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2 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information (Section I: General Information).

The information in this manual represents available services when medically necessary for a Medicaid member.

2.1 General Policy

This manual is updated periodically and changes are announced through the Medicaid Information Bulletins (MIBs) published on the Medicaid Website. To sign up for the Utah Medicaid Newsletter and receive e-mail notification of policy changes and MIBs, refer to [Utah Medicaid Official Publications](#) and subscribe to the Utah Medicaid Newsletter.

2.1.1 Mandatory Patient Counseling

Federal law (42 U.S.C. 1396r-8) requires that counseling be performed when dispensing a medication to a Medicaid member. The federal requirement to counsel a Medicaid member is stricter than the counseling requirement in the Utah Administrative Code R156-17b-610. The federal law does not require that counseling be delivered if the Medicaid member, or member's agent, refuses the counseling. The Utah Administrative Code requires that the offer to counsel be documented and retained for five (5) years. Only a pharmacist, pharmacy intern, or DMP may orally provide counseling to a member or member's agents and answer questions concerning prescription drugs (R156-17b-610-5).

Reimbursement for counseling is included in the dispensing fee and is not separately reimbursable.

Providing the package insert to a Medicaid member does not meet the federal law's requirement for mandatory patient counseling.

2.1.2 Drug Utilization Review (DUR) Program

Utah Medicaid is required to have a Drug Utilization Review (DUR) program as mandated by 42 U.S.C. 1396r-8 and UCA 26-18, Part 2.

The State Drug Utilization Review Board uses Retrospective Drug Utilization Review (RetroDUR) studies to review prescribing and dispensing patterns for Medicaid members to develop prospective Drug Utilization Review edits, including: prior authorizations (PAs), step-therapy (ST), and quantity limits (QLs). The Board is comprised of actively practicing providers nominated by the Utah Medical Association, the Utah Pharmaceutical Association, and the Utah Dental Association. The University of Utah College of Pharmacy collaborates on the development of drug criteria sets under contract with the Division of Medicaid and Health Financing (DMHF).

For additional information about the Drug Utilization Review (DUR) Board, meeting agendas, or meeting materials refer to Utah Medicaid [Drug Utilization Review Board](#).

2.2 Fee for Service or Managed Care

For information regarding member eligibility, refer to Utah Medicaid Provider Manual, Section I: General Information.

2.3 Definitions

For definitions general to Medicaid, refer to Utah Medicaid Provider Manual, Section I: General Information.

2.4 Procedure Codes

Outpatient pharmacy claims submitted to Utah Medicaid electronically using the National Council of Prescription Drug Plans (NCPDP) Version D.0 standard do not need to be submitted with a Current Procedural Terminology (CPT®) code or Healthcare Common Procedure Coding System (HCPCS) code.

Claims for provider-administered drugs require the correct CPT or HCPCS code plus National Drug Code (NDC) as described in Chapter 6 of this Pharmacy Services manual.

3 Provider Participation Requirements

Refer to Utah Medicaid Provider Manual, Section I: General Information for provider participation information.

4 Member Eligibility

For information regarding verification of a member's Medicaid eligibility, refer to Utah Medicaid Provider Manual, All Providers General Information, Section I, or to the [Eligibility Lookup Tool](#).

Medicaid members may be referred to and enrolled in the Restriction Program. This program provides safeguards against inappropriate and excessive use of Medicaid services. For more information please contact us: 801-538-9045 or toll free: 800-662-9651 #900.

5 Program Coverage

5.1 Prescription Medications

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) covers prescription medications that are prescribed by qualified practitioners enrolled with Utah Medicaid as a Medicaid benefit in compliance with Federal law (42 U.S.C. 1396r-8). All covered medications must:

- require a prescription for dispensing (Rx Only),
- have a National Drug Code (NDC) number,
- be eligible for the federal Medicaid drug rebate,
- be approved by the Food and Drug Administration (FDA),
- meet the Center for Medicare and Medicaid Services (CMS) definition of a “covered outpatient drug” (42 CFR 447.502), and
- be listed in the Medi-Span drug file.

5.2 Prescribed Over the Counter Products

Utah Medicaid allows payment for Medicaid approved Over-the-Counter drugs (OTC) if they are prescribed for a member and listed on the Medicaid approved OTC Drug List. For a list of OTC's that can be reimbursed refer to the [Resource Library](#) OTC Drug List. OTC drugs that are different formulations or products than those listed on the OTC list are not a covered benefit.

Note: OTC drugs on the approved list are not a benefit through the outpatient pharmacy program for a Medicaid member who is a resident of a nursing home. The nursing home rate paid by Medicaid to the nursing home includes payment for OTC drugs.

5.3 New Products

Any new drug product, including a new size or strength of an existing approved product, may be reviewed by the Drug Utilization Review Board to determine whether the drug should be subject to restrictions or limitations. New drugs may be withheld from coverage for no more than twelve (12) weeks while restrictions or limitations are being evaluated as described in R414-60-9.

If a Medicaid member needs a new drug product, a [New to Market Drugs](#) prior authorization request must be submitted to Utah Medicaid.

5.4 Cough and Cold Products

Pursuant to R414-60-5, Utah Medicaid only covers the following prescription cough and cold preparations:

- Guaifenesin with Dextromethorphan (DM) 600mg/30mg tablets
- Guaifenesin with Hydrocodone 100mg/5mL liquid
- Promethazine with Codeine liquid
- Guaifenesin with Codeine 100mg/10mg/5mL liquid
- Carbinoxamine with Pseudoephedrine 1mg/15mg/5mL liquid
- Carbinoxamine/Pseudoephedrine/DM 15mg/1mg/4mg/5mL liquid

5.5 Compounded Prescriptions

Compounded non-sterile prescriptions are a covered benefit if at least one ingredient is a drug that would otherwise qualify for coverage. Covered compounds can contain both covered and non-covered ingredients; however, if a compound contains non-covered ingredients then it must be submitted with the Submission Clarification Code = 8.

Compounded sterile prescriptions are subject to the same compound rules as non-sterile compounds; however, they must be prepared by a pharmacy that has certified to Utah Medicaid that they adhere to the standards described in The United States Pharmacopeia/National Formulary chapter <797>, “Pharmaceutical Compounding: Sterile Preparations.” The finished product must also be analyzed by a third party to confirm sterility, potency, and purity. Any pharmacy wishing to be approved to prepare sterile products for Utah Medicaid members may contact Utah Medicaid at medicaidpharmacy@utah.gov.

Note:

1. Bulk compounding powders are not covered by Utah Medicaid for compounded prescriptions.
2. Dispensing fee does include the preparation costs for compounded prescriptions. A pharmacy may not charge a Medicaid member an additional fee for any service that is reimbursed as part of the dispensing fee.

5.6 Immunizations

Adult members (age 19 and older): Claims for the Hepatitis B, pneumonia, seasonal and pandemic flu, and herpes zoster vaccines administered by pharmacists can be processed through the pharmacy point-of-sale for non-pediatric member. A dispensing fee will be applied to each non-pediatric immunization claim at the pharmacy point of sale, in addition to the reimbursement for the immunization.

Pediatric members (age 18 and younger): Claims for immunizations administered by pharmacists to Medicaid

members eligible for the [Vaccines for Children \(VFC\) program](#) may also be submitted through the point-of-sale system. As vaccines provided through the VFC program are supplied at no cost to the providers, there will be no reimbursement for the immunization. These VFC claims will only be reimbursed for a dispensing fee for each immunization provided to a VFC eligible member. Pharmacies that do not participate in the VFC program are not reimbursed differently than pharmacies that do participate in the VFC program.

For Children's Health and Evaluation Care (CHEC) retro-eligible members, contact the Bureau of Medicaid Operations 1-800-662-9651 for claims payment resolution.

5.7 Glucose Monitors and Test Strips

Preferred glucose monitors are based on the preferred test strip being available on the Preferred Drug List for the Medicaid members at no charge. Claims for these preferred glucose monitors can be submitted using the billing information that is included on the Preferred Drug List under Diagnostic Products.

Preferred blood glucose test strips on the Preferred Drug List are a Medicaid covered benefit through the pharmacy program, up to a maximum of 200 strips per month. Prescriptions for quantities in excess of 200 test strips require prior authorization using the [Quantity Override Request](#) prior authorization form. Claims for non-preferred test strips must be submitted through the medical supply program and will not be authorized through the pharmacy point-of-sale system.

5.8 Federal Medicaid Drug Rebate Program

Federal law (42 U.S.C. 1396r-8) mandates that drug manufacturers participate in the federal Medicaid drug rebate program in order for their prescription medications to be eligible to be paid for using federal Medicaid funds. Certain medications are exempt from the federal Medicaid drug rebate requirement by law (e.g. vaccines).

Utah Medicaid only covers prescription medications that are eligible to be paid for with federal funds. For a prescription medication to be eligible for coverage, the manufacturer must participate in the federal drug rebate program.

Note: Vaccines are exempt from the federal Medicaid drug rebate requirement.

5.9 Mandatory Generic Drug Policy

Utah Code 58-17b-606 mandates that when a multisource legend drug is available in the generic form, Utah Medicaid may only reimburse for the generic form of the drug unless:

- The prescriber demonstrates a medical necessity for dispensing the non-generic, brand-name legend drug, or
- A financial benefit will accrue to the state from dispensing the non-generic, brand-name legend drug.
- The generic form of the drug is unavailable in the marketplace.

Prior Authorization requests for brand-name multisource drugs must be submitted to Utah Medicaid using the [Brand Name](#) prior authorization form. These requests must be accompanied by documentation from the Medicaid member's record that support an unacceptable adverse drug reaction to the generic version that does not occur with the name brand or that the generic version(s) failed to achieve therapeutic efficacy.

When making a determination about whether to cover a non-preferred product due to a lack of availability of a preferred product, Utah Medicaid relies primarily on the FDA Drug Shortages database and the ASHP Drug Shortages List. If a drug is not listed on either of these websites as being unavailable, the onus is on the pharmacy to demonstrate to Medicaid that a product is unavailable in the marketplace. This can be demonstrated by providing to Medicaid an invoice from a wholesaler that shows that the product is unavailable in the marketplace along with a brief description (e.g. discontinued, on backorder with expected availability date, etc.). Sensitive data may be redacted or obscured. In the case that a wholesaler does not have a product, but the product is available in the marketplace, the expectation is that a different provider would be capable of providing the product. This does not demonstrate that a product is not available.

Other acceptable documentation that a product is unavailable on the market would include any official written communication from a manufacturer or a wholesaler indicating that a product has been discontinued, is currently on shortage (with expected date of availability), or other statement that there are no commercially available preparations.

Note: Member preference does not constitute a medical necessity

5.10 Tamper Resistant Prescription form or Pad requirements

Federal law (42 U.S.C. 1396b(i)(23)) requires that all Medicaid prescriptions not executed electronically must be written on tamper-resistant prescription forms or pads. Section 1927(k)(3) of the Social Security Act provides exclusions from this provision for residents of nursing facilities, intermediate care facilities for the intellectually disabled (ICF/ID), or other specified institutional and clinical settings so long as the Medicaid member never has the opportunity to handle the prescription. This law does not apply to prescriptions that are executed by electronic means, including: those that are faxed, taken over the phone, or electronically prescribed. For prescriptions that are not prescribed by electronic means the prescription must contain all three of the following characteristics to be considered tamper-resistant:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

If a pharmacy fills a prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered through post-payment review.

Documentation by the pharmacy of verbal confirmation of a non-compliant written prescription from the prescriber, or a nurse or administrative staff person authorized to act on the prescriber's behalf, also satisfies the tamper-resistant requirement. At a minimum, the documentation must include the date, time, and name of the individual who verbally confirmed the validity of the non-compliant prescription.

5.11 Preferred Drug List (Excluding Psychotropic Medications)

Utah Medicaid maintains a Preferred Drug List (PDL) to encourage the use of clinically efficacious and cost effective therapies. The Pharmacy and Therapeutics (P&T) Committee advises the DUR Board and DMHF in

choosing preferred agent(s) for each selected class of drugs based on safety and clinical efficacy. For additional information about the P&T Committee, meeting agendas, or meeting materials refer to Utah Medicaid [P&T Committee](#).

Non-preferred medications require prior authorization from the prescriber and must satisfy one of the following:

- The member has had a trial and failure of at least one (1) preferred agent in the drug class.
- There is evidence of a potential drug interaction between the member's current medication regimen and the preferred drug(s).
- There is evidence of a contraindication that prevents the member from using the preferred drug(s).
- There is objective clinical evidence that the member is at high risk of adverse events due to a therapeutic interchange with a preferred drug.

A prior authorization form for non-preferred medications can be obtained online from the Pharmacy [Prior Authorization](#) website. The Utah Medicaid [Preferred Drug List](#) is available online.

5.12 Preferred Drug List for Psychotropic Medications only

For the purposes of the Preferred Drug List (PDL), psychotropic medications are defined as the following:

- Atypical antipsychotics,
- Anti-depressants,
- Anti-convulsants/mood stabilizers,
- Anti-anxiety medications,
- Epilepsy medications, and
- Attention deficit hyperactivity disorder stimulants

If a prescriber writes "dispense as written" on a prescription for a non-preferred psychotropic drug, the pharmacy may submit a "Dispense As Written" (DAW) Code of "1" on the claim. Submitting the DAW code will allow the claim to bypass the prior authorization requirement for the non-preferred drug psychotropic drug at the point-of-sale.

Note:

1. The DAW Code will not allow claims for the brand-name version of multisource drugs to process, even though the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription. If a Medicaid member needs the brand-name version that is listed as non-preferred, a prior authorization request must be submitted to Utah Medicaid using the [Brand Name](#) prior authorization form. See 4-2 Mandatory Generic Policy for more information.
2. In order for a prescription to be eligible for the pharmacy to submit the DAW Code of "1" to bypass the edit for a non-preferred psychotropic medication the prescriber must write "dispense as written" on the prescription. Check boxes or pre-printed forms that include "dispense as written" are not acceptable substitutes for the prescriber writing, "dispense as written" on the prescription.

5.13 Dual Eligible Members (Medicare Part D)

Outpatient prescription drugs for dual eligible members (who are defined as individuals who have Medicare and Medicaid coverage), will not be covered by Utah Medicaid in accordance with SSA 1935(a). Medicaid members with dual coverage receive a limited drug benefit through Medicaid; the majority of their prescription drugs are

received through Medicare Part D. Drugs which are excluded from the Medicare Part D benefit, in accordance with SSA, Section 1927(d)(2), and are otherwise covered by Utah Medicaid for other Medicaid members are eligible to be covered for dual eligible members.

Note: Medications that are not covered by a Medicare Part D plan for any reason other than the medication being excluded from the Medicare Part D benefit by law (e.g. prior authorization or formulary placement) are not eligible to be covered by Utah Medicaid.

5.14 Dual Eligible Members (Medicare Part B)

Medicaid may potentially cover any remaining patient liability for Medicare Part B covered drugs for dual eligible members as described in Utah State Plan, Attachment 4.19-B, Supplement 1 to Attachment 4.19-B, Page 3.

For billing Medicare/Medicaid crossover claims, please see Section I: General Information in Utah Provider Manual, 11-5.1 Medicare Crossover for more information.

5.15 Co-payment required for Medicaid Prescriptions

When applicable, Medicaid members are required to pay a co-payment for each prescription filled as described in 42 CFR 447.56(a)(1) and Utah State Plan, Attachment 4.18-C, Page 1 under “Pharmacy services”, with a maximum of five (5) copays per month. Medicaid members enrolled in an Accountable Care Organization (ACO) have some drugs that are covered under Fee-for-Service (FFS) Medicaid.

Pharmacy copays for Medicaid members enrolled in an ACO will be split between FFS Medicaid and the ACO plan:

- For drugs covered by the ACO, the maximum number of copays is three (3) per month.
- For drugs covered by FFS Medicaid, the maximum number of copays is two (2) per month.

Reversal of a previously filled prescription with a co-pay will require a refund of the co-pay to the Medicaid member, and will cause the next prescription filled for that Medicaid member to be adjudicated with a co-pay.

Some Medicaid members or medications are exempt from the copayment requirement as described in Utah State Plan, Attachment 4.18-C, Page 3 under sub-bullet K.

In accordance with federal regulation (42 CFR 447.52), a Medicaid provider may not refuse service to a Medicaid member based on their patient’s inability to pay their copayment.

5.16 Days’ Supply

Unless otherwise restricted or Noted below, Utah Medicaid will pay for up to a one (1) month supply of a medication per dispensing.

Utah Medicaid will allow up to a ninety (90) days’ supply of select medications. For a list of medications that can be reimbursed for up to a ninety (90) days’ supply refer to the [Resource Library](#) 90 Day Supply Reference.

Prenatal vitamins with folic acid and DHA for pregnant women, multiple vitamins with or without fluoride for children through age five (5), fluoride supplements and contraceptives are covered for up to a ninety (90) days’

supply per dispensing.

5.17 Initial fills for Short-Acting Opioids

Utah Medicaid will restrict the initial fill of short-acting opioids that exceed a 7-day supply or 3 day for dental providers. When a claim for a short-acting opioid is submitted to Utah Medicaid, the pharmacy claims processing system will determine whether the member has had a prescription for the same medication in the previous 60 days. If the member has not had a claim for the same medication in the previous 60 days, the system will treat the claim as an initial fill and allow no more than a 7-day supply. If a claim has been filled for the member for the same medication in the previous 60 days, then the claims processing system will allow the claim to process for up to a 30-day supply; however, the claim will be subject to all limitations and restrictions.

5.18 Outpatient Cancer Therapy

Utah Code 58-17b-805 allows for prescribing practitioners to dispense medications to their patients in lieu of having the prescriptions filled at a pharmacy. Utah Medicaid will reimburse a prescribing practitioner that dispenses medications pursuant to this law if they register with Utah Medicaid as a pharmacy and submit electronic point-of-sale claims.

5.19 ACO Carve-Out Drugs

The following classes of medications and individual drugs are carved-out from ACO coverage and are part of the FFS Medicaid benefit:

- Transplant Immunosuppressive Drugs
- Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Drugs
- Anti-psychotic Drugs
- Anti-depressant Drugs
- Anti-anxiety Drugs
- Anti-convulsant Drugs
- Hemophilia Drugs
- Opioid Use Disorder Treatments

5.20 Tobacco Cessation Products

Both over-the-counter and prescription tobacco cessation products are available under the pharmacy program for Medicaid members with a prescription. The prescriber can provide a prescription to be filled by the pharmacy for the member to be covered by Medicaid. For additional information, refer to Utah Medicaid [Tobacco Cessation Program](#).

6 Non-Covered Services and Limitations

For information on non-covered Services and limitations that apply to all Utah Medicaid programs and the circumstances in which a Medicaid member may be billed for non-covered Medicaid services, refer to the Utah Medicaid Provider Manual, Section I: General Information.

6.1 Non-Covered Services

Only drugs and services described previously as covered are reimbursable by Utah Medicaid. In addition to the non-covered services listed in the [Utah Medicaid Provider Manual](#), All Providers General Information Section I,

the following is a list of non-covered drugs through the Utah Medicaid pharmacy program:

- Drugs not eligible for federal Medicaid funds
- Drugs for anorexia, weight loss or weight gain
- Drugs to promote fertility
- Drugs for cosmetic purposes or hair growth
- Drugs for the symptomatic relief of cough and colds, except for the medications defined as covered services in Chapter 4-11 Cough and Cold Products of the Pharmacy Services manual
- Vitamins, except for:
 - Prenatal vitamins for pregnant women
 - Vitamin drops, with or without fluoride, for children through age five (5)
 - Fluoride supplements
- Nonprescription drugs (over-the-counter, or OTC), except for the medications defined as covered services in Chapter 4-10 Prescribed Over-The-Counter Products of the Pharmacy Services manual
- Drugs for which the manufacturer requires, as a condition of sale, that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs for the treatment of sexual or erectile dysfunction
- Drugs given by a hospital to a patient at discharge (take-home drugs)
- Breast milk, breast milk substitutes, baby food, or medical foods, prescription metabolic products for in-born errors of metabolism (e.g. phenylketonuria and maple syrup urine disease) as defined in the Utah Medicaid Provider Manual, Medical Supplies and Durable Medical Equipment manual in Chapter 2-3.2 Oral or Tube Supplemental Nutrition and Total Oral Nutrition.
- Drugs available only through single-source distribution programs, unless the distributor is enrolled with Utah Medicaid as a pharmacy provider.

6.2 Off-label Use

Utah Medicaid may restrict coverage of a drug to the FDA approved indication (labeled indication). Prescribers may appeal a denial of an off-label use for a drug by submitting a prior authorization request with the following:

- The specific diagnosis, including the appropriate ICD-10 code(s);
- The off-label use must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years;
- The off-label request must have a defined dosage regimen;
- The off-label request must have a defined duration of treatment;
- The off-label request must show a clear and significant clinical or economic advantage over existing approved drug regimens or medical procedures.

If the prior authorization request is denied, a Medicaid member may request an administrative hearing according to the process defined in Utah Medicaid Provider Manual, Section I: General Information.

6.3 Limitations

Medicaid coverage of pharmaceuticals is subject to limitations including, but not limited to, prior authorization, maximum and minimum limits, duration of therapy limits, frequency limits, therapeutic duplication limit, age restrictions, and gender restrictions.

Numerous drugs require prior authorization based on clinical, safety, or other factors in order to qualify for Utah Medicaid coverage. [Prior authorization forms](#) and criteria are available online. For a listing of limitations, Drug Criteria and Limits and Opioid Quantity Limits Complete List, refer to the Utah Medicaid [Resource Library](#).

6.4 Kits and Combination Products

Unless a kit or combination product is listed as a preferred agent on the Preferred Drug List, all kit and combination products will be subject to prior authorization. Prior authorization requests for kits or combination products not listed as preferred agents on the Preferred Drug List must be submitted to Utah Medicaid with the [Combo Product](#) or [Dosing Kit](#) prior authorization form.

6.5 Refills and Early Refills

Utah Medicaid will pay for a prescription refill only when 80% of the previous prescription has been exhausted, with the exception of opioids. For example, a prescription for a 30 days' supply has been 80% exhausted on the 24th day after it was dispensed and can be refilled on the 25th day. Utah Medicaid will pay for a prescription refill for narcotic analgesics after 100% of the previous prescription has been exhausted.

Prescription refills must be requested by Medicaid member, or the member's agent, based on continued medical necessity. Automatically refilled prescriptions, or cycle filled prescriptions, are not eligible for reimbursement.

Utah Medicaid will only pay for an early refill of a medication in cases of lifesaving necessity. Utah Medicaid will not pay for an early refill in the following circumstances:

- Member preference for a particular brand-name or generic version of a drug or vice versa;
- Lost, stolen, or destroyed prescriptions;
- Early refills to accommodate travel (a.k.a. "vacation refill");
- Prescriptions that have not been used according to the prescribed directions;
- Refills for Medicaid members entering, or leaving, a long term care facility, including "take home" supplies when a Medicaid member is temporarily leaving a nursing home facility.

6.6 Monthly Dispensing Fee

Pursuant to R414-60-7, Utah Medicaid will only pay one dispensing fee per twenty-four (24) days per medication per Medicaid member per pharmacy. Claims for the same medication for a Medicaid member at the same pharmacy filled more frequently will pay without an additional dispensing fee.

6.7 Blood Factors and Hemophilia Management

Utah Medicaid restricts claims for hemophilia blood factors to a single provider, except in emergency situations. Utah Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX.

The sole source provider of blood factors is University Hospital Home Infusion Services. Questions concerning hemophilia case management and blood factors VII, VIII and IX should be directed to this provider by calling: (801) 213-9600. A Hemophilia Outcomes Tracking Form for use by case management is found in the Utah Medicaid Pharmacy [Resource Library](#).

6.8 Drugs Requiring Diagnosis Codes

Claims for opioids for the treatment of cancer-related pain must be submitted with a current valid ICD-10 diagnosis code to bypass the cumulative limits listed in Drug Criteria and Limits found in the [Resource Library](#).

The prescriber is responsible to provide the current correct diagnosis for narcotic analgesics for cancer pain. The diagnosis code may be hand-written by the prescriber on the prescription or computer generated by prescribing software. Pharmacy providers may also obtain diagnosis codes verbally from prescribers, and note the date, time, and name of the physician's representative providing the diagnosis code on the original hard-copy prescription. In addition, updated or renewed prescriptions for a given drug may reference an original handwritten or computer-generated prescription for the appropriate diagnosis code.

The pharmacist must enter the diagnosis code into the appropriate diagnoses field when processing a claim.

Note:

1. A listing of the ICD-10 diagnosis codes accepted by Utah Medicaid by category is included in the ICD-10 Neoplasms located in the [Resource Library](#).
2. If a pharmacy fills a narcotic analgesic prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered through post-payment review.

7 Billing

Utah Medicaid requires all pharmacy claims to be submitted electronically through the pharmacy point-of-sale system using the National Council of Prescription Drug Plan (NCPDP) version D.0 standard. The point-of-sale system provides pharmacists with the capability to submit pharmacy claims electronically and have "real time" claim processing. To assist pharmacies in submitting electronic claims, Utah Medicaid posts a NCPDP version D.0 payer sheet located in the [Resource Library](#).

7.1 Prior Authorization

For general prior authorization information, refer to Utah Medicaid Provider Manual, Section I: General Information and Chapter 5 of the Pharmacy Services manual for prior authorization information. Pharmacy prior authorizations must be initiated by a Medicaid prescriber, or in consultation with an authorized Medicaid prescriber.

When a medical emergency occurs for a medication that requires prior authorization, a pharmacy provider may dispense up to a 72-hour supply of the medication without obtaining prior authorization. When contacted, Utah Medicaid may enter an override for up to a 72-hour supply of the medication. All subsequent claims must satisfy all prior authorization criteria or other limitations for the medication.

7.2 Decimal Quantities

Pharmacies must submit claims to Utah Medicaid using the actual metric decimal quantities of medications dispensed to Medicaid members based on the National Council of Prescription Drug Plans (NCPDP) billing unit for drugs. Rounding unit, or package, sizes or submitting quantities that are inconsistent with the NCPDP billing unit on a claim is not allowed and will be rejected at point of sale.

7.3 Prescription Order

All claims for covered medications, including over-the-counter medications, must be prescribed by a licensed prescriber acting within the scope of his or her licenses. Prescription orders must contain all the required information and be issued in compliance with all state and federal laws and regulations.

7.4 National Prescriber Identifier Requirement on Pharmacy Claims

Federal regulation 42 C.F.R. 455.410(b) requires all prescriptions for Utah Medicaid members to be issued by a prescriber who is enrolled with Utah Medicaid. Prescriptions that are issued by a non-enrolled prescriber or claims submitted with a National Prescriber Identifier (NPI) not associated with an enrolled prescriber will be denied.

Utah Medicaid requires the NPI submitted on a pharmacy claim to be the NPI of the prescriber that issued the prescription. Claims submitted with an incorrect prescriber NPI will either be denied or subject to recoupment on post-payment review.

7.5 Medication Not Received by the Member

If a Medicaid member has not received a medication billed to Utah Medicaid within ten (10) days of the date it was filled, the pharmacy provider must reverse the claim and credit back the payment amount to Utah Medicaid.

7.6 Proof of Receipt

Pharmacy providers must maintain documentation of receipt of a prescription by the Utah Medicaid member or the member's authorized representative. The documentation may be kept as a signature log or another method that clearly identifies the medication(s) received by the Medicaid member, the date the medications were received, and who received the medications.

7.7 Provider Administered Drug (“J-code”) Billing

The provider administered drugs are administered in physicians' offices or outpatient facilities by doctors or eligible staff. These drugs must be reasonable, necessary, and indicated for the diagnoses, or effective treatments of specific illnesses or injuries based on accepted standards of medical practice. All other program plan coverage and limitations still apply.

As described in Utah State Plan, Attachment 4.19-B on Page 19b under Provider Administered Drugs section, covered provider administered drugs will be reimbursed according to the Average Sale Price (ASP) Drug Pricing File, published quarterly by the Centers for Medicare and Medicaid Services (CMS), for drugs that have an ASP price set by CMS.

Covered provider administered drugs for which CMS does not publish an ASP price will be reimbursed in accordance with the Utah Medicaid fee schedule published on Medicaid's Coverage and Reimbursement Code Look-up Tool.

Coverage and payment rates for provider administered drugs are based on the Healthcare Common Procedure Coding System (HCPCS) code and HCPCS units. Coverage status and HCPCS code rates can be verified by using the Utah Medicaid, Bureau of Coverage and Reimbursement, [Coverage and Reimbursement Code Lookup](#).

Additionally, claim lines for provider administered drugs must contain both the appropriate HCPCS codes and the

National Drug Code (NDC) of the medication administered to the Medicaid member. The NDC of the product administered to the Medicaid member must be valid and eligible for the federal Medicaid drug rebate and active in order for the claim line to be considered for reimbursement. Utah Medicaid will compare the submitted HCPCS code to the submitted NDC by using a crosswalk, available at Bureau of Coverage and Reimbursement Policy, Coverage and Reimbursement Fee Schedule Download, [HCPCS/NDC Crosswalk](#). If the submitted combination is unmatched, the claim will deny. The HCPCS to NDC crosswalk and billing requirements apply to claims administered in physician offices (CMS-1500 claim) and in outpatient settings (UB-04 claim).

Providers and interested parties who wish to submit requests for consideration of additional HCPCS to NDC matches, or to make changes to existing matches, may do so via the [Physician Administered Review Request Form](#).

Note:

1. NDCs must be submitted with eleven (11) digits in a 5-4-2 digit format (without dashes). NDCs submitted as ten (10) digit codes or eleven (11) digit codes with dashes will result in the claim denying. The first five (5) digits of the NDC are the manufacturer's labeler code, the middle four (4) digits are the product code, and the last two (2) digits are the package size. If one were to encounter a NDC that is less than eleven (11) digits, add the missing digits as follows:
 - For a 4-4-2 NDC, add a 0 to the beginning of the code as the first digit.
 - For a 5-3-2 NDC, add a 0 as the sixth digit.
 - For a 5-4-1 NDC, add a 0 as the tenth digit.
2. A covered entity using medications purchased through the 340B program should refer to the 340B chapters of this manual for additional information.

The following information must be provided on a CMS-1500 Claim Form when billing for provider administered drugs:

- NDC – Box 24D, shaded area
- Drug Unit Price – Box 24F, shaded area
- Basis of Measurement Qualifier and Units – Box 24G, shaded area. Use the following qualifiers: ML – for milliliters
- GR – for grams UN – for units
- F2 – for international units

When billing the CMS-1500 electronically, the information needs to be reported in the following X12 fields (contact your software vendor for specific information):

- 2410 LIN03= NDC number preceded with N4 (LIN02=N4)
- 2410 CTP05-1= Units qualifier (GR, ML, UN, F2)
- 2410 CTP04= Number of units (place the number of units immediately after the units qualifier)
- 2410 CTP03= Cost or Unit Price

Outpatient hospital claims that include lines for drugs must provide the NDC when billing Medicaid on the UB-04 claim form. The NDC code must be included on the claim line immediately below the REV Code and Procedure Code (Form locator 43), the Units preceded by a qualifier (Form locator 46), and the Unit Price (Form locator 47).

When billing the UB-04 electronically, the information needs to be reported in the following X12 fields (contact your software vendor for specific information):

- 2410 LIN03= NDC number preceded with N4 (LIN02=N4)
- 2410 CTP05-1= Units qualifier (GR, ML, ME, F2)
- 2410 CTP04= Number of units (place the number of units immediately after the units qualifier)
- 2410 CTP03= Cost or Unit Price

For provider administered drug used for the treatment of an opioid use disorder, a pharmacy may bill Medicaid. The pharmacy may only release this provider administered drug used for the treatment of an opioid disorder to the administering provider or provider's staff for treatment.

7.8 340B Outpatient Pharmacy (Point-of-Sale) Billing

All claims submitted to Utah Medicaid from a 340B covered entity for medications that were purchased through the 340B program must be submitted with the provider's 340B actual acquisition cost in the Ingredient Cost Field, a value of "8" in the Basis of Cost field, and a value of "20" in the Submission Clarification Code field. Claims submitted without the provider's 340B actual acquisition cost in the Ingredient Cost Field, a value of "8" in the Basis of Cost field, and a value of "20" in the Submission Clarification Code field indicate that the covered entity purchased the medication outside of the 340B program and Utah Medicaid will pursue the federal Medicaid drug rebate and supplemental rebate on those claims.

Claims submitted to Utah Medicaid from a 340B covered entity for medications that were not purchased through the 340B program may be submitted in accordance with Utah Medicaid's and the pharmacy's normal business practices.

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid, unless the covered entity, the contract pharmacy and the State Medicaid agency have established a written arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the OPA (Office of Pharmacy Affairs), HRSA (Health Resources & Services Administration), by the 340B covered entity.

7.9 340B Provider Administered Drug (J-Code) Billing

All claims submitted to Utah Medicaid from a 340B covered entity for medications that were purchased through the 340B program must be submitted with the provider's 340B actual acquisition cost as the billed charges and the "UD" modifier after the HCPCS code on each claim line. Claims submitted without the provider's 340B actual acquisition cost as the billed charges and the "UD" modifier on the claim line indicate that the covered entity purchased the medication outside of the 340B program and Utah Medicaid will pursue the federal Medicaid drug rebate on those claims.

For dual-eligible beneficiaries who participate in both the Medicare and Medicaid programs, when a 340B covered entity submits a crossover drug claim to Utah Medicaid, it must contain a "JG" or "TB" modifier.

When applicable, providers are required to report either modifier "JG" or "TB" on OPPS claims (bill type 13X). Though modifier "TB" is an informational modifier, reporting is mandatory for following providers:

Hospital Type (determined by CMS)	Pass-through Drug (SI “G”)	Separately Payable Drug (SI “K”)	Vaccine (SI “F” “L” or “M”)	Packaged Drug (SI “N”)
Not Paid under OPSS				
CAH	TB, Optional	TB, Optional	N/A	TB or JG, Optional
Non-Excepted Off-Campus PBD	TB	TB	N/A	TB or JG, Optional
Paid under the OPSS, Excepted from the 340B Payment Adjustment for 2018				
Children’s Hospital	TB	TB	N/A	TB or JG, Optional
PPS-Exempt Cancer Hospital	TB	TB	N/A	TB or JG, Optional

7.10 Drugs purchased at Nominal Price

Providers that purchase covered outpatient drugs at Nominal Price and using those covered outpatient drugs to bill Utah Medicaid must submit the actual acquisition cost of the medication on the claim as outlined in the State Plan, Attachment 4.19-B, Section S on page 19a(2).

7.11 Drugs purchased through the Federal Supply Schedule

Providers that purchase covered outpatient drugs through the Federal Supply Schedule (FSS) and using those covered outpatient drugs to bill Utah Medicaid must submit the actual acquisition cost of the medication on the claim as outlined in the State Plan, Attachment 4.19-B, Section S on page 19a(2).

Providers that are using FSS covered outpatient drugs to bill Utah Medicaid but are paid through a bundled payment or “All Inclusive Rate” are not required to submit the actual acquisition cost on the claim.

7.12 Pharmacy Reimbursement

Utah Medicaid reimbursement is outlined in the State Plan, Attachment 4.19-B, Section S on Page 19.

All claims must be submitted with the National Drug Code (NDC) of the product dispensed. A pharmacy may not dispense a product and bill Medicaid using the NDC of a different brand or generic product.

7.13 Usual and Customary Charges

A pharmacy may not submit a charge to Utah Medicaid that exceeds the pharmacy’s usual and customary charge for the medication. The usual and customary charge is the lowest amount a provider charges to the general public and reflects all advertised savings (e.g. \$4 generic), discounts, special promotions or any other programs available to the general public.

7.14 Estimated Acquisition Cost

The Estimated Acquisition Cost (EAC) for Utah Medicaid is the Wholesale Acquisition Cost (WAC) as outlined

in the State Plan, Attachment 4.19-B on Page 19a.

7.15 Federal Upper Limit

The Centers for Medicare and Medicaid Services (CMS) publishes the Federal Upper Limit (FUL) as defined in the Affordable Care Act and 42 C.F.R. 447.512 – 514. Utah Medicaid is required to use the FUL and ensure that the payments for drugs subject to the FUL do not exceed it.

The Federal Upper Limits are updated by CMS monthly and Utah Medicaid cannot override a FUL price established by CMS.

7.16 Utah Maximum Allowable Cost

The Utah Maximum Allowable Cost (MAC) is the National Average Drug Acquisition Cost (NADAC), published by the Centers for Medicare and Medicaid Services (CMS). If CMS does not publish a NADAC for a drug, the Division of Medicaid and Health Financing may establish a State MAC for a drug. The current and historical NADAC drug files can be accessed on the CMS website.

For questions or concerns regarding NADAC pricing, please contact: Myer's National Average Drug Acquisition Cost (NADAC) Help Desk (855) 457-5264
info@mslcrps.com

Pharmacies may also submit NADAC pricing inquiries using the following form:

<https://www.medicaid.gov/medicaid/prescription-drugs/downloads/retail-price-survey/hdform.pdf>.

7.17 Dispensing Fees

Utah Medicaid pays a dispensing fee to reimburse pharmacies for all costs associated with transferring a medication to a Medicaid member as outlined in the State Plan, Attachment 4.19-B on Page 19a. The dispensing fee is inclusive of all costs associated with dispensing a medication including, but not limited to: staff time and knowledge, preparing a medication for dispensing, packaging, physically providing the completed prescription to the member, delivery, and facility overhead and maintenance costs. A pharmacy may not charge a Medicaid member an additional fee for any service that is reimbursed as part of the dispensing fee.

7.18 Indian Health Program

Indian Health providers are reimbursed for pharmacy services in accordance with the Utah Medicaid Indian Health Provider Manual.

8 End Stage Renal Disease (ESRD)

Dialysis services are provided under the Utah Medicaid State Plan to cover Medicaid members principally for the three (3) month period between the first dialysis service and commencement of the Medicare End Stage Renal Disease (ESRD) benefit. The Medicaid State Plan also allows for coverage of dialysis services for Medicaid members who do not qualify for Medicare coverage. ESRD facilities are required to assist Medicaid members in applying for and pursuing final Medicare eligibility during the first three (3) months of providing dialysis services.

An ESRD facility may be reimbursed by Utah Medicaid for providing dialysis services only if the ESRD facility

is enrolled with Utah Medicaid and Medicare as an ESRD provider.

The ESRD facility must be in compliance with applicable federal, state, and local laws and regulations for licensure, certification and/or registration.

A non-ESRD facility will need to identify an ESRD provider that is contracted with Utah Medicaid to provide services during Medicaid member's admission and stay. This contracted ESRD provider will bill Utah Medicaid for ESRD services rendered during the stay.

8.1 Definitions for ESRD

Definitions specific to ESRD services are provided below.

8.1.1 Composite Payment

A per treatment unit of payment that applies to all claims for dialysis services. The composite payment rate includes payment for all training, services, evaluations, laboratory tests, items, supplies, medications and equipment necessary to treat ESRD or perform dialysis.

8.1.2 Dialysis

A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi permeable membrane. The two types of dialysis that are currently in common use are hemodialysis and peritoneal dialysis.

8.1.3 Dialysis Service

The type of care or service furnished to an ESRD patient and includes all training, services, evaluations, laboratory tests, items, supplies, medications and equipment necessary to perform dialysis in a facility, outpatient, or home setting.

8.1.4 End Stage Renal Disease (ESRD)

That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

8.1.5 ESRD Facility

A facility which is enrolled with Utah Medicaid and Medicare to furnish at least one specific dialysis service. Such facilities include:

Renal Transplantation Center: A hospital unit which is approved to furnish directly transplantation and other medical and surgical specialty services required for the care of the ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement. A Renal Transplantation center may also be a Renal Dialysis Center.

Renal dialysis center: A hospital unit which is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients (including inpatient dialysis furnished directly or under arrangement). A hospital need not provide renal transplantation to qualify as a renal dialysis center.

Renal dialysis facility: A unit which is approved to furnish dialysis service(s) directly to ESRD patients.

Self-dialysis unit: A unit that is part of an approved renal transplantation center, renal dialysis center, or renal dialysis facility and furnishes self-dialysis services.

Special purpose renal dialysis facility. A renal dialysis facility which is approved to furnish dialysis at special locations on a short term basis to a group of dialysis patients otherwise unable to obtain treatment in the geographical area. The special locations must be either special rehabilitative (including vacation) locations serving ESRD patients temporarily residing there, or locations in need of ESRD facilities under emergency circumstances.

8.2 Covered Services for ESRD

8.2.1 Services Provided by an ESRD Facility

Dialysis services, including hemodialysis and peritoneal dialysis treatments, provided by an ESRD facility are a covered service for categorically and medically needy Medicaid members for three months pending the establishment of Medicare eligibility. Dialysis services may be covered for longer than three months if a member is not eligible for Medicare.

8.2.2 Services Performed at Home

Dialysis services, including hemodialysis and peritoneal dialysis treatments, performed at home are covered when they are supervised by an enrolled ESRD facility and performed by an appropriately trained Medicaid member. The composite rate for hemodialysis and peritoneal dialysis performed at the home are the same as the rate paid for services delivered in a facility and includes payment for all training, services, evaluations, laboratory tests, items, supplies, medications and equipment necessary to treat ESRD or perform dialysis in the home setting.

8.2.3 Service Provided by a Non-ESRD Facility

Dialysis services, including hemodialysis and peritoneal dialysis treatments, at a Non-ESRD facility are covered when performed by an ESRD provider contracted with Utah Medicaid. The ESRD provider is responsible for billing their services and supplies during the Medicaid member's admission and stay.

8.3 Non-Covered Services and Limitations for ESRD

8.3.1 Non-Covered Services

Dialysis services delivered by an ESRD facility that is not enrolled with Utah Medicaid or Medicare as an ESRD provider.

Dialysis services delivered by a ESRD facility that is not in compliance with all applicable federal, state, and local laws and regulations for licensure, certification and/or registration.

Individual components of dialysis services billed separately from the composite rate.

8.3.2 Limitations

Payment for dialysis services are only eligible to ESRD facilities that have enrolled with Utah Medicaid and are also enrolled with Medicare as an ESRD provider.

Dialysis services are reimbursed through a composite rate. Payment for services which are part of the composite rate are not eligible to be reimbursed separately from the composite rate.

Regardless of the dialysis method used, composite payments are limited to one unit per session and no more than one unit per day. Continuous cycling peritoneal dialysis, or any other dialysis services that occurs overnight, is eligible for one composite payment.

8.4 Billing for ESRD Services

The dialysis composite payment rate for all covered dialysis revenue codes is based on the Medicare ESRD Prospective Payment System base rate as identified and approved in Attachment 4.19-B on Page 12a of the Utah Medicaid State Plan.

Bill dialysis services as a UB-04 Claim using one of the following Revenue Codes. Refer to the provider manual, Section I: General Information, for detailed billing instructions or to the UB-04 Billing Manual.

Covered Dialysis Revenue Codes Revenue code 0821 (Hemodialysis) Revenue code 0831 (Peritoneal Dialysis)
Revenue code 0841 (Continuous Ambulatory Peritoneal Dialysis) Revenue code 0851 (Continuous Cycling Peritoneal Dialysis)

Each dialysis session should be billed as one (1) unit for the appropriate Revenue Code and all covered dialysis revenue codes are reimbursed at the same rate. It is not necessary to bill separately for services delivered during the dialysis session that are included in the composite payment. Claim lines submitted on the UB-04 Claim for services included in the composite rate will be denied.

Procedure codes for ESRD services with accompanying criteria and limitations can be verified by using the Utah Medicaid, Bureau of Coverage and Reimbursement, [Coverage and Reimbursement Code Lookup](#).

9 References

Utah State Plan, Attachment 4.18-C Utah State Plan, Attachment 4.19-B
Social Security Act,
§§ 1927(d)(2) and 1927(k)(3)
§ 1935(a)
42 CFR 447.52(e) and 502
42 CFR 455.410
42 U.S.C. §§ 1396b (i)(23); 1396r-8; 1396r-8(g)(2)(A)
UCA Title 26, Chapter 18, Part 2 UCA 58-17b-606
Utah Administrative Code R414-60