NEW YORK STATE OF OPPORTUNITY. Department of Health

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PHARMACY FEE-FOR-SERVICE BILLING GUIDANCE: *LONG TERM CARE (LTC) & FOSTER CARE (CHILD CARE) FACILITIES*

All pharmacy claims included in the rate must be billed to the Facility. Information on LTC pharmacy claims can be found in the June 2011 Special Edition Medicaid Update*; information regarding Foster Care claims can be found here* https://www.health.ny.gov/health_care/medicaid/program/carveout.htm.

The following process is necessary to successfully bill pharmacy claims that are not covered in the rate by identifying and billing the appropriate coverage. Additionally, this guidance must be followed prior to sending NY State Medicaid requests for retroactive claim overrides.

Determine Third-Party Liability (TPL) and Medicaid Eligibility coverage,

using *any and all* resources available including: the facility billing office**,** Medicaid Eligibility Verifying Eligibility & Third-Party Liability System (MEVS)**,** ePACES.

Providers should check for TPL and eligibility coverage updates at least twice monthly following first Date of Service (DOS).
NY State Medicaid is always the payor of last resort, every effort must be taken to obtain correct billing information.

- If TPL is applicable, providers must bill TPL first, including commercial plans or Medicare, billing Medicaid if appropriate as secondary. Any claim issues must be resolved with the TPL, including prior authorization requirements, prior to submitting the claim to Medicaid. (NOTE: If the primary insurer doesn't cover a medication, then Medicaid will not cover the claim.) Failure to submit the claim to the TPL will result in denial of the claim by Medicaid.
    - If member has Medicare, providers will bill:
        - Medicare Part B for Part B covered drugs, or
        - Medicare Part D for other prescription drugs.
        - If member has Medicare Parts A or B or both and does not have Medicare Part D, Providers will bill Part D covered claims to LINET: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html. *Initiating Medicare Part D enrollment by utilizing LINET at first DOS will facilitate payment of claims.*

Billing claims that require Medicaid Prior Authorization (PA):

for members whose active eligibility status began after the date the pharmacy service was provided (retroactive billing).

- If date of notification of eligibility is within 90 days of DOS, call Magellan for PA at 877-309-9493.

- If date of notification of eligibility is after 90 days of DOS, LTC/FC Facility pharmacies may send the claim information for retro-PA consideration to the Medicaid Pharmacy unit at PPNO@health.ny.gov within 30 days from the date of notification of eligibility. **All claims submitted for PA after 30 days of eligibility determination will be denied.**

- Any claim submitted with a DOS after the date of notification of eligibility will be denied. These claims should have been billed on DOS.

Reminders:

- It is the responsibility of the providers, both the facility and the pharmacy, to actively and regularly seek TPL enrollment and Medicaid eligibility for their patients.

- It is the pharmacy's responsibility to bill timely and to the appropriate party, i.e., the facility, commercial plan, Medicare, or Medicaid. Information regarding timely filling is found here: https://www.emedny.org/ProviderManuals/AllProviders/Guide_to_Timely_Billing.pdf

- All pharmacies must submit their transactions through the online Prospective Drug Utilization Review (Pro-DUR) program using the NCPDP transaction format. NCPDP format specifications can be found in the MEVS Manual.

- All pharmacy claims are subject to Medicaid Pharmacy Program requirements, including Prior Authorization and criteria requirements.

- If upon claims submission the patient is determined ineligible, the Pro-DUR transaction will adjudicate. **If a PA message is received that states: "UNABLE TO PROCESS A PHARMACY PA PLEASE CALL MAGELLAN" the pharmacy should alert the prescriber at first and every occurrence** to align medication therapy with the Preferred Drug Program when appropriate, found here**:** https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf**.** This is the opportune time to explore non-PA alternatives and facilitate payment. A PA will not be issued by the clinical call center for a patient who is ineligible.

- Original prescriptions must be filled within 60 days (30 days for controlled substances) of prescriber written/order date; a system edit will deny claims beyond this limitation. The same drug/strength/quantity, i.e., prescription, cannot have more than one prescription number per same written date. **Bypassing the edit by giving a refill a new prescription number and new written date is considered fraudulent billing, and subject to audit**.

Data Definitions:
Eligibility Date – the date that begins active eligibility status.
Date of Notification of Eligibility – the date eligibility was updated or activated in the Medicaid system.