUIRED FOR COB**. Payer ID of secondary payer.
66 – OTHER PAYER ID QUALIFIER	**REQUIRED FOR COB**.
67 – OTHER PAYER DATE	**REQUIRED FOR COB**. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
68 – OTHER PAYER REJECT CODES	**CONDITIONAL**. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).
COMPOUND	
69 – DOSAGE FORM DESCRIPTION CODE	**MANDATORY**.
70 – DISPENSING UNIT FORM INDICATOR	**MANDATORY**.
71 – ROUTE OF ADMINISTRATION	**OPTIONAL**.
72 – INGREDIENT COMPONENT COUNT	**MANDATORY**.
73 – PRODUCT NAME	**REQUIRED**. Submit for each compound component.
74 – PRODUCT ID	**REQUIRED**. Submit for each compound component.
75 – PRODUCT ID QUALIFIER	**REQUIRED**. Submit for each compound component.

Field Name/Description	Instructions
76 – INGREDIENT QTY	**REQUIRED**. Submit for each compound component.
77 – INGREDIENT DRUG COST	**OPTIONAL**. Submit for each compound component.
78 – BASIS OF COST	**OPTIONAL**. Submit for each compound component. Enter “08” if 340B claim. Enter “17” if FSS drugs. Enter “16” if NP drugs.
PRICING	
79 – USUAL & CUSTOMARY CHARGE	**REQUIRED**. Enter the usual and customary charge.
80 – BASIS OF COST DETERMINATION	**CONDITIONAL**. Enter code “09” to indicate unit dose drug. Enter “08” if 340B claim. Enter “17” if FSS drugs. Enter “16” if NP drugs. Otherwise, leave blank.
81 – INGREDIENT COST SUBMITTED	**REQUIRED**. Enter the pharmacy’s submitted product component cost of the dispensed prescription. Amount also included in the gross amount due. 340B, FSS, and NP pricing submitted in this field when applicable.
82 – DISPENSING FEE SUBMITTED	**REQUIRED**. Enter the pharmacy’s usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.
83 – PROFESSIONAL SERVICE FEE SUBMITTED	**REQUIRED**. Enter the pharmacy’s usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.
84 – INCENTIVE AMOUNT SUBMITTED	Leave blank.
85 – OTHER AMOUNT SUBMITTED	Leave blank.
86 – SALES TAX SUBMITTED	**NOT USED**.
87 – GROSS AMOUNT DUE	**REQUIRED**. Enter the **total** charge for this item. The total claim charge must be equal to the sum of the submitted ingredient cost submitted and the submitted dispensing fee.
88 – PATIENT PAID AMOUNT	Leave blank.
89 – OTHER PAYER AMOUNT PAID #1	**NOT USED**.
90 – OTHER PAYER AMOUNT PAID #2	**NOT USED**.
91 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #1	**REQUIRED FOR IA COB CLAIMS**.
92 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #2	**REQUIRED FOR IA COB CLAIMS**.

Field Name/Description	Instructions
93 – NET AMOUNT DUE	**REQUIRED**. Enter the total price less the deductible amount. **NOTE:** If resubmitting a claim that is over 12 months old, the word "resubmit" must clearly appear on the claim to avoid denials for timely filing. This procedure can be used only if the original submission was within the last 12 months.

F. Edits and Special Billing Information

1. Claims for Deceased Members

Submit claims for all Iowa Medicaid members using the dispensing date. Pharmacy claims must be billed before a member's date of death for claims processing. Failure to bill before the date of death may result in claim recoupment for any claims processed after that date of death.

2. Common Billing Errors

Medications can often be described using three measures: each, grams, and milliliters. It is important to choose the correct unit of measure when billing.

Medication	Correct Unit for Billing	Quantity	Days' Supply
Bactroban cream (mupirocin)	Grams	Varies; should be divisible by 15 grams	Varies
Bactroban ointment (mupirocin)	Grams	Varies; should be divisible by 15 or 22 grams	Varies
Byetta 5 mcg (exenatide)	Ml (Submit in decimal format; do not round)	1.2 ml	30
Byetta 10 mcg (exenatide)	Ml (Submit in decimal format; do not round)	2.4 ml	30
Copaxone (glatiramer)	Each	1	30
Diastat ACDL gel (diazepam)	Each (kit contains 2 syringes; bill # of kits)	1	Varies
Enbrel 25 mg	Each	1	1
Enbrel 25 mg/0.5 ml (etanercept)	Ml (Submit in decimal format; do not round)	Varies claims should be divisible by 0.5 ml	30

Medication	Correct Unit for Billing	Quantity	Days' Supply
Enbrel SureClick (etanercept)	Ml	Varies	30
Fragmin (dalteparin)	Ml (Submit in decimal format; do not round)	Varies	Varies
Gamunex 10% (immune globulin)	Ml (Each vial is 10 ml)	Varies	Varies
Humira (adalimumab)	Each (kit contains 2 syringes)	2	30
Kineret (anakinra)	Ml (Submit in decimal format; do not round)	Varies; should be divisible by 0.67	30
Lovenox (enoxaparin)	Ml (Submit in decimal format; do not round)	Varies	Varies
Miacalcin NS (calcitonin)	Ml (Submit in decimal format; do not round)	3.7	30
Nascobal (cyanocobalamin)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.3 ml	30
Neupogen 400 mcg (filgrastim)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 1.6 ml	30
Neupogen 600 mcg (filgrastim)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 0.5 ml	30
Pegasys (peginterferon Alfa-2a)	Each (kit contains 4 syringes)	1	28
Proair HFA (albuterol)	Grams	Varies; claims should be divisible by 8.5 grams	Varies
Proventil HFA (albuterol)	Grams	Varies; claims should be divisible by 6.7 grams	Varies
Rebif pack (interferon Beta-1a)	Ml (Submit in decimal format; do not round)	4.2 ml	30
Rebif syringe (interferon Beta-1a)	Ml (Submit in decimal format; do not round)	6 ml	30

Medication	Correct Unit for Billing	Quantity	Days' Supply
Restasis (cyclosporine)	Each	32/64	30
Risperdal Consta (risperidone)	Each	2	28
Stadol nasal spray 10 mg/ml (butorphanol)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.5 ml	Varies
Synagis 50 mg (palivizumab)	Ml (Submit in decimal format; do not round)	0.5 ml	30
Synagis 100 mg (palivizumab)	Ml	1 ml	30
Ventolin HFA (albuterol)	Grams	Varies; claims should be divisible by 18 grams	Varies
Xopenex HFA (levalbuterol)	Grams	Varies; claims should be divisible by 15 grams	Varies

3. Compounded Prescriptions

Iowa Medicaid will process claims for compounded prescriptions in the NCPDP D.Ø format using the multiple ingredient functionality. All applicable edits, including Preferred Drug List (PDL) rules, apply to each NDC submitted. Providers must submit the NDCs for the active ingredients dispensed to create the compound.

A dispensing fee will be added to the claim when applicable based on the reimbursement logic described previously. There will be no additional fee paid to prepare the compounded prescription. Providers need to submit the quantity of the active ingredients used in the compound for reimbursement, not the quantity of the total amount of the compound made.

4. Coverage of Active Pharmaceutical Ingredients and Excipients

Active Pharmaceutical Ingredients (APIs) are the active components in a drug entity that produces pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment or prevention of disease, or to affect the structure or any function of the body.

Excipient is an inactive substance used in drug compounding.

Medicaid will cover certain API and excipient products, although the manufacturers have not entered into a rebate agreement with CMS. These products are listed on the Preferred Drug List located on the website www.iowamedicaidpdl.com. Pharmacies shall provide these products and bill Medicaid through the pharmacy point of sale. Prior authorizations (PA) will be submitted through the Pharmacy PA system. Payment will be made in the same manner as prescription drugs.

5. Date of Birth Verification

The point of sale system edits for the exact date of birth from the eligibility file for Iowa Medicaid members. Field # 304-C4 (Date of Birth) on the NCPDP Payer Sheet is mandatory. The NCPDP rejection message will state "09-Missing/Invalid Date of Birth." Claims should be resubmitted with the correct date of birth for the member.

6. Override Codes

A 72-hour emergency supply of medication may be dispensed using prior authorization type code "1" as a point of sale override. The provision for a 72-hour supply can be used in an emergency situation only one time per member, per drug, per year.

A seven-day override of the prior authorization requirement will be allowed while the prescriber is requesting prior authorization for certain mental health drugs. The override applies to drugs that are deemed to have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class. The pharmacy may use a prior authorization type code "7" as a point of sale override for these applicable mental health drugs. The seven-day provision can be used only one time per member, per drug, per 30 days.

In the event an exception to the 90-day supply requirement is determined to be medically appropriate, a pharmacist may use the SCC "02" override code at the point of sale.

7. Proper Reporting of NDCs

The Iowa Medicaid Program can cover only drugs from manufacturers who have signed national Medicaid drug rebate agreements with CMS. Drug companies sign the agreements for specific drug manufacturer codes called national drug codes (NDC).

National drug code (NDC) means the eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container

at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Since rebates are determined by Iowa Medicaid's utilization data, it is imperative that pharmacies and providers bill Iowa Medicaid using the correct NDC number of the drug dispensed or administered. Reimbursement is only made for the specific NDC dispensed or administered.

If a provider is dispensing or administering one drug and billing for an NDC different from the drug being dispensed or administered, it is considered fraud, which can result in claims being recouped, sanctions, and termination of provider agreements. The Program Integrity Unit will be monitoring for this in their reviews.

8. Prospective Drug Utilization Review

The goal of Prospective Drug Utilization Review (pro-DUR) is to identify potential drug therapy concerns to allow the pharmacist to use professional judgment regarding the need for intervention, such as whether to contact the prescribing physician. The following pro-DUR edits will cause claims to deny:

Edit	Number and Message	Reason for the Denial	* Override Provided
Age Edits	75 - PRIOR AUTHORIZATION REQUIRED	Certain medications are payable only for specific age groups.	PA required.
Cost Effectiveness	75 - PRIOR AUTHORIZATION REQUIRED	Certain strengths should be substituted with more cost-effective strengths of the same medication.	PA required.
Dosage Form	75 - PRIOR AUTHORIZATION REQUIRED Additional text : NON-PREFERRED	Certain dosage forms should be substituted with more cost-effective dosage forms of the same medication.	PA required.
Excessive Days' Supply	19 - M/I DAYS' SUPPLY Additional text: EXCEEDS ALLOWABLE DAYS' SUPPLY	The supply submitted is more than 31 days.	Request an exception to policy if there is a valid reason why a supply more than 31 days is required.

Edit	Number and Message	Reason for the Denial	* Override Provided
Initial Prescription Supply Limit	76 - PLAN LIMITS EXCEEDED	The supply submitted is more than 15 days on select drugs. OR The supply submitted for an opioid is more than 7 days for opioid naïve members.	PA required. See Fifteen Day Initial Prescription Supply Override. OR PA required. See Initial Days' Supply Limit Override.
Gender Edits	70 –PRODUCT/ SERVICE NOT COVERED – GENDER-SPECIFIC DRUG	Certain medications are payable only for a specific gender.	PA required.
High Dollar Claims	78 - COST EXCEEDS MAXIMUM Additional text: CLAIM EXCEEDS $5,000.00, PLEASE CALL POS HELP DESK	All claims submitted in excess of $5,000 will be rejected. After verifying that the quantity and days' supply of the claim are correct, contact the Pharmacy POS Help Desk. See below.	A one-time override will be granted if quantity and days' supply are accurate and consistent. Additional medical documentation is required for longer overrides.
Hospice Edits	75 - PRIOR AUTHORIZATIO N REQUIRED – NOT COVERED FOR HOSPICE MEMBER	If member has hospice coverage and medication is required to be paid by hospice.	Override may be considered if hospice does not provide payment. Call POS Help Desk.
Incarcertion Edit	65 - PATIENT IS NOT COVERED Service not covered for recipient, limited benefits for date	Pharmacy claims submitted through POS for members identified as being incarcerated will reject.	No override provided. Member must update incarceration status, if applicable.

Edit	Number and Message	Reason for the Denial	* Override Provided
Maximum Daily Limits	76 - PLAN LIMITS EXCEEDED	If the total daily limit exceeds the established limit.	PA required.
Quantity Limits	76 - PLAN LIMITS EXCEEDED	If the quantity submitted exceeds the established quantity limit.	PA required. See Quantity Limit Override.
Refill Too Soon	79 - REFILL TOO SOON Additional text: RX NUMBER/FILL DATE/NPI OR NABP/DATE FOR NEXT FILL	If less than 90% of the previously paid claim for that medication has not been used. See Refill Too Soon.	If there is a change in dose; lost, stolen, or destroyed drug; or travel.
Step Therapy Edits	75 - PRIOR AUTHORIZATIO N REQUIRED	Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List.	PA required.
Tablet Splitting	19 - M/I DAYS' SUPPLY Additional text: MUST SPLIT TABLETS	Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.	PA required.
Therapeutic Duplication	88 - DUR REJECT MESSAGE Additional text: SITUATIONAL	If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed.	PA required.

*Always verify that the quantity and days' supply on the claim are correct; then for an override contact the Pharmacy POS Help Desk at (877) 463-7671 or (515) 256-4608 (local).

a. Age Edits

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
FDA indicated drugs for the treatment of Alzheimer's dementia (donepezil, galantamine, memantine, and rivastigmine)	Payable for members 40 years of age and older	PA is required for members under 40 years of age.
Aldara (imiquimod)	Payable for members 12 years of age and older	PA is required for members under 12 years of age.
Alpha$_2$ Agonists for ADHD	Payable for members 6 through 17 years of age.	PA is required for members under 6 years of age and over 17 years of age.
Antipsychotics	Payable for members 5 years of age or older for risperidone and 6 years of age or older for all other anti-psychotics.	PA is required for members under 5 years of age for risperidone and under 6 years of age for all other antipsychotics.
Asmanex 110 mcg	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.
Benznidazole	Payable for members 2 through 11 years of age.	PA is required for members under 2 years of age and over 11 years of age.
Buprenorphine Sublingual tablet	Payable for members 16 years of age and older.	PA is required for members under 16 years of age.
Buprenorphine/Naloxone Sublingual tablet	Payable for members 16 years of age and older.	PA is required for members under 16 years of age.
Clorazepate	Payable for members 9 years of age and older.	PA is required for members under 9 years of age.

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
CNS Stimulants: Adderall, Adzenys ODT, Desoxyn, Dexedrine, Dyanavel XR, Evekeo, Mydayis, Vyvanse	Payable for members 3 through 20 years of age.	PA is required for members under 3 years of age and over 20 years of age.
CNS Stimulants: Adderall XR, Dexedrine ER, Focalin, Focalin XR, Aptensio XR, Concerta, Cotempla XR ODT, Daytrana, Metadate CD, Methylin, QuilliChew, Quillivant XR, Ritalin IR/LA/SR	Payable for members 6 through 20 years of age.	PA is required for members under 6 years of age and over 20 years of age.
Codeine Containing Products	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Edurant	Payable for members 12 years of age and older.	PA is required for members under 12 years of age.
Femara (letrozole)	Payable for members 50 years of age and older.	PA is required for member under 50 years of age.
Flurazepam	Payable for members 15 years of age and older.	PA is required for members under 15 years of age.
Isentress 25 mg and 100 mg chewable tablets	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.
Jakafi	Payable for members 12 years of age and older.	PA is required for members under 12 years of age.
Nicotine Replacement Therapy	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Nuvigil (armodafinil)	Payable for members 17 through 20 years of age.	PA is required for members under 17 years of age and over 20 years of age.

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Oxazepam	Payable for members 6 years of age and older.	PA is required for members under 6 years of age.
Provigil (modafinil)	Payable for members 16 through 20 years of age.	PA is required for members under 16 years of age and over 20 years of age.
Revlimid	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Serevent	Payable for members 4 years of age and older.	PA is required for members under 4 years of age.
Singulair 4 mg granules	Payable for members less than 2 years of age	PA is required for members 2 years of age and older.
Smoking Cessation Therapy-Oral	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Tramadol Containing Products	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Veltassa	Payable for members 12 years of age and older.	PA is required for members under 12 years of age.
Veregen (sinecatechins)	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.

b. Cost Effectiveness Edit

Drug	Dosage	Alternative
Buspirone tablet	30 mg	Deny. Use two buspirone 15 mg tablets.
Hydroxyzine pamoate capsules	100 mg	Deny. Use hydroxyzine pamoate 50 mg capsules.
Imipramine pamoate capsules		Deny. Use imipramine HCL tablets.
Rheumatrex		Deny. Use methotrexate.

c. Dosage Form Edits

Form	Drug	Dosage	Alternative
Prozac tablets	fluoxetine	20 mg	Deny. Use the capsule dosage form.

d. Excessive Days' Supply

The claim will be rejected if the supply submitted is more than the maximum allowed days' supply. Most drugs have a 31-day supply allowance, however some drugs have a mandatory 90-day supply. To see a full list of drugs with a mandatory 90-day supply, see the 'Mandatory 90-Day Supply Prescription List' under the PDL/PA tab on the Iowa Medicaid PDL website (www.iowamedicaidpdl.com.) If there is a valid reason why a supply of more than the maximum allowed days is required, request an exception to policy.

e. Gender Edits

Drug Name/Class	Gender Edit
Prenatal vitamins	Payable for female members
Estrogen Derivatives	PA required for male members
Progestins	PA required for male members
Antiandrogen (finasteride)	PA required for male members
Aldosterone Antagonists, Selective (spironolactone)	PA required for male members
Contraceptives	PA required for male members

f. High-Dollar Claims

All claims more than $5,000 submitted through the pharmacy point of sale system will be rejected with a denial message stating, “Claim exceeds $5,000, please call POS Help Desk at (877) 463-7671 or (515) 256-4608 locally.”

After verifying that the quantity and days’ supply on the claim are correct, contact the Pharmacy POS Help Desk for consideration of an override. A technician or pharmacist will review the information submitted and determine if an override shall be issued.

As a part of this process, the Iowa Medicaid Program Integrity Unit may request additional medical documentation regarding the case from the prescriber or pharmacy. This policy is intended to help ensure that proper billing procedures are being followed.

g. Hospice Edits

For members enrolled in hospice, medications in the following therapeutic categories should be submitted to hospice for coverage consideration. If hospice does not provide payment for a medication in one of the below categories, or if the member is no longer enrolled in hospice, the pharmacy may call the Pharmacy POS Help Desk for coverage consideration.

Analgesics — non-narcotic
Analgesics — opioid
Antianxiety agents
Antidiarrheals
Antiemetics
Antihistamines
Antispasmodics
Cough/Cold/Allergy
Hypnotics
Laxatives
Muscle relaxant combinations
Ophthalmic agents

h. Maximum Daily Edits

Drug Name/Class	Edit	Prior Authorization (PA) Requirement
Gabapentin	Maximum milligrams per day edit 3600mg	PA is required for members exceeding 3600mg per day. See Quantity Limit Override form.
Opioids	Maximum morphine milligram equivalents (MME) 90 per day	PA is required for members exceeding 90 MME per day. See High Dose Opioid PA form.
Pregablin	Maximum milligram per day edit 600mg	PA is required for members exceeding 600mg per day. See Quantity Limit Override form.

i. Refill Too Soon

The claim will be denied if not enough time has elapsed for the member to use 90 percent of the supply issued under previously paid claim for that medication. An override will be considered if:

- There is a change in dose;
- The previously issued supply has been lost, stolen, or destroyed; or
- The member is traveling and will not be able to pick up the next refill at the normal time.

j. Step Therapy Edits

Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List. The steps for Antipsychotics-Atypicals are:

- Step 1: Preferred generic drugs. No PA required.
- Step 2: Preferred brand name drugs. No PA required if a preferred generic trial is found in the paid claims system in the past 12 months.
- Step 3: Non-preferred drugs. PA required.

k. Tablet Splitting

Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.

No current medications noted.

l. Therapeutic Duplication

If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed, overlapping claims will be considered on an individual basis.

Deny regardless of prescriber:

Antipsychotics	Duplicate therapy edits on all antipsychotics for members 0 – 17 years of age. A 30-day grace period is allowed for transition between antipsychotic medications. After 30 days of concomitant use, provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Antipsychotics	Duplicate therapy edit for members 18 years of age and older. Limited to two chemically distinct antipsychotics, provide prescriber verified documentation of the necessity in the treatment plan.
Non-steroidal anti-inflammatory drugs (NSAIDs)	After 60 days of concomitant use, provide prescriber verified documentation of the necessity of the duplication in the treatment plan.

9. Status Change for Preferred Brand Name Drugs

When the status of a previously preferred brand-name drug changes to non-preferred, pharmacies are given a transition period of up to 30 days to allow utilization of existing stock of the brand-name product.

If additional stock remains beyond this period, pharmacies may call the Pharmacy POS Help Desk at (877) 463-7671 or (515) 256-4608 (local) to request an override for the non-preferred brand-name drug with a recent status change.

10. Travel or Vacation Supplies of Medication

Requests for medications for travel or vacation should be planned well in advance of the departure date.

The pharmacy can process the first month's prescription(s) as usual and then may call the Pharmacy POS Help Desk at (877) 463-7671 or (515) 256-4608 (local) to obtain up to a one-month supply of medications to total up to a 60-day supply of medication.

Exceptions to policy will not be granted if other sources for payment are available.

11. 340B Drug Pricing Program

The term **340B Program** refers to the federal 340B Drug Pricing program as set forth in Section 340B of the Public Health Service (PHS) Act (1992) and managed by Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so these facilities can offer some medications to their patients at reduced prices.

To become eligible to participate in the 340B Program, the provider must submit a request to the Office of Pharmacy Affairs (OPA) within the Health Resources and Services Administration (HRSA). The OPA website is www.hrsa.gov/opa/. The online registration is available at the following link: https://340bregistration.hrsa.gov/.

It is very important that the OPA has accurate and up-to-date information, particularly your exact name and street address. It your responsibility to:

- Contact the OPA with any changes in your information; and
- Tell your wholesaler or manufacturer that you are registered for 340B discount prices when you place an order.

Providers must enroll with Iowa Medicaid in order to bill and receive reimbursement for self-administered drugs purchased through the 340B Program.

a. Covered Entity (CE)

A **340B Covered Entity (CE)** is a facility and/or program listed in the 340B statute as eligible to purchase drugs through the 340B program and appear on the HRSA 340B database.

The CE has full responsibility and accountability for compliance with all requirements to prevent diversion of covered drugs to individuals other than patients of the CE, and to prevent situations in which a drug is subject to both the 340B discount and a Medicaid rebate claim.

Use of a contract pharmacy arrangement (single or multiple) does not lessen a CE's duty to ensure that the 340B Program is being administered in compliance with the statute and HRSA guidelines.

It is imperative that all CEs participating in the 340B Program not only comply with program requirements but also be able to document compliance with those requirements in the event of an audit.

To prevent duplicate discounts, HRSA requires CEs to indicate on the OPA website if they purchase drugs at 340B pricing for Medicaid patients (Medicaid Exclusion File), so Medicaid does not bill for rebates. HRSA directs CEs to follow state guidelines when billing for 340B drugs. CEs may not use a contracted pharmacy unless it has reached an agreement with the state Medicaid agency on a method to prevent duplicate discounts.

b. Iowa Medicaid Billing/Reimbursement for CE Outpatient In-House Pharmacy or Contracted Pharmacy

340B requirements below are reviewed through a post payment review. Overbillings are subject to recoupment.

1. 340B Covered Entities

The CE must decide if they are carving Medicaid "OUT" or "IN," and that decision applies to both fee-for-service and managed care claims.

Fee-for-Service (FFS) means providers bill Iowa Medicaid directly for prescriptions they provide to FFS members.

Medicaid Carve-In means a 340B entity has elected to use drugs purchased at 340B prices to bill for Medicaid patients. If an entity chooses to use 340B drugs to bill Medicaid, it must indicate this on the Medicaid Exclusion File and list the appropriate Medicaid provider numbers or NPIs.

Medicaid Carve-Out means a 340B entity has elected to use non-340B drugs to bill for Medicaid patients. Entities may choose to do this so they can receive regular Medicaid reimbursement.

All 340B CEs that use 340B drugs and serve Medicaid FFS members must do one of the following:

- Medicaid **CARVE OUT** all prescriptions from the 340B program when Medicaid is a payer for any portion of the claim:
  - Use non-340B drugs for all Medicaid members you serve.
  - Bill Medicaid only for drugs purchased outside the 340B program billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected where appropriate.
  - Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File.

  This allows rebates to be collected by Medicaid where appropriate.
- Medicaid **CARVE IN** all prescriptions into the 340B program:
  - Use 340B drugs for all Medicaid members you serve.
  - Inform the OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid members.
  - Do not bill Medicaid for 340B acquired drugs if your NPI is not listed on the HRSA Medicaid Exclusion File.
  - Purchase all drugs billed to Medicaid on the CE's NPI under 340B unless the product is not eligible for 340B pricing.

  This ensures these claims are excluded from Medicaid rebate.
- Billing:

  Submit pharmacy claims for 340B-acquired drugs to Medicaid at your 340B AAC and with values of "08" in Basis of Cost Determination field 423-DN **or** in Compound Ingredient Basis of Cost Determination field 490-UE **and** insert "20" in the Submission Clarification Code field 420-DK.

  If the product is not eligible for 340B pricing, do not include the basis of cost determination or submission clarification code values and bill at the regular Medicaid rate.

2. 340B Contract Pharmacies

340B Contract Pharmacies means a pharmacy under contract with a CE that lacks its own pharmacy. The contract pharmacy is authorized to dispense 340B-discounted drugs on behalf of the CE.

Contract pharmacies may not submit claims to Medicaid FFS for 340B-acquired drugs. A 340B contract pharmacy must **carve out** Medicaid FFS from its 340B operation.

12. Interpreter Services

Translation and interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for your pharmacy. The services must facilitate access to Medicaid covered services.

For translation and interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services.
- Interpreters may be employed or contracted by the billing provider.
- The interpretive services must facilitate access to Medicaid-covered services.

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services. Reimbursable time may include the interpreter's travel and wait time.

a. Documentation of the Service

The billing provider must document in the patient's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- The cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).

The following are instructions for billing interpretive services when that service is provided by an outside commercial translation service.

- Bill code T1013 on the professional CMS-1500 claim form:
  - For telephonic interpretive services use modifier “UC” to indicate that the payment should be made at $1.70 per minute.
  - The lack of the UC modifier will indicate that the charge is being made for the 15-minute face-to-face unit.
- Enter the number of minutes used for the provision of the service.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is NOT used, and the units exceed 24, the claim will be paid at 24 units.

G. Remittance Advice And Field Descriptions

For information on remittance advice and field descriptions, refer to the Billing Iowa Medicaid provider manual.