
CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES

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REIMBURSEMENT FOR PHARMACY SERVICES

This section describes the methodologies that Medicaid uses to reimburse for prescribed drugs.

Reimbursement Methodology

The amount of reimbursement to pharmacies is determined by federal regulations and state policy. The fiscal intermediary has weekly checkwrites to reimburse the provider for those valid claims which are processed.

Medicaid reimburses the lowest of the:

- National Drug Acquisition Cost (NADAC) plus the professional dispensing fee;
- If NADAC is not available, use the Wholesale Acquisition Cost (WAC) plus the professional dispensing fee;
- Federal Upper Limit (FUL) plus the professional dispensing fee; or
- Providers' usual and customary charge to the general public.

340B Purchased Drugs

Payment for self-administered drugs that are purchased by a covered entity through the 340B program shall be made at the 340B actual acquisition cost, which can be no more than the 340B ceiling price, plus the professional dispensing fee.

National Drug Code (NDC) System

Drugs are identified by the National Drug Code (NDC). The NDC is an 11-digit number. The first five digits identify the manufacturer or supplier, the next four digits identify the product and the last two digits identify the package size.

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The provider must enter the entire 11-digit NDC for the actual product and package size dispensed on the claim as the NDC is critical for accurate reimbursement. Billing an NDC number other than the one for the product dispensed is a false claim and a violation of Medicaid policy.

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid drug file.

Medicaid uses ingredient costs that are supplied and updated each week by a nationally recognized compendia.

Professional Dispensing Fee

The pharmacy provider will be reimbursed at the appropriate ingredient cost plus the professional dispensing fee or the usual and customary charge, whichever is less.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid enrollees will not exceed \$10.99 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid enrollees and obtained through the Public Health Service 340B Program will be \$10.99 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

Provider Fee

Pharmacy providers and dispensing physicians are responsible for a ten cent (10¢) provider fee on **all** prescriptions they fill. The Medicaid professional dispensing fee does not include the provider fee mandated under state law.

Usual and Customary Charges

Federal regulations governing the Medicaid Program require that participating providers agree to charge no more for services to eligible recipients than they charge for similar services to the general public.

In implementing this regulation, the Medicaid Program states that providers in the Pharmacy Program may not charge a higher professional dispensing fee, on the average, for recipients' prescriptions than is charged for non-recipients' prescriptions. Consequently, pharmacists are required to indicate their usual and customary charge on their claims for prescription services even if this charge exceeds the Medicaid maximum payment.

Exception: Pharmacy providers should bill the usual and customary (U&C) charge; however, reimbursement of covered mosquito repellents will be set at a maximum of the average acquisition

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cost (AAC) plus a \$3.00 dispensing fee. If an AAC rate for mosquito repellent is not on file, the claim will deny at Point of Sale (POS) with “NDC price missing, call Myers and Stauffer (M&S).”

Federal Upper Limits (FUL) Regulations

Federal Upper Limit prices are established by the Centers for Medicare and Medicaid Services (CMS). Federal regulations prohibit Medicaid from reimbursing providers more than the FUL, except as instructed.

When a prescriber indicates the brand name product is medically necessary for a particular recipient, certifying that in his professional judgment the generic equivalent is not indicated, therefore the FUL or LMAC limitations will not apply. The following procedure will apply in these cases:

- The certification must be in the prescriber’s handwriting and signed unless the prescription is submitted electronically;
- The certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription or submitted electronically with prescriber approval;
- The standard phrases written by the prescriber on the prescription should testify to the medical necessity of the brand name drug. The only acceptable phrases are “brand necessary” or “brand medically necessary”;
- If multiple prescriptions are written on the same prescription blank, the prescriber must certify which drugs require the brand name product, indicating “Brand Medically Necessary” for each prescription which requires the branded product;
- Phrases such as *do not substitute*, *no generics* or *dispense as written* are not acceptable for overriding MAC limitations;
- Providers should verify that the appropriate wording is properly documented at the time of dispensing; and
- Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable.

Co-Payments for Prescription Services

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The co-payment will be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the co-payment amount for which the recipient is liable. Providers shall continue billing their usual and customary charges for prescription services. The fiscal intermediary will calculate and deduct the co-payment amount from the amount allowed.

Co-payment Schedule

The following is the prescription co-payment schedule:

Calculated State Payment	Co-Payment
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

Co-payment Exemptions

The following pharmacy services are exempt from the co-payment requirement:

- Medicaid household members with a monthly income of \$800 dollars or less (effective through December 31, 2019);
- Family planning services and supplies;
- Emergency services;
- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are inpatients in long-term care facilities or other institutions;
- Native Americans;
- Alaskan Eskimos;

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- Women who are receiving services on the basis of breast and cervical cancer;
- Recipients receiving preventive services such as the following:
 - Aspirin 81 mg for women ages 12-19 years of age and men ages 45-79 years of age;
 - Folic acid 0.4mg and 0.8mg for women ages 12-54 years of age; and
 - Vitamin D 400 IU for women and men ages 65 and older;
- Recipients receiving hospice services; and
- Recipients with waiver type cases.

NOTE: Refer to Appendix D, POS User Guide for billing instructions.

Other Co-payment and Policies

In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the co-payment amount. The recipient's assertion of his/her inability to pay the co-payment establishes the inability. Under 42 CFR 447.15, this service statement does not apply to any individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the co-payment. Providers shall not waive the recipient's co-payment liability.

The pharmacy provider shall collect a co-payment for each drug dispensed by the provider and covered by Medicaid. **This co-payment is NOT taxable.** Providers should not collect tax on the co-payment.

Quantities dispensed by pharmacists shall not be adjusted to reflect the co-payment amounts paid by the recipient. By participation in the Pharmacy Program, providers have agreed to accept, as payment in full, the amounts paid by the agency plus any deductible, co-insurance or co-payment.

In accordance with CFR 447.56, co-payments of Medicaid household members are not to exceed five percent of the family income.

Department monitoring and auditing will be conducted to determine provider policies and compliance. Violators of this policy will be subject to penalty such as suspension from the program for one year.

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Medicare Crossover Claims

Refer to Section 37.7 Medicare Prescription Drug Coverage regarding payment of services for which Medicaid reimburses providers for participants' responsibilities of coinsurance and deductible payments.

Third Party Liability Claims

Refer to Section 37.8 Third Party Liability/Coordination of Benefits, regarding services which must be billed to Medicaid as the payor of last resort.