Connecticut Department of Social Services
Medical Assistance Program
www.ctdssmap.com

Provider Bulletin 2018-53
August 2018

TO: **Pharmacy Providers**

RE: **Pharmacy Claim Rejections**

The Department of Social Services (DSS) uses a variety of processes to help ensure the safe and appropriate use of drugs by HUSKY Health members. These measures help identify potential clinical issues such as therapeutic duplication and drug-disease contraindications. The processes are also intended to address specific safety issues, public health concerns, the potential for fraud and abuse, or the potential for significant overuse and misuse of covered drugs. These processes may result in a **temporary** denial or rejection of payment at the pharmacy/Point of Service (POS). The purpose of this bulletin is to reinforce with pharmacy providers the best way to correct certain rejections or claim denials immediately. DSS wants to minimize the risk that HUSKY Health members will leave the pharmacy without a medically necessary prescribed medication.

QUANTITY LIMITS/DAYS SUPPLY LIMITS

Medical Services Policy Section 174D.II.a establishes maximum allowable unit and days' supply for prescription drugs. DSS will not reimburse for "an original prescription or refill that exceeds the supply requirement for a period of thirty (30) days not to exceed two hundred and forty (240) units except in the following instances:

1) Prescriptions for chronic conditions or maintenance drugs shall be for at least a thirty (30) day supply not to exceed two hundred and forty (240) units unless a lesser amount is prescribed.
2) Oral contraceptives may be dispensed for a maximum period of three (3) months."

Claims for non-maintenance drugs that are submitted for greater than a 30 day supply, regardless of the quantity dispensed, will be denied and providers will receive an electronic notification stating "**Exceeds the Maximum Days Supply Allowed**". **If a pharmacy receives this messaging, the pharmacist must re-submit the claim with the quantity that is needed for a 30 day supply.** Claims for maintenance drugs may be submitted for greater than a 30 day supply up to DSS' defined maximum quantity.

Note: Maintenance and non-maintenance drug classification is determined by First Data Bank.

DIAGNOSIS RESTRICTIONS

Pharmacy providers must include an International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code(s) on claims in certain circumstances. The inclusion of diagnosis codes is required to fulfill requirements for limited coverage plans (such as the Tuberculosis [TB] benefit plan), for certain medications, or for some DSS audits (e.g., for extended enteral nutrition).

For members who are in the TB coverage group plan, a TB ICD-10 diagnosis code must be submitted on all pharmacy claims. If there is no TB diagnosis code on the claim, the pharmacy will receive an electronic notification stating "**TB Diagnosis Code Required**".

In instances where certain medications require a diagnosis code (e.g., for central nervous system stimulants), the pharmacy claim must be submitted with an approved ICD-10 diagnosis code in order for it to be paid. If the claim is **not** submitted with an approved diagnosis code, the pharmacy will receive an electronic message stating "**NDC Not Consistent with Any Billed Diagnosis**".

For enteral nutritional products exceeding 21,600 ml in a 24 day period, a "high caloric need" diagnosis code is required on the pharmacy claim. In these instances, if there is not an appropriate diagnosis code submitted on the claim, the pharmacy will receive an electronic message stating "**Enteral Quantity Exceeded**".

If a pharmacy receives any of these messages, the pharmacist must re-submit the claim with an approved ICD-10 diagnosis code in order for the claim to be paid by the Connecticut Medical Assistance Program (CMAP). The diagnosis code must be entered on the prescription by the prescriber. If there is no diagnosis code on the prescription, the pharmacist should contact the prescriber to obtain one.

PROSPECTIVE DRUG UTILIZATION REVIEW (DUR) CONFLICT CODE SUBMISSIONS

The Prospective Drug Utilization Review (Pro-DUR) Alert system was developed to assist pharmacists in making informed decisions when filling prescriptions for Medical Assistance clients. The automated POS system contains historical client claim information from all pharmacies (not just the dispensing pharmacy) and uses standardized Pro-DUR criteria to review the claim. Examples of these criteria are Drug-Drug interaction, High Dose alert, overutilization alert (Early Refill), Ingredient Duplication, Drug Age interaction, Low Dose alert, Therapeutic Duplication, etc. **When the pharmacy submits a claim and receives any of the Pro-DUR alerts, the pharmacist has the ability to re-submit the claim immediately with appropriate conflict codes in order to get paid by CMAP.**

PRIOR AUTHORIZATION (PA)

If a medication requires PA for Brand Medically Necessary (BMN) or a non-preferred drug on the Preferred Drug List (PDL) and no PA is on file, DSS will allow for a one-time 14 day supply fill. **The pharmacy will receive a message indicating that a one-time fill will be allowed with instructions to input all 9's in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of '1' in the Prior Authorization Type Field, NCPDP 461-EU. The claim can then be resubmitted immediately in order for the client to receive their medication and for the pharmacy to receive payment. The pharmacy should then follow up with the prescriber to either obtain PA or switch to an alternate medication which is a preferred product.**

For opioid drugs which require PA, DSS will allow for payment of a one-time seven (7) day temporary supply. The pharmacy will receive similar messaging to the one sent for BMN or PDL PAs.

In **addition** to the one-time 14 day temporary supply for BMN and PDL situations, DSS also allows for a 5 day **emergency supply**. If the pharmacist or prescriber is unable to obtain PA and the client requires the medication after the one-time 14 day override has been used, the pharmacy may call the Pharmacy Prior Authorization Assistance Call Center, available 24 hours a day, 7 days a week, at 1-866-409-8386 to request a one-time 5 day emergency supply of the medication. Note the 5 day

emergency supply **is not allowed for opioid medications** which require PA.

IMPORTANT INFORMATION

In any of the above situations, it is imperative that the Medicaid client not leave the pharmacy without any medication. The pharmacist has the ability to re-submit the claim immediately with certain override codes, modifications, or diagnosis codes to ensure the client is able to receive their medication.

ADDITIONAL RESOURCES

For additional information on quantity limits/days' supply limits, medications which require a diagnosis code, Pro-DUR override instructions, or any other topic pertaining to claim submission, providers should refer to Chapter 8 of the Pharmacy Provider Manual. To access the manual, go to the CMAP Web site at www.ctdssmap.com. From the Home page, go to Information → Publications → scroll down to Chapter 8 of the Provider Manual, choose pharmacy from the dropdown menu and click view chapter.

For PA information, providers should refer to Chapter 9, Section 9.6 of the Provider Manual. Pharmacy PA instructions begins on page 20.

If the pharmacy has any difficulty submitting the claim or has questions, the pharmacist may call the Pharmacy Prior Authorization Assistance Center toll-free at 1-866-409-8386.