MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 22, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, RECIPIENT HIPAA PRIVACY & CIVIL RIGHTS OFFICER

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

**BACKGROUND AND EXPLANATION**

In accordance with Nevada Special Legislative Session, Assembly Bill 3, the DHCFP is proposing revisions to the Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs, Section 1203.1B. The DHCFP has elected to utilize selective contracting in order to deliver optimal therapy management with sufficient utilization controls for specialty pharmacy drugs used in the treatment of Hemophilia, Hepatitis C and Intravenous Immunoglobulin within the Fee-for-Service Program. The DHCFP has established a new payment algorithm for these specific drugs. Further, the DHCFP has created a professional service contract in which the vendor provides clinical and customer service support to recipients and ordering providers.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Financial Impact on Local Government:

SFY 2021: $28,293,152
SFY 2022: $59,501,311

These changes are effective January 12, 2021.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL OL<br>MSM Ch 1200 – Prescribed Drugs | MTL 09/17<br>MSM Ch 1200 – Prescribed Drugs |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **1203.1B(2)** | **SERVICE DELIVERY MODEL - Outpatient Pharmaceuticals** | Addition of Specialty Pharmacy Drug Program. |

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

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

b. Certification must be written directly on the prescription blank.

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

d. A prior authorization is required to override genetic substitution.

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

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

1203.1B SERVICE DELIVERY MODEL

For the rate and reimbursement methodology see MSM Chapter 700, Rates. For POS claims refer to the Pharmacy Manual, and for Medicaid Management Information System (MMIS) claims refer to the Nevada Medicaid and NCU Billing Manual (Billing Manual).

1. Institutional settings

a. Medical/Surgical, Specialty, Psychiatric Hospitals and free-standing inpatient hospice facilities – All pharmacy services are included in the daily per diem rate for inpatient services, which are billed through MMIS.

b. Long Term Care (LTC)

1. Nursing Facilities (NF) – Legend (prescription) pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and Total Parenteral Nutrition (TPN) solution and additives.

Legend pharmaceuticals are billed separately directly by a licensed pharmacy through POS.

Non-legend (over the counter) pharmaceuticals are not separately reimbursable by the DHCFP.

2. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

3. Hospice services in NFs, all drugs related to the documented terminal illness and palliative, symptom relief are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

2. Outpatient Pharmaceuticals

a. Covered outpatient drugs (COD(s)) are reimbursed separately from medical services, in the following settings, in accordance with Section 1927 of the SSA.

1. Retail pharmacies (billed through POS).

2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics (billed through POS).

a. Disposable supplies are billed separately with a 33 Provider Type number (billed through MMIS).

b. Refer to the Nevada Medicaid and Check Up Pharmacy Billing Manual.

3. COD(s) administered in an outpatient setting, such as a physician's office (NVPAD).

a. COD(s) are billed utilizing the appropriate National Drug Code (NDC) and NDC quantity (billed through MMIS).

b. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code (billed through MMIS).

4. Hospital based outpatient clinics.

a. COD(s) are billed utilizing the appropriate NDC and NDC quantity

(billed through MMIS).

b. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

5. End Stage Renal Disease (ESRD) Facilities.

a. Any COD(s) not included in the Prospective Payment System (PPS) Rate are billed using the appropriate NDC and NDC quantity.

b. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

c. COD(s) included in the PPS Rate as documented in the CMS Manual System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

6. Emergency Rooms.

a. COD(s) are billed utilizing the appropriate NDC and NDC quantity (billed through MMIS).

b. CODs are not reimbursed separately, in the following settings, in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC). COD(s) are included in the facility rate. COD(s) may not be billed separately.

2. Outpatient facilities/clinics/Federally Qualified Health Centers (FQHCs) that are paid per encounter, cannot be reimbursed separately for CODs when drugs are included in their encounter rate.

3. Outpatient hospice reimbursement for CODs related to the documented terminal illness and palliative, symptom relief, are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

c. Specialty Pharmacy Drug Program

1. The Specialty Pharmacy Program supports the health care provider/patient relationship to help better manage rare and complex chronic conditions.

2. A specialty drug is a prescription drug that requires special handling, administration or monitoring. “Specialty” drugs include biological drugs, blood-derived products, complex molecules and select oral, injectable and

infused medications identified by the Department and reimbursed as referenced in the Pharmacy Billing Manual.

3. Patients using specialty medications may have conditions that require support and care coordination.

4. Certain specialty medications included in the program may be subject to:

   a. Drug Prior Authorization Criteria (located within MSM Chapter 1200).

   b. Administrative Guide Protocols; for example, mandatory sourcing through participating specialty pharmacies.

   c. Quantity/Supply Limits; for example, maximum days' supply or quantity of medications that can be dispensed or billed at one time

   d. Notifications Requirements; for example, providers must submit clinical information about the member in order for a covered prescription to be dispensed.

5. Detailed Specialty Pharmacy Drug Program billing guidance can be found, https://www.medicaid.nv.gov/providers/rx/billinginfo.aspx.

   Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Disposable Medical Supplies

   Please refer to MSM Chapter 1300, Durable Medical Equipment (DME), for instructions on billing and any applicable limitations for these items.

4. Unit Dose (Repackage and Re-Stock) Repackage

   Nevada Medicaid provides reimbursement incentives for LTC providers who repackage non-unit dose pharmaceuticals; An additional $0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

   This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

   In accordance with the CMS, State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State BOP. In addition, NFs