Medical Assistance Administration

Prescription Drug Program

Billing Instructions

February 2003

[WAC 388-530]

About this publication

This publication **SUPERSEDES** all previous MAA Prescription Drug Program Billing Instructions and the following Numbered Memorandums:

99-52 MAA, 00-53 MAA, 00-54 MAA, 00-73 MAA, 01-08 MAA, 01-16 MAA, 01-50 MAA, 01-57 MAA, 01-59 MAA, 01-73 MAA, 02-01 MAA, 02-07 MAA, 02-11 MAA, 02-12 MAA, 02-57 MAA, 02-62 MAA, 02-67 MAA, 02-76 MAA, 02-78 MAA, 02-84 MAA, 02-90 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
February 2003

MAA's Publications are available on-line at: http://maa.dshs.wa.gov.
Click on Provider Publications/Fee Schedules.

Table of Contents

Important Contacts v

Definitions 1

Section A: Drug Program
What is the goal of the Prescription Drug Program? A.1
Who may prescribe, administer, or dispense legend drugs and controlled substances? A.1
Guidelines for completing prescription forms which will be filled by a pharmacist A.2
Abuse and misutilization A.3

Section B: Client Eligibility
Types of identification that prove eligibility B.1
Who is eligible? B.2
Are Healthy Options managed care clients eligible for pharmacy services? B.3

Section C: Coverage/Program Limitations
What drugs, devices, and supplies **are covered**? C.1
How does MAA determine which drugs to cover? C.2
What drugs, devices, and supplies **are not covered**? C.3
Is there a "days supply" limit? C.5
How many prescriptions are allowed per month if less than a 34-day supply is prescribed? C.6
Limitations on certain drugs C.7
Is it possible to receive early refills? C.8
Emergency fills C.9
Which drugs may be dispensed without a prescription? C.9
Generic drugs C.9
Voluntary cost per milligram (mg) savings C.10
Less-Than-Effective drug index C.11

Table of Contents (cont.)

Section D: Compliance Packaging

What is included in compliance packaging? D.1
How do I determine if a client is eligible for compliance packaging? D.1
How do I bill for compliance packaging? D.2

Section E: Compounded Prescriptions

What is compounding? E.1
Which items are not covered for compounding? E.1
Is prior authorization required for compounded prescriptions? E.2
How do I bill for compounded prescriptions? E.3

Section F: Therapeutic Consultation Service (TCS)

Overview of TCS F.1
Drugs excluded from the four brand name prescription per calendar month review F.1
Preferred drug list F.2
What should I do when I get a POS computer alert for a TCS review? F.3

Section G: Special Programs/Services

Smoking cessation for pregnant women G.1
Clozaril/Clozapine and related services G.2
Emergency contraception pills (ECP) G.3
Emergency contraception (EC) counseling G.3
Patient Requiring Regulation (PRR) Program G.5
Prescription service by mail G.6

Table of Contents (cont.)

Section H: Authorization

Who determines authorization status for drugs in MAA's drug file? H.1
How are drugs added to MAA's drug list? H.1
Prior authorization/reject edit conflict codes H.2
Prior authorization
    When does MAA require prior authorization? H.3
    How do I obtain prior authorization? H.3
    What information should a pharmacist have ready before calling MAA for an authorization number? H.3
Drugs that **do not require** prior authorization H.4
Expedited prior authorization (EPA)
    What is the EPA process? H.5
    How is an EPA number created? H.5
    EPA guidelines H.6
    EPA list/criteria H.7
Revia (Naltrexone) authorization form [DSHS 13-677] H.19
Limitation extensions (LE)
    What is a limitation extension? H.20
    How do I get LE Authorization? H.20

Section I: Reimbursement

Drug Rebate Program I.1
Estimated acquisition cost (EAC) I.2
Federal upper limits (FUL) I.3
Maximum Allowable Cost (MAC) Program
    Automated Maximum Allowable Cost (AMAC) Program I.5
    State Maximum Allowable Cost Program (SMAC) I.5
Tax I.7
Dispensing fees I.7
Payment I.8
MAC price list I.9

Table of Contents (cont.)

Section J: Billing

General information J.1
Drug quantities J.1
National Association of Boards of Pharmacy (NABP) number J.2
NCPDP Billing Unit Standards J.2
Billing a client J.4
Hospice clients J.8
Healthy Options managed care clients
- Healthy Options clients who self-refer J.9
- Community mental health centers J.9
- Family planning agencies J.10
- Health departments J.10

Family Planning Only and TAKE CHARGE clients J.11
Skilled Nursing Facility clients
- Over-the-Counter (OTC) drugs J.12
- Medications for skilled nursing facility clients on leave J.12
- Emergency kits J.13
- Skilled Nursing Facility Unit Dose Delivery Systems J.13
- How do pharmacies become eligible for a unit dose dispensing fee? J.13
- How do pharmacies bill MAA under a true or modified unit dose delivery system? J.14
- Who is responsible for the cost of replacing client's bulk medications? J.15
- What records do pharmacies need to keep? J.15
- What needs to be submitted annually to MAA? J.15

Third Party Liability J.16
How to bill for clients eligible for Medicare and Medicaid J.18
How do I bill for a baby who is using his/her parent's PIC? J.20

Table of Contents (cont.)

Section K: Point-of-Sale (POS)

What is Point-of-Sale (POS)? K.1
Do pharmacies have to use the on-line POS system? K.1
Do pharmacies need a separate agreement with MAA to use POS? K.1
What is the time limit for billing?
  Initial claims K.2
  Resubmitted claims K.3
  Overpayments that must be refunded to DSHS K.3
National Drug Code (NDC) K.4
Prospective Drug Use Review (Pro-DUR) K.4
MAA-Approved NCPDP DUR Codes K.5
Prospective Drug Use Review (Pro-DUR) Edits K.6
NCPDP Payor Sheet for Washington Medicaid K.8
Other Information K.10

Section L: Claim Form Instructions for Hard Copy Billing

Completing the Pharmacy Statement [DSHS 13-714]
General instructions L.1
Sample: Pharmacy Statement [DSHS 13-714] L.3

Completing the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers
General instructions L.5
Sample Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form L.10

Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)]

Where do I call to submit change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9245
Olympia WA 98507-9245

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Electronic billing:

Call/Write:
(360) 725-1267
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511

What is the web site address for pharmacy information?

MAA's Pharmacy Web Site:
http://maa.dshs.wa.gov/pharmacy/

Who do I call for prior authorization?

Pharmacy Prior Authorization Section
Drug Utilization and Review
(800) 848-2842

Backup documentation ONLY must be mailed or faxed to:
Pharmacy Prior Authorization Section
Drug Utilization and Review
PO Box 45506
Olympia WA 98504-5506
Fax (360) 586-2262

Who do I call to begin a Therapeutic Consultation Service (TCS) Review?

Toll Free (866) 246-8504

Who do I contact if I have questions regarding…

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
Email: providerinquiry@dshs.wa.gov
or call: (800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Real-time, on-line Point-of-Sale claims adjudication?

Affiliated Computer Services, Inc.
(ACS - formerly known as *Consultec*)
Technical POS Help Desk
(800) 365-4944

Prescriptions by Mail

Providers Call: 1-888-327-9791
Clients Call: 1-800-903-8639
Or go to MAA's website:
http://maa.dshs.wa.gov/RxByMail/

This is a blank page.

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance program. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgement.

Actual acquisition cost – The actual price a provider paid for a drug marketed in the package size of drug purchased, or sold by a particular manufacturer or labeler. Actual acquisition cost is calculated based on factors including, but not limited to:

1. Invoice price, including other invoice-based considerations, such as prompt payment discounts;
2. Order quantity and periodic purchase volume discount policies of suppliers (wholesalers and/or manufacturers);
3. Membership/participation in purchasing cooperatives;
4. Advertising and other promotion/display allowances, free merchandise deals; and
5. Transportation or freight allowances.

[WAC 388-530-1050]

Automated Maximum Allowable Cost (AMAC) – The rate established by the Medical Assistance Administration (MAA) for a multiple-source drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products, at least one of which must be under a federal drug rebate contract.
[WAC 388-530-1050]

Authorization number – A number assigned by MAA that identifies a specific request for approval for services or equipment.

Authorization requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions.

Average Wholesale Price (AWP) - The average price of a drug product that is calculated from wholesale prices nationwide at a point in time and reported to MAA by MAA's drug pricing file contractor.
[WAC 388-530-1050]

Brand name - The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Client – An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department's Economic Services Administration that administers social and health services at the community level.

Compliance packaging – Reusable, nonreusable drug packaging containers (e.g., Mediset, bingo cards, blister packs).

Compounding - The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription. [WAC 530-530-1050]

Contract drugs - Drugs manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS). [WAC 388-530-1050]

Core Provider Agreement – The basic contract between MAA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs.

Covered outpatient drug - A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, which is used for a medically accepted indication.

Department - The state Department of Social and Health Services (DSHS).

DESI (Drug Efficacy Study Implementation) – See "Less Than Effective Drug."

Dispensing fee – The fee MAA sets to reimburse pharmacy providers for dispensing MAA-covered prescriptions. The fee is MAA's maximum reimbursement for expenses involved in the practice of pharmacy and is in addition to MAA's payment for the costs of covered ingredients. [WAC 388-530-1050]

Drug Evaluation Unit (DEU) – A unit or group designated by MAA that makes drug coverage recommendations after studying the clinical and pharmacoeconomic attributes of drugs using the Academy of Managed Care Pharmacy drug review submission process. The DEU has physician and pharmacist staff and an advisory committee of actively practicing physicians and pharmacists. [WAC 388-530-1050]

Drug file – A list of drug products, pricing, and other information provided to MAA's drug database and maintained by a drug file contractor. [WAC 388-530-1050]

Drug rebates – Payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services. [WAC 388-530-1050]

Drug-related supplies – Nondrug items necessary for the administration, delivery, or monitoring of a drug or drug regimen. [WAC 388-530-1050]

Drug Utilization Review (DUR) – A review of covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes. [WAC 388-530-1050]

Emergency kit - A set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the needs of each nursing facility's client population and is for use during those hours when pharmacy services are unavailable. [WAC 388-530-1050]

Estimated Acquisition Cost (EAC) – MAA's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.
[WAC 388-530-1050]

Expedited prior authorization (EPA) - The process for authorizing selected drugs in which providers use a set of numeric codes to indicate to MAA the acceptable indications, conditions, diagnoses, and criteria that are applicable to a particular request for drug authorization.
[WAC 388-530-1050]

Explanation of benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Federal upper limit (FUL) – The maximum allowable payment set by the Centers for Medicare and Medicaid Services (CMS) [formerly known as "*HCFA"] for a multiple-source drug. [WAC 388-530-1050]

Generic Code Number (GCN) sequence number – A number used by MAA's drug file contractor to group together products that have the same ingredients, route of administration, drug strength, and dosage form. It is applied to all manufacturers and package sizes. [WAC 388-530-1050]

Generic name – The official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

***HCFA=Health Care Financing Administration**

Less-than-effective drug or DESI – Those drugs that lack substantial evidence of effectiveness as determined by the Food and Drug Administration (FDA).
[Refer to 388-530-1050]

Long-term therapy – A drug regimen a client receives, or will receive, continuously through and beyond 90 days.
[WAC 388-530-1050]

Managed care – A comprehensive system of medical and health care delivery including preventive, primary specialty, and ancillary health services. These services are provided through a managed care organization (MCO) or primary care case management (PCCM) provider.
[WAC 388-538-050]

Maximum allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Maximum Allowable Cost (MAC) - The maximum amount that MAA pays for a specific dosage form and strength of a multiple-source drug product.
[WAC 388-530-1050]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medically accepted indication – Any use for a covered outpatient drug:

(1) Which is approved under the federal Food, Drug, and Cosmetic Act; or
(2) The use of which is supported by one or more citations included or approved for inclusion in any of the following compendia of drug information.

 (a) The American Hospital Formulary Service Drug Information;
 (b) The United States Pharmacopoeia Drug Information.
 (c) DRUGDEX Information System.

[Refer to WAC 388-530-1050]

Medically necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly "course of treatment" available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Modified unit dose delivery system – (also known as blister packs or "bingo/punch cards") A method in which each patient's medication is delivered to a nursing facility:

- In individually sealed, single-dose packages or "blisters"; and
- In quantities for one month's supply, unless the prescriber specifies a shorter period of therapy.

[WAC 388-530-1050]

Multiple-source drug - A drug marketed or sold by:

1. Two or more manufacturers or labelers; or
2. The same manufacturer or labeler:
   a. Under two or more different proprietary names; or
   b. Under a proprietary name and a generic name.

[WAC 388-530-1050]

National drug code (NDC) - The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The NDC is composed of digits in 5-4-2 groupings. The first five digits comprise the labeler code assigned to the manufacturer by the FDA. The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.
[WAC 388-530-1050]

Noncontract drugs - Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).
[WAC 388-530-1050]

Obsolete NDC – An NDC replaced or discontinued by the manufacturer or labeler.
[WAC 388-530-1050]

Over-the-counter (OTC) drugs – Drugs that do not require a prescription before they can be sold or dispensed.
[WAC 388-530-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and which consists of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Pharmacist - A person licensed in the practice of pharmacy by the state in which the prescription is filled.
[WAC 388-530-1050].

Pharmacy - Every location licensed by the State Board of Pharmacy in the state where the practice of pharmacy is conducted.
[WAC 388-530-1050]

Point-of-sale (POS) - A pharmacy claims processing system capable of receiving and adjudicating claims on-line. [WAC 388-530-1050]

Practitioner – An individual who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner. [WAC 388-530-1050]

Preferred Drug – MAA's drug(s) of choice within a selected therapeutic class. [WAC 388-530-1050]

Prescriber – A physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. [WAC 388-530-1050]

Prescription - An order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices, in the course of the practitioner's professional practice, for a legitimate medical purpose. [WAC 388-530-1050]

Prescription drugs (*Legend drugs)*- Drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only. [WAC 388-530-1050]

Prospective drug use review (Pro-DUR) A process in which a request for a drug product for a particular client is screened, before the product is dispensed, for potential drug therapy problems. [WAC 388-530-1050]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provide services to eligible clients.

Provider number – An identification number issued to provides who have a signed contract(s) with MAA.

Reconstitution – The process of returning a single active ingredient, previously altered for preservation and storage, to its approximate original state. Reconstitution is not compounding. [WAC 388-530-1050]

Remittance and status report (RA) - A report produced by the Medicaid Management System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Retrospective Drug Utilization Review (Retro-DUR) - The process in which client's drug utilization is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care. [WAC 388-530-1050]

Revised Code of Washington (RCW) - Washington State law.

Single source drug - A drug produced or distributed under an original new drug application approved by the FDA. [WAC 388-530-1050]

Skilled nursing facility (SNF) - An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities;

and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Terminated NDC – An NDC that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life. [WAC 388-530-1050]

Therapeutic alternative – A drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile when administered to patients in a therapeutically equivalent dosage. [WAC 388-530-1050]

Therapeutic consultation service (TCS) – The prescriber and an MAA-designated clinical pharmacist jointly review prescribing activity when drug claims for an MAA client exceed program limitations. [WAC 388-530-1050]

Therapeutically equivalent – Drug products that contain different chemical structures but have the same efficacy and safety when administered to an individual, as determined by:

1. Information from the Food and Drug Administration (FDA);
2. Published and peer-reviewed scientific data;
3. Randomized controlled clinical trials; or
4. Other scientific evidence.

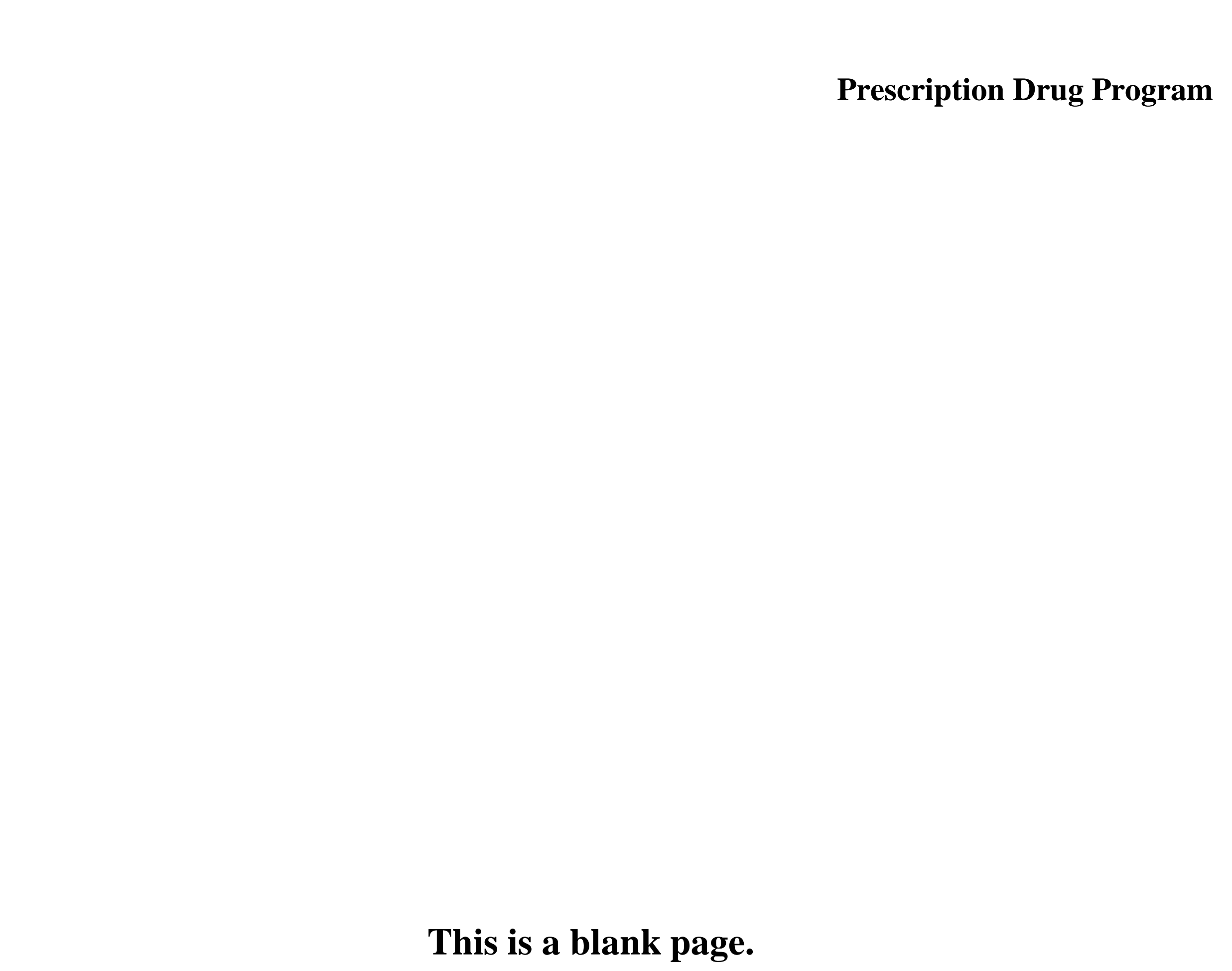
[WAC 388-530-1050]

Third party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

True unit dose delivery - A method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage. [WAC 388-530-1050]

Usual and customary charge - The fee that the provider typically charges the general public for the product or service. [WAC 388-530-1050 and WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.



This is a blank page.

About the Program

What is the goal of the Prescription Drug Program?

The goal of the Prescription Drug Program is to provide quality pharmaceuticals and pharmacy services to clients served by the Medical Assistance Administration (MAA). This program is governed by federal regulations and provides coverage for pharmaceuticals manufactured by companies who have signed a federal rebate agreement.

This may entail:

- Covering drugs without prior authorization;
- Requiring that the drug be prior authorized; or
- Not covering certain drugs.

The specific details are included in these instructions.

It is MAA's goal to assist the prescriber, the pharmacy, and the client with well coordinated services.

Who may prescribe, administer, or dispense legend drugs and controlled substances?

Primary authority for the prescribing of legend drugs and controlled substances comes from individual professional practice acts, and is usually found in the section of the act that defines the scope of practice for the profession. The definition of scope of practice is the responsibility of the board that licenses the professional.

The Legend Drug Act (69.41.030 RCW) and the Uniform Controlled Substances Act (69.50.101 RCW) each define which practitioners may prescribe these drugs.

For the purposes of MAA's Prescription Drug Program, the practitioners listed below, when properly licensed and registered under the Legend Drug Act and Uniform Controlled Substances Act, **may prescribe, administer, or dispense legend drugs and controlled substances.**

PROFESSION	RESTRICTION	LAW/RULE
Physician (MD)	None	18.71 RCW
Osteopathic Physician and Surgeon (DO)	None	18.57 RCW
Dentist (DDS or DMD)	Dental practice	17.32.685 RCW only
Podiatric Physician (DPM)	Podiatry practice	18.22.185 RCW only
Advanced Registered Nurse Practitioner (ARNP)	Scope of practice	18.88.280 RCW
Medical Physician Assistant (PA)	Prescriptive Authority	18.71 RCW/WAC 308-52
Osteopathic Physician Assistant (PA)	Prescriptive Authority	18.57A RCW/WAC 308-138A
Optometrist (OD)	Topical Eye Drugs only	18.53.010 RCW/WAC 308-53
Pharmacist (RPh, PharmD)	Prescriptive Authority	18.64.005 RCW/ WAC 246-863-100

Guidelines for completing prescription forms which will be filled by a pharmacist:

1. Complete all sections of the prescription form.
2. Sign the form and include all necessary identification numbers.
3. Make your instructions as clear and legible as possible.
4. Indicate your 7-digit DSHS prescriber (provider) number or Drug Enforcement Agency (DEA) number.
5. Make every effort to select a drug from the list of drugs not requiring prior authorization (see Section H, Authorization) to avoid delays and possible denial of prior authorization requests.
6. Promote generic substitution whenever possible.
7. Specify the quantity to be dispensed.
8. Indicate if the client resides in a skilled nursing facility.
9. Indicate the number of authorized refills.
10. Indicate the expedited prior authorization code for the prescribed drug on the prescription when applicable, or specify medical justification if authorization is required.
11. Indicate if the client is a Healthy Options self-referred client, if known.

Abuse and misutilization

The following practices constitute abuse and misutilization:

- **Excessive Fees** (commonly known as *prescription splitting* or *incorrect or excessive dispensing fees*): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:

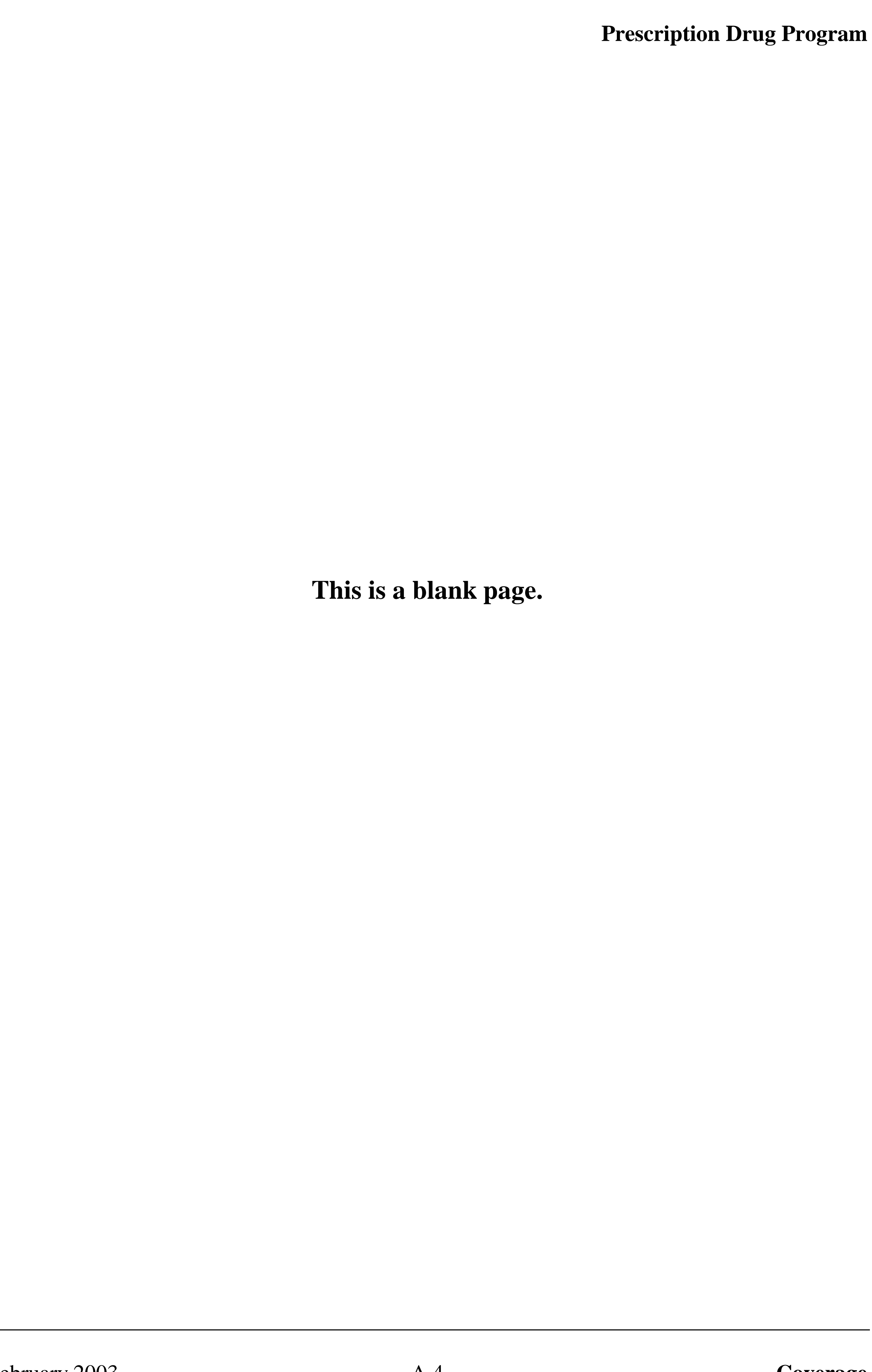
  - ✓ Supplying medication in amounts less than necessary to cover the period of the prescription; **and/or**

  - ✓ Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.

- **Excessive Filling**: Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity ***except*** when MAA specifies a mandatory amount in excess of the quantity prescribed.

- **Prescription Shorting**: Billing for drug or supply greater than the quantity actually dispensed.

- **Substitution to Achieve a Higher Price**: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug *was* available.



This is a blank page.

Client Eligibility

Types of identification that prove eligibility

The following is a list of valid types of identification that can be used to identify medical programs for which an MAA client is eligible:

- A white DSHS Medical ID card with green print, issued by the Department of Social and Health Services (DSHS);
- A printout of a medical identification screen from the client's local CSO. To be valid, the printout must be notarized or marked by the CSO with a stamp identifying the location of the CSO;
- An award letter from the CSO; or
- Medical eligibility verification (MEV) provided by an authorized MEV vendor.

The CSO computer printout or award letter can be used as valid identification since both list the eligibility information that appears on the client's DSHS Medical ID card. If a client presents a CSO printout that does not have an official stamp on it, it is not valid identification.

- MAA recommends you make a photocopy of valid identification when it is presented to you, in order to have a copy for your file.

Check the identification for the following information:

- Beginning and ending eligibility dates
- The Patient Identification Code (PIC)
- Other specific information (e.g., Medicare, private insurance, or Managed Care coverage, Hospice, Patient Requiring Regulation, etc.)
- Retroactive or delayed certification eligibility dates, if any.

The Point-of-Sale (POS) system does not solve the problem of identifying clients who are not currently on MAA's eligibility file. For clients whose DSHS Medical ID cards show that they are eligible, but the POS system denies their claims for lack of eligibility, please take the following steps:

- **FAX** a copy of the client's Medical ID card to Claims Entry at (360) 586-1403. **Please do not fax claims to this number**; or
- Mail in a **completed** paper claim with a photocopy of the client's Medical ID card attached.

MAA will update faxed copies of Medical ID cards within two working days in order for claims to be resubmitted.

Who is eligible?

Fee-for-service clients presenting DSHS Medical ID cards with the following identifiers are eligible for pharmacy services covered under MAA's Prescription Drug Program:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only
Family Planning Only	Family Planning Only *(limited coverage)*
GA-U No Out-of-State Care	General Assistance – Unemployable No Out-of-State Care
General Assistance – No Out-of-State Care	Alcohol and Drug Addiction Treatment and Support Act (ADATSA), ADATSA Medical Only
LCP-MNP	Limited Casualty Program - Medical Needy Program
TAKE CHARGE Family Planning Only	TAKE CHARGE Program *(limited coverage)*

Note: To provide clarification (as a result of significant inquiries), clients presenting Medical Identification cards with the following identifiers are not eligible for MAA's Prescription Drug Program:

- ✓ **MIP-EMER Hospital Only – No out-of-state care** (Medically Indigent Program-EMER Hospital Only – No out-of-state care)
- ✓ **QMB-Medicare Only** (Qualified Medicare Beneficiary-Medicare Only)

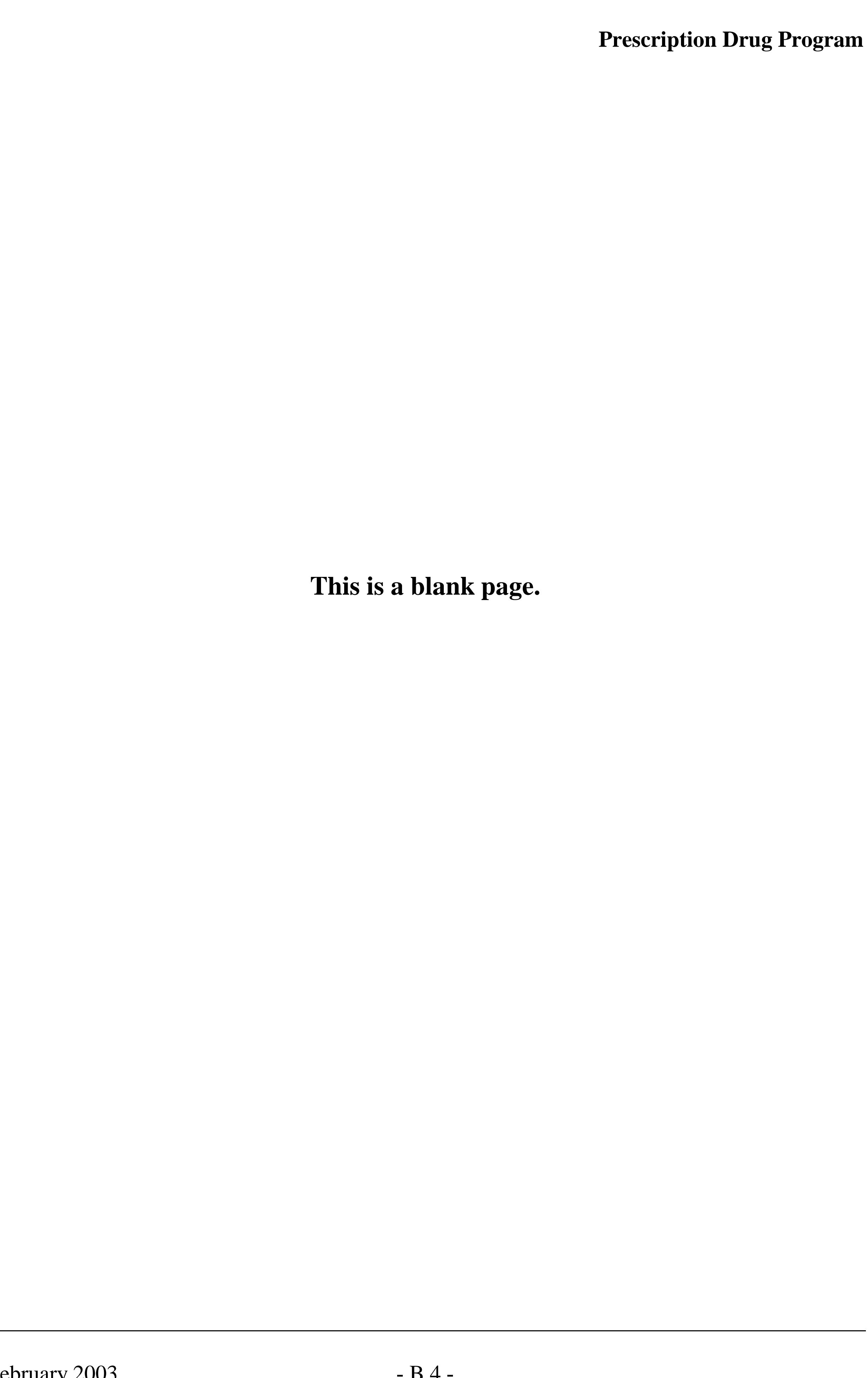
Are Healthy Options managed care clients eligible for pharmacy services?

Yes! Healthy Options managed care clients **are eligible** for pharmacy services **under their designated plan**. An identifier in the Health Maintenance Organization (HMO) column on the client's DSHS Medical ID card indicates that the client is enrolled in a Healthy Options managed health care plan.

See the *Billing* section for information regarding Healthy Options clients who self-refer outside their plan for pharmacy services.

Newborns of managed health care clients are the responsibility of the mother's plan for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Note: Client's enrollment can change monthly. Prior to serving a Healthy Options client, make sure you have received approval from both the plan and the client's Primary Care Provider (PCP), if necessary. Then, send claims to the client's managed care plan for payment.



This is a blank page.

Coverage/ Program Limitations

What drugs, devices, and supplies <u>are</u> covered?
[Refer to WAC 388-530-1100 and 1125]

The Medical Assistance Administration (MAA) covers medically necessary drugs and pharmaceutical supplies when they are prescribed for medically accepted indications, subject to the restrictions described in this billing instruction and other applicable Washington Administrative Code (WAC).

Note: For exceptions to the prescription requirement, see page C.9.

MAA reimburses a provider for drugs only when the manufacturer has signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS). For further information regarding MAA's Drug Rebate Program see Section I - Reimbursement.

MAA covers:

1. Outpatient drugs (generic or brand name).

2. Over-the-counter (OTC) drugs when the drug:

   - Is prescribed by a provider with prescribing authority;
   - Is a less costly therapeutic alternative;
   - Does not require prior authorization; AND
   - Is not listed under "What drugs, devices, and supplies are not covered?" on page C.3.

3. Drugs requiring prior authorization when:
   - Prior authorized by MAA; or
   - The drugs are listed on MAA's published expedited prior authorization (EPA) list, the client meets the EPA criteria for the drug, and the dispensing pharmacist follows MAA's EPA guidelines. (See Section H - Authorization)

4. Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, packaged for individual use.

5. Drugs with obsolete national drug codes (NDCs) for up to two years from the date the NDC is designated obsolete, unless the drug is expired.

6. Drugs and supplies used in conjunction with family planning, including drugs dispensed for emergency contraception and nonprescribed OTC contraceptive supplies.

   Example: Condoms (including female condoms), vaginal spermicidal foam with applicator and refills, vaginal cream, gel, and jelly (with applicator), and vaginal suppositories.

7. Prenatal vitamins, only when prescribed and dispensed to pregnant women. Prior authorization is required for pregnant woman outside the age range of 10-40.

8. Fluoride preparations for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

9. Drugs, devices, and supplies provided under unusual and extenuating circumstances to clients by providers who request and receive MAA approval.

10. Drug-related supplies as determined in consultation with federal guidelines.

MAA evaluates requests for drugs, devices, and pharmaceutical supplies that are subject to limitations or other restrictions in these billing instructions on a case-by-case basis. MAA approves the requested services that are beyond the stated limits or restrictions in these billing instructions when MAA determines that the services are medically necessary, under the standards of covered services in WAC 388-501-0165. **See Limitation Extensions, page H.19.**

How does MAA determine which drugs to cover?

MAA determines if certain drugs are medically necessary and covered with or without restrictions based on evidence contained in compendia of drug information and peer-reviewed medical literature.

Decisions regarding restrictions are based on, but are not limited to:

- Client safety;
- FDA-approved indications;
- Quantity;
- Client age and/or gender; and
- Cost.

Restrictions apply, but are not limited to:

- Drugs covered in the nursing facility per diem rate;
- Number of refills within a calendar month; and
- Refills requested before 75% of the previously dispensed supply is scheduled to be exhausted.

What drugs, devices, and supplies are not covered?
[Refer to WAC 388-530-1150]

MAA does not cover:

1. Brand name or generic drugs, when the manufacturer has **not signed a rebate agreement** with the federal Department of Health and Human Services.

2. Drugs prescribed:

   - For weight loss or gain.
   - For infertility, frigidity, impotency, or sexual dysfunction.
   - For cosmetic purposes or hair growth.
   - To promote smoking cessation, except as described on page G.1 under *Smoking Cessation for Pregnant Women*.

3. OTC drugs when prescribed for a client residing in a skilled nursing facility.

4. Vitamins and mineral products, except those listed on page C.2.

5. Nutritional supplements such as shakes, bars, puddings, powders, etc.

6. A drug prescribed for an indication that is not evidence based as determined by:

   - MAA in consultation with federal guidelines; or
   - The Drug Utilization and Education (DUE) Council; and
   - MAA medical consultants and pharmacist(s).

7. Drugs listed in the federal register as "**less than effective" (DESI drugs**) or which are identical, similar, or related to such drugs. (Refer to: http://www.hcfa.gov/medicaid/drugs/ for a list of DESI drugs.)

8. Drugs that are:

   - Not approved by the Food and Drug Administration (FDA); or
   - Prescribed for non-FDA approved indications or dosing, unless prior authorized; or
   - Unproven for efficacy or safety.

9. Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

10. Drugs requiring prior authorization for which MAA authorization has been denied.

11. Preservatives, flavoring and/or coloring agents.

12. A drug with an obsolete National Drug Code (NDC) more than two years from the date the NDC is designated obsolete by the manufacturer.

13. Products or items that do not have an 11-digit NDC.

14. Less than a one-month supply of drugs for long-term therapy.

MAA does not reimburse enrolled providers for:

1. Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

    - Diagnosis-related group (DRG);
    - Ratio of costs-to-charges (RCC);
    - Nursing facility per diem;
    - Managed care capitation rates;
    - Block grants; or
    - Drugs prescribed for clients who are in MAA's hospice program when the drugs are related to the client's terminal condition.

2. Any drug regularly supplied as an integral part of program activity by other public agencies (e.g., immunization vaccines for children).

3. Prescriptions written on pre-signed prescription blanks filled out by skilled nursing facility operators or pharmacists. MAA may terminate the Core Provider Agreement of pharmacies involved in this practice.

4. Drugs used to replace those taken from skilled nursing facility emergency kits.

5. Free pharmaceutical samples.

6. Drug products after the NDC termination date.

7. Drug products whose shelf life has expired.

MAA evaluates a request for a drug that is listed as noncovered under the provisions of WAC 388-501-0160 that relates to noncovered services. The request for a noncovered drug is called a "request for an exception to rule." See WAC 388-501-0160 for information about exceptions to rule.

Is there a "Days Supply" limit? [Refer to WAC 388-530-1250]

Most drugs are limited to a 34-day supply.

Exceptions:

- Drugs where the smallest package size exceeds a 34-day supply;
- Drugs with special packaging instructions; or
- Any of the following:

  ✓ Acetaminophen
  ✓ Antacid tablets
  ✓ Aspirin
  ✓ Calcium Carbonate tablets
  ✓ Calcium Gluconate tablets
  ✓ Calcium Lactate tablets
  ✓ Cyanocobalamin
  ✓ Ferrous Fumarate tablets
  ✓ Ferrous Gluconate tablets
  ✓ Ferrous Sulfate tablets
  ✓ Fluoride drops
  ✓ Niacin tablets
  ✓ Niacinamide tablets
  ✓ Nitroglycerin buccal and sublingual tablets
  ✓ Polyvitamin drops w/fluoride
  ✓ Prenatal vitamins

- **Dispensed up to a 90-day supply:**

  ✓ Estrogen Vaginal Ring;

  ✓ Prescription Contraceptives:
  Vaginal
  Injectable
  Oral
  Transdermal

How many prescriptions are allowed per month if less than a 34-day supply is prescribed? [Refer to WAC 388-530-1250]

If less than a 34-day supply, no more than two prescriptions of the same drug are allowed in any calendar month. The third fill requires prior authorization.

Exceptions:

- Over the counter contraceptives; or
- Suicidal clients or clients at risk for potential drug abuse;
- Clients being monitored by prescriber (e.g., clozapine-see page G.2).

Four fills in a calendar month are allowed for the following drugs (fifth fill will require authorization):

1. Antibiotics
2. Anti-asthmatics
3. Schedule II & III drugs
4. Antineoplastic agents
5. Topical preparations
6. Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations

Exception:

- When a client has been on the medication longer than 90 days (the time defined as "chronic") fill for a 34-day supply.

Limitations on Certain Drugs

MAA has set limits on certain drugs based on FDA-approved indications.

To view MAA's current List of Limitations on Certain Drugs
go to: http://maa.dshs.wa.gov/pharmacy

If you do not have access to the Internet, you may obtain a hard copy of MAA's List of Limitations of Certain Drugs by

Emailing:
Provider Relations Unit
providerinquiry@dshs.wa.gov

Faxing:
Provider Relations Unit
(360) 586-1209

Writing to:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562

Calling:
Provider Relations Unit
(800) 562-6188

Physicians and pharmacists should monitor the use of these drugs and counsel patients when the limits are exceeded. Prior authorization is required in order to exceed these limits.

See the Expedited Prior Authorization list (page H.5) for other limits on certain drugs.

Is it possible to receive early refills?

[Refer to WAC 388-530-1100(2)(iii)]

MAA denies refills requested before 75% of the previously dispensed supply is scheduled to be exhausted.

However, the following circumstances are justification for early refills:

- If a client's prescription is lost, stolen, or destroyed (only once every 6 months, per medication).
- If a client needs a refill sooner than originally scheduled due to a prescriber dosage change. (The pharmacist must document the dosage change.)
- If a client is suicidal, at-risk for potential drug abuse, or being monitored by the prescriber.
- If a client needs a take home supply of medication for school or camp, or for skilled nursing facility clients.

For any other circumstance, the provider must contact MAA's Pharmacy Prior Authorization Section to request approval and a prior authorization number (see Important Contacts section).

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If a client residing in a skilled nursing facility has his/her prescription lost or stolen, the replacement prescription is the responsibility of the skilled nursing facility. Clients who experience difficulties in managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

BILLING:

Hard copy billers must enter one of the following justifications in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].

Electronic billers must enter one of the following justification identifiers in the following position, accordingly:

Tape format .... in the 46th position of the HD record
EMC format.............................. in the 54th position of the HD record
Multi-insurer format................. in the 79th position of the P3 record

Point-of-Sale billers must enter one of the following comments in the Prior Authorization/Medical Certification Code & Number field.

Hard copy	Electronic Billers	POS Billers
"Involuntary Treatment Act (ITA)"	I	5
"Lost or Stolen Drug Replacement"	S	5
"School or Camp"	Q	8
"Monitoring"	Q	8
"Suicidal Risk (SR)"	Q	8
"Take Home Supply (Skilled Nursing Facility Client)"	Q	8

Emergency fills [Refer to WAC 388-530-1250(6)]

In emergent situations, pharmacists may fill prescription drugs that require authorization without an authorization number. Justification for the emergency fill must be provided to MAA no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

Please refer to Section G: Authorizations.

Which drugs may be dispensed without a prescription?
[Refer to WAC 388-530-1100(4)]

MAA covers specific over-the-counter (OTC) family planning drugs, devices, and supplies without a prescription. The following OTC contraceptives may be dispensed without a prescription to any MAA client with a current DSHS Medical ID card:

- Condoms (including female condom)
- Vaginal spermicidal foam with applicator and refills
- Vaginal jelly with applicator
- Vaginal creams and gels
- Vaginal suppositories

BILLING:
Pharmacies may bill MAA fee-for-service using the product specific NDC number and prescribing provider number **9777707**. Regardless of the contraceptive, please bill the NDC as stated on the package.

Generic drugs

Prescribers and pharmacies should prescribe and dispense the generic form of a drug, whenever possible. Prior authorization may be required for reimbursement of brand name drugs at brand name pricing when a generic equivalent is available. If the brand name drug is prescribed instead of a generic equivalent, the prescriber must provide medical justification for the use of the brand name drug to the pharmacist. Prior authorization is based on medical need such as adverse reactions (clinically demonstrated, observed and documented) which have occurred when the generic drug has been used.

Generic drugs should be substituted for listed brand name drugs when:

- They are approved by the FDA as therapeutically equivalent drugs; and
- They are permitted by the prescribing physician under current state law.

To request authorization, call MAA's Drug Utilization and Review at 1-800-848-2842.

See Section F for Therapeutic Consultation Service guidelines.

Voluntary Cost Per Milligram (mg) Savings

MAA has identified medications that result in cost savings when dispensed in the lower cost per milligram form. Therefore, MAA asks pharmacists to dispense the following drugs in the least costly per milligram (mg.) dose by splitting higher dosage tablets in half.

Drug Name	Required Dosage	Tablet to split
Effexor	25 mg	50 mg
Effexor	37.5 mg	75 mg
Effexor	50 mg	100 mg
Paxil	10 mg	20 mg
Serzone	50 mg	100 mg
Zoloft	50 mg	100 mg

Splitting Requirements

When dispensing medications listed above, exact dosing must be clearly explained and emphasized as part of client counseling. Do not ask the client to split medications. Pharmacists **must** split medications for clients.

Pharmacists are reminded of their professional obligation to inform the prescriber when changes have been made in dispensing the prescription. MAA encourages prescribers to consider this pharmacy program savings effort when writing prescriptions.

Less-Than-Effective drug index

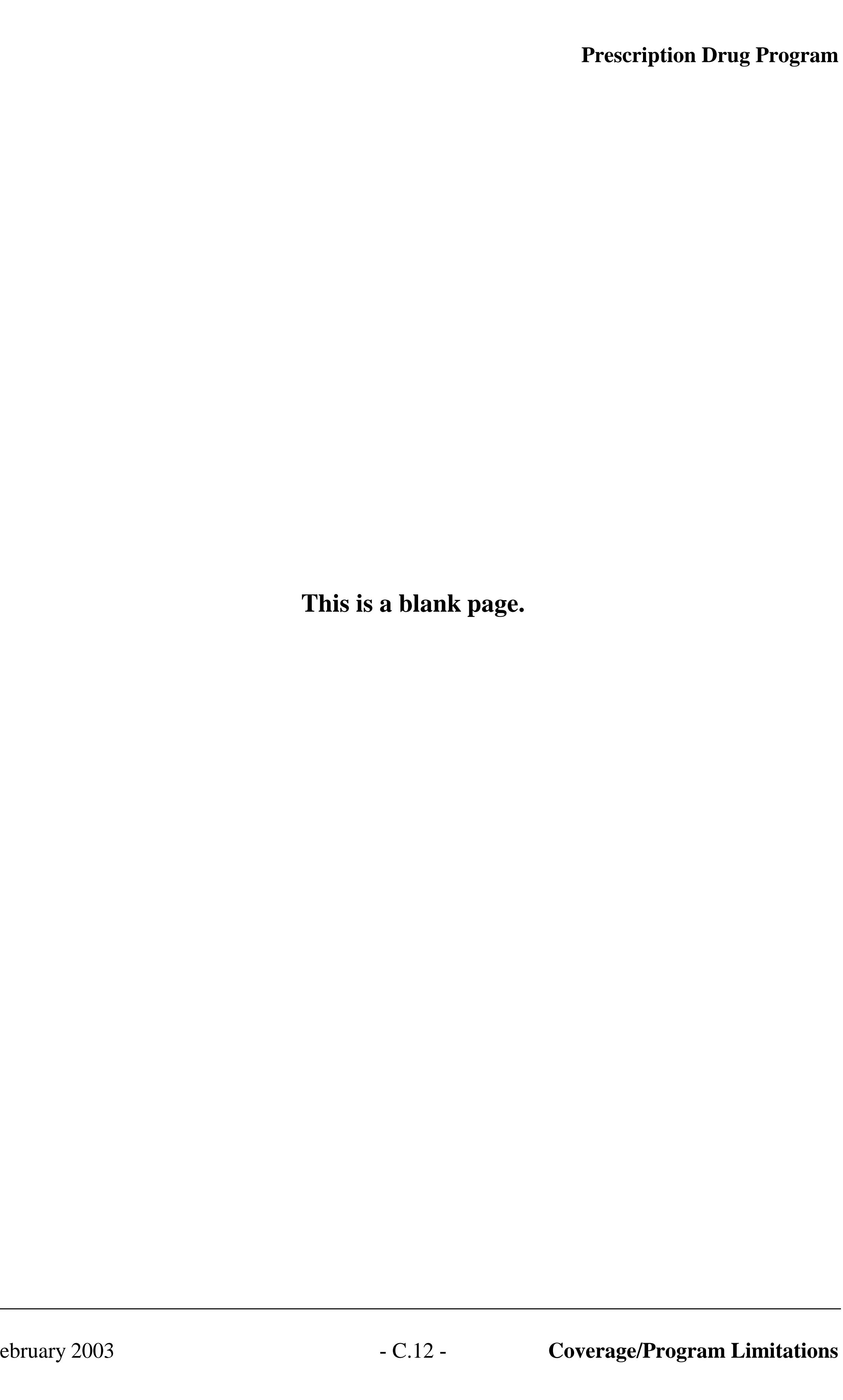
Follow the link below to view drugs classified by the Food and Drug Administration (FDA) as Less-Than-Effective (DESI) drugs. *The pharmacist assumes full responsibility for prescriptions filled with less-than-effective drugs. MAA does not reimburse for such prescriptions.*

FDA classifications of specific drug indications abstracted from the *Federal Register* and listed are based on findings by the National Academy of Sciences/National Research Council (NAS/NRC) Drug Efficacy Study.

When a drug is reviewed by the FDA, a Notice of Opportunity for a Hearing (NOOH) and the date of that notice are published in the *Federal Register*. Once the FDA's final determination of ineffectiveness is made, MAA will immediately stop payment for a Less-Than-Effective drug, retroactive to the NOOH date originally published in the *Federal Register*.

MAA does not reimburse for a drug's trade name or dosage form if, by its generic makeup and route of administration, it is identical, similar, or related to a drug on the Less-than-Effective drug index.

To view the Centers for Medicare and Medicaid's Less-Than-Effective list, go to: http://cms.hhs.gov/medicaid/drugs.



This is a blank page.

Compliance Packaging

The Medical Assistance Administration (MAA), the Home Care Association of Washington (HCAW) and the Washington State Pharmacy Association (WSPA) developed the following guidelines in a cooperative effort to improve drug therapy outcomes for the most *"at-risk"* segment of the Medical Assistance population.

What is included in compliance packaging?
[Refer to WAC 388-530-1625(2)]

Compliance packaging includes:

- Reusable hard plastic containers of any type (e.g., Medisets, weekly minders, etc.); and
- Nonreusable compliance packaging (e.g., blister packs, bingo cards, bubble packs, etc.).

How do I determine if a client is eligible for compliance packaging? **[Refer to WAC 388-530-1625(1)]**

Prescribers are encouraged to communicate to high-risk clients the need for compliance packaging if, in their professional judgement, such packaging is appropriate.

Clients will be considered high-risk and eligible to receive compliance devices if they:

- **Do not reside** in a skilled nursing facility or other inpatient facility; **and**
- Have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or tuberculosis.

-AND-

- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day; **or**
- Have demonstrated a pattern of noncompliance that is potentially harmful to the client’s health. The client’s pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider’s file.

Prefilling a syringe is not considered compliance packaging.

How do I bill for compliance packaging?

To bill for compliance packaging:

1. Bill on a HCFA-1500 claim form.
2. Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.
3. Use the following procedure codes, as appropriate.

Procedure Description	Procedure Code	Maximum Allowable
Reusable compliance device or container	4800A*	$6.00 maximum per device (limit of 4 per client, per year).
Reusable compliance device or container, extra large capacity	4804A*	$16.91 maximum per device (limit of 4 per client, per year).
Filling fee for reusable compliance device or container	4801A	$2.50 per fill (limit of 4 fills per client, per month).
Nonreusable compliance device or container	4802A	$3.00 (limit of 4 **fees** per client, per month) Includes reimbursement for materials and filling time. Bill one unit each time compliance packages are filled.

* May be billed in combination but not to exceed a total of 4 per year.

Written requests for a limitation extension should be sent to:

Division of Medical Management
Pharmacy Research Specialist
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Compounded Prescriptions

What is compounding? [Refer to WAC 388-530-1500(1)(3)]

Compounding is the act of combining two or more **active** ingredients or the adjustment of therapeutic strengths and/or forms by a pharmacist in the preparation of a prescription. MAA does not consider drug reconstitution to be compounding. MAA reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

☞ **Note:** The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

Which items are <u>not</u> covered for compounding?
[Refer to WAC 388-530-1500(2)]

- Coloring agents, preservatives, and flavoring agents used in compounded prescriptions **except** when they are necessary as a complete vehicle for compounding (e.g., simple syrup).

- Ingredients manufactured by a company who has not signed a federal rebate agreement, except as specified below.

  MAA reimburses for compounding ingredients from the following noncontract, chemical supply companies:

  <u>Labeler Code/Company</u>

  00395 Humco Labs
  00802 Emerson Labs
  10106 J T Baker
  17317 Amend
  49452 A-A Spectrum

  MAA does not reimburse other chemical supplier's products unless the companies allow the state access to their product codes and pricing files (OBRA 90, Section 1927). The company that supplies the compound ingredient has the responsibility to provide an 11-digit NDC for each of its products.

Is prior authorization required for compounded prescriptions? [Refer to WAC 388-530-1500(5)(b and c)]

Drugs appearing in the **following list do not require prior authorization** when used as ingredients in compounded prescriptions, even if they require prior authorization for other uses.

Note: If the drug does not appear in the following list, MAA applies current authorization requirements to drugs used as ingredients in compounded prescriptions. Drugs that require prior authorization for payment from MAA require prior authorization whether they are used independently or as an ingredient in a compounded prescription. MAA denies payment for a drug requiring prior authorization used as an ingredient in a compounded prescription when prior authorization was not obtained.

Acetominophen powder
Aluminum Chloride
Aminophylline
Aminosyn Solution
Aquaphor Ointment
Aromatic Elixir
Boric Acid
Calamine Phenolated
Camphor
Capsules, Empty
Cefobid
Cefotan
Cetaphil
Cherry Syrup
Colloidion liquid
Desonide
Dopamine HCL in 5% Dextrose
Erythromycin suspension
Eucalyptus Oil
Eucerin Cream
Eucerin Plus
Floxin I.V.
Fungizone
Glycerin (non-suppository)
Green Soap
Heparin Sodium, Solution
Hydrocortisone Cream
Hydrocortisone Lotion
Hydrocream Base
Hydrophilic Base
Isoproterenol HCL
Kerodex 51
Kerodex 71
Lac-Hydrin Lotion
Lactated Ringers
Lactose
Lanolin Anhydrous, plain
Lanolin Hydrous, plain
Lidocaine
Menthol
Methylcellulose
Miconazole Nitrate Cream
Moisturel
Nitroglycerin
Oxacillin
Phenol
Podophyllum Resin
Polyethylene Glycol Base
Polytar Shampoo
Potassium Iodide
Salicylic Acid Crystals
Salicylic Acid Powder
Simple Syrup
Sodium Chloride
Sodium Petrolatum
Sulfur Powder
Tannic Acid Powder
Tazicef in Dextrose
Theophylline in 5% Dextrose
Thymol
Tobramycin Sulfate
Travasol
Urea
Vitamin A & D Ointment
Xylocaine
Zinc Oxide

Note: OTC products used for compounding are included in the nursing facility per diem and are not reimbursed for by MAA.

How do I bill for compounded prescriptions

[Refer to WAC 388-530-1500(4)(5)]

- Pharmacies must bill separately for ingredients used for compounded prescriptions using the 11-digit NDC for each ingredient.
- Bill only the quantity used for that ingredient. **Do not bill the combined total quantity.**
- Bill **each** ingredient with a “2” in the compound code field.

MAA reimburses a dispensing fee for each ingredient. The additional dispensing fees are payment for the pharmacist's compounding time. MAA does not pay a separate fee for compounding time or preparation fees.

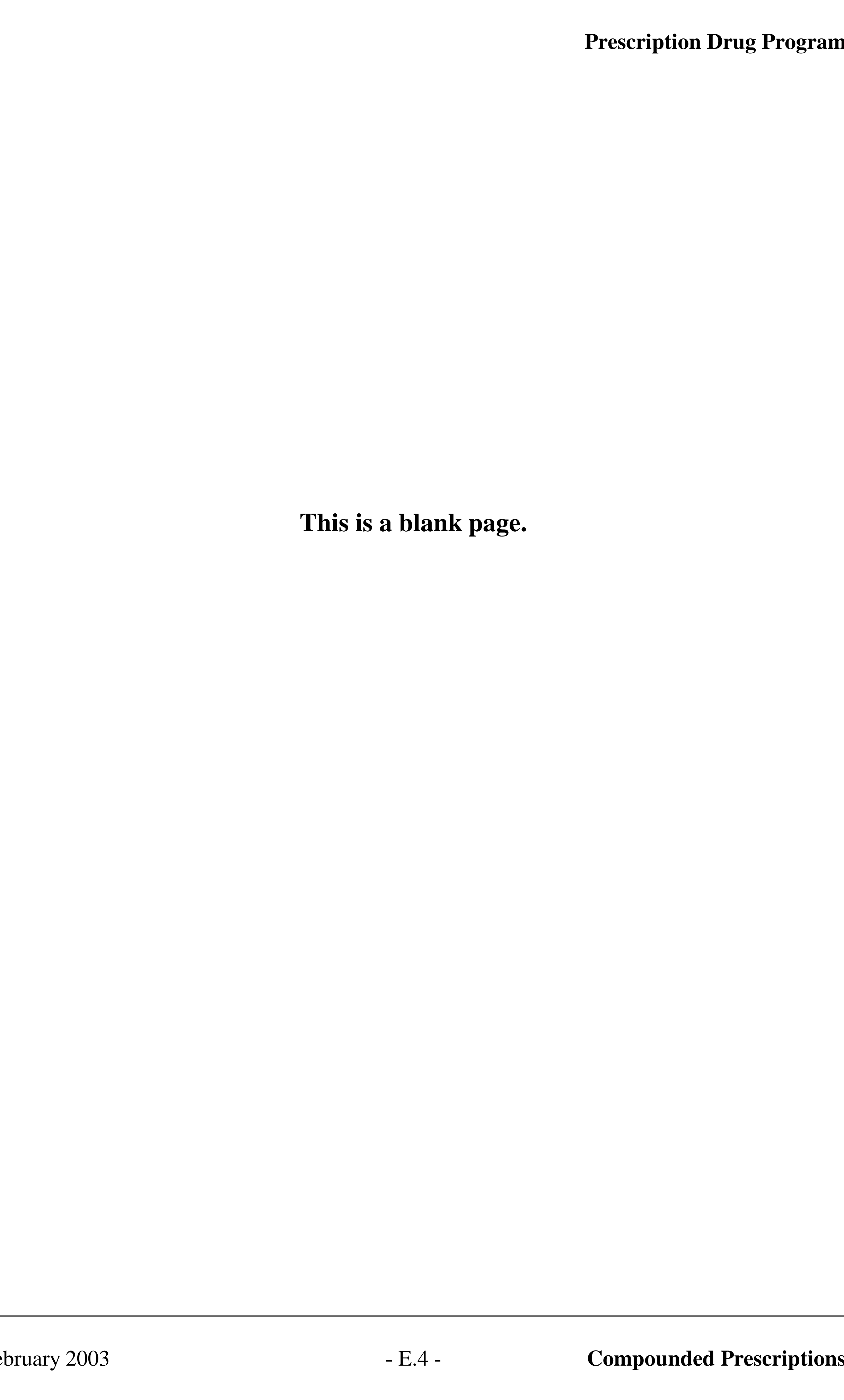
BILLING:

Electronic billers must enter a “2” in the following position, accordingly:

Tape format .... in the 46th position of the HD record
EMC format.......................... in the 54th position of the HD record
Multi-insurer format............. in the 79th position of the P3 record

Hard copy billers must enter “Compound Prescription” in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers must enter a “2” in the Compound Code field.



This is a blank page.

Therapeutic Consultation Service (TCS)

[Refer to WAC 388-530-1260]

Overview of TCS

MAA provides a complete drug profile review for each client when a drug claim for that client triggers a TCS consultation. The purpose of TCS is to facilitate the appropriate and cost-effective use of prescription drugs. MAA-designated clinical pharmacists review profiles in consultation with the prescriber or the prescriber's designee by telephone.

TCS occurs when a drug claim:

- Exceeds four brand name prescriptions per calendar month; or
- Is for a nonpreferred drug within MAA's selected therapeutic classes (see MAA's Preferred Drug List on page F.2). **This does not apply to the Voluntary Preferred Drug List.**

When a pharmacy provider submits a claim that exceeds the TCS limitations for a client, MAA generates a Point-of-Sale (POS) computer alert to notify the pharmacy provider that a TCS review is required. The computer alert provides a toll-free telephone number (866) 246-8504 to the pharmacy for the prescriber or prescriber's designee to call.

Drugs excluded from the four brand name prescription per calendar month review

Drugs excluded from the four brand name prescription per calendar month review:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Chemotherapy drugs
- Contraceptives
- HIV medications
- Immunosuppressants
- Hypoglycemia rescue agents
- Generic drugs

Preferred Drug List

MAA chooses a drug or drugs from a selected therapeutic class for placement on the preferred list when:

- There is evidence that one drug has superior safety, efficacy, and effectiveness compared to others in the same drug class; or
- The drugs in the class are essentially equal in terms of safety and efficacy; and
- The selected drug or drugs may be the least costly in the therapeutic class.

Preferred Drug List

Selected Therapeutic Drug Class	Preferred Drug(s)
Histamine H2 Receptor Antagonist (H2RA)	Ranitidine
Proton Pump Inhibitors (PPIs)	Protonix® or Prevacid®

Voluntary Preferred Drug List

The following drug classes are voluntary preferred drugs that will be suggested to prescribers during TCS consultation. Non-preferred drugs in these drug classes will not trigger a review unless the request is the fifth request for a brand name drug in a calendar month.

Selected Therapeutic Drug Class	Preferred Drug(s)
Non-sedating antihistamines	Generic loratidine
Statin-type cholesterol-lowering agents	LDL lowering $\leq$30% = generic lovastatin LDL lowering $\geq$31% through 40% = Zocor® (first choice) or Lipitor® (second choice) LDL lowering $\geq$41% = Lipitor®. Pravachol® may be used when drug-drug interactions with concurrent drug therapy are likely (gemfibrozil, protease inhibitors)
Angiotensin-Converting Enzyme Inhibitors (ACE-I)	Generic captopril, enalapril and lisinopril

What should I do when I get a POS computer alert for a TCS review?

Important Reminders:

- Physicians may have their designee call (866) 246-8504 for TCS consultations.

- Physicians or their designees may call for TCS consultations during the following time periods (Pacific Time):

Monday through Friday	8:00 am to 6:00 pm
Saturday	8:00 am to 1:00 pm

- If the TCS consultation cannot take place because the prescriber or prescriber's designee is unavailable, the pharmacy provider has the option to dispense an emergency supply of the requested drug. (Refer to page C.9 for information on emergency dispensing.)

- Pharmacy staff must call 1-866-246-8504 for authorization to fill prescriptions written by emergency room physicians that trigger the TCS edits. Do not ask emergency room physicians to call TCS.

- As drugs are added to the Preferred Drug List, their Expedited Prior Authorization (EPA) codes are no longer valid.

- Prescribers are requested to provide their DEA numbers to pharmacies.

- Pharmacists must include the MAA provider number or presciber's DEA on all MAA pharmacy claims.

- Prescriptions for clients residing in skilled nursing facilities are not subject to TCS edits. However, MAA may retrospectively review the clients' drug profiles.

Pharmacy Requirements:

- The pharmacy provider must notify the prescriber that the prescriber or prescriber's designee must call the TCS toll-free telephone number (866) 246-8504 to begin a TCS consultation. Emergency room physicians are not to be contacted; pharmacy staff must call TCS instead.

Prescriber Provider Requirements:

- When the pharmacy provider contacts the client's prescriber, the prescriber or prescriber's designee must call the TCS toll-free telephone number (866) 246-8504 to begin a TCS review.

- After the prescriber or prescriber's designee and the MAA-designated clinical pharmacist review the client's drug profile and discuss clinically sound options and cost-effective alternative drug(s), the prescriber(s) may choose to do one of the following:

  - ✓ Change the prescription to an alternative drug or preferred drug and contact the client's pharmacy with the new prescription; or

  - ✓ Provide the MAA designee with the medical justification and continue with the brand-name drug; or

  - ✓ Not agree to prescribe an alternative drug or preferred drug and not provide medical justification for the requested drug. In this case:

    - ➢ The MAA designee authorizes a one-month supply of the requested drug with no refills and sends the initiating prescriber a copy of the client's drug profile and a therapy authorization turnaround form.

    - ➢ The prescriber signs the therapy authorization turnaround form and returns it to the MAA designee.

    - ➢ Upon receipt of the therapy authorization turnaround form, the MAA designee authorizes the prescription for up to 12 months, depending on the legal life of the prescription.

Special Programs/Services

Smoking Cessation for Pregnant Women

The Medical Assistance Administration (MAA) reimburses eligible providers for including smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

- ✓ MAA covers Zyban® only;
- ✓ The product must be prescribed by a physician, ARNP, or physician assistant;
- ✓ The client for whom the product is prescribed must be 18 years of age or older;
- ✓ The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and
- ✓ The prescribing provider must include both of the following on the client's prescription:
  - ➢ The client's estimated or actual delivery date; and
  - ➢ Indicate that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

Clozaril/Clozapine and Related Services

MAA reimburses pharmacists for Clozaril/Clozapine plus a dispensing fee.
Bill Clozaril/Clozapine using the appropriate NDC on either the POS system or the Pharmacy Statement [DSHS 13-714]. The DSHS 13-714 form is available for electronic download at: http://www.wa.gov/dshs/dshsforms/forms/eforms.html.

Any licensed or registered pharmacist with clinical experience in monitoring patient mental and health status may provide and bill case coordination (medication management) for clients receiving Clozaril/Clozapine.

Persons providing case coordination serve as a focal point for the client's Clozaril/Clozapine therapy. All services must be documented and are subject to quality assurance review. Case coordinators are expected to:

- Coordinate a plan of care with the client or the client's caregiver, the prescriber, and the pharmacy;
- Assure services are provided to the client as specified in the plan of care;
- Assure weekly blood samples are drawn, blood counts are within normal range, and client is compliant with plan of care;
- Follow-up with the client on missed medical appointments;
- Maintain detailed, individual client records to document progress;
- Provide feedback to the prescriber on the client's progress, immediately report abnormal blood counts, and client non-compliance; and
- Assure smooth transition to a new case coordinator, when necessary.

Use the following procedure codes to bill for Clozaril/Clozapine related services on a HCFA-1500 claim form or the appropriate electronic format:

Procedure Code	Description	Reimbursement
36415	Routine Venipuncture	per RBRVS fee schedule
0857J	Case Coordination	$10 per week, per client
85022[1]	Blood Count (CBC)	per RBRVS fee schedule

☞ **Note:** Due to close monitoring requirements, MAA allows up to five (5) fills per month.

CPT™ is a registered trademark of the American Medical Association.
CPT® codes and descriptions are copyright 2002 American Medical Association.

[1] **Can be billed by CLIA certified laboratories only.**

Emergency Contraception Pills (ECP)

Emergency contraception pills are reimbursable through the MAA Point-of-Sale (POS) prescription drug system. To receive payment, pharmacies must bill MAA fee-for-service using the specific NDC and prescribing provider number 9777707. Pharmacies who are members of, or subcontract with, managed care plans must bill the prescription cost to the plans. MAA reimburses pharmacists for ECP plus a dispensing fee. Bill ECP using the appropriate NDC.

Emergency Contraception (EC) Counseling

When a pharmacist with an EC protocol approved by the Board of Pharmacy prescribes ECPs, the pharmacy may bill MAA for the counseling portion.

Prior to billing for EC counseling, MAA must have a letter or fax on file requesting reimbursement for EC counseling along with a copy of the pharmacist's approved protocol certificate from the Board of Pharmacy.

The request must state, "*Attached is the approved protocol certificate from the Board of Pharmacy,*" and must include the pharmacy's MAA provider number. Send the initial request and certificate copy to:

Medical Assistance Administration
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562
FAX: (360) 586-1209

Use the following procedure code and diagnosis code to bill for EC counseling.

Diagnosis Code	Description	State-Unique Procedure Code	Maximum Allowable
V25.09 Contraceptive Management	EC Counseling	4805A	$13.50

The counseling is a service-related item, not a drug, and must be billed on a HCFA-1500 claim form. The pharmacy must use its MAA-assigned provider number (beginning with a "6"), not the National Association of Boards of Pharmacy (NABP) number. The prescribing provider number 9777707 must be entered in *Referring Provider field* (field 17a), and diagnosis code V25.09 (contraceptive management) must be used.

Anti-emetics

Pharmacists with prescriptive authority for emergency contraception pills may prescribe and bill for selected anti-emetics only when these drugs are dispensed in conjunction with emergency contraception pills. MAA will reimburse the following only when they are prescribed and dispensed in the strength/dose form listed:

Meclizine hydrochloride	25 mg tablets
Diphenhydramine hydrochloride	25 mg tablets/capsules
Dimenhydrinate	50 mg tablets
Promethazine hydrochloride	25 mg tablets or 25 mg suppository
Metoclopramide	5 mg, 10 mg tablets
Prochlorperazine	25 mg suppository

Patient Requiring Regulation (PRR) Program

[Refer to WAC 388-501-0135]

PRR is a health and safety program for clients needing help in the appropriate use of medical services.

A client in PRR is restricted to one primary care provider (PCP) and one pharmacy. Enrollment in the PRR program is for two years, after which a review is conducted to determine if the restriction will be lifted or if it is necessary for the client's enrollment in the program to be continued for another year. Clients enrolled in the PRR program are identified with an **"X"** in the **Restricted** column of the client's Medical Identification card.

PRR criteria:

- Any three of the following conditions have been met or exceeded in a 90-day period:
  - ✓ Two emergency room visits;
  - ✓ Four different physicians;
  - ✓ Ten prescriptions;
  - ✓ Four pharmacies; or
  - ✓ Four prescribers.

-OR-

- Client has made repeated and documented efforts to seek unnecessary health services; and
- Client has been counseled at least once by a health care provider about the appropriate use of health care services.

For more information, or to report over-utilization of services, contact:

PRR Program
PO Box 45532
Olympia, WA 98504-5532
(360) 725-1780
FAX (360) 753-0286

Prescription Service by Mail

Medco Health Solutions Inc., a national prescription benefits manager, holds a provider agreement with the Medical Assistance Administration (MAA) to distribute prescription drugs by mail. There is no charge to providers or clients for this service.

Medco Health operates a dozen licensed pharmacies in the U.S. In Washington State, the Medco Health pharmacy is located in Spokane.

Clients should check with their primary care physician first if they are interested in the home delivery option.

How to Submit Prescriptions

Prescribers can fax, or telephone prescriptions to Medco Health. Use the Prescription Fax Form when faxing a prescription to Medco Health (go to: http://maa.dshs.wa.gov/rxbymail to download form). Put the client's Patient Identification Code (PIC) in Step 1 under Prescription Drug Card Member #. The client's PIC is located in the upper left corner of the client's Medical ID card.

Clients can mail their prescriptions directly to Medco Health. For new prescriptions, two forms must be completed initially and mailed to Medco Health. The first form includes identification and eligibility information. The second provides brief health history information for the Home Delivery pharmacists. Go to: http://maa.dshs.wa.gov/rxbymail to download forms.

Delivery Options

Most medications dispensed by Medco Health are delivered by mail. Delivery usually takes from 7 to 10 days. For security reasons, certain medication(s) may need to be shipped by parcel service or certified mail. Medco Health will not provide "expedited shipping" options for Medical Assistance clients. This option is used by some health care plans, but requires customers to pay the additional charges. Medical Assistance does not allow its clients to be assessed this kind of fee.

Expanded Days Supply

If the client is using the mail-order service, certain drugs may be dispensed for up to a 90-day supply (except schedule II-V). These include preferred drugs as listed in the Therapeutic Consultation Service program, generic drugs, and drugs that do not require prior or expedited prior authorization. Prescribers must indicate a 90-day supply on the submitted prescription.

Refills

Prescribers can authorize refills for up to one year; clients receive a reorder slip along with their medication. The slip must be mailed back to Medco Health, with refills usually taking about eight days. Medco Health recommends that its customers mail in their reorder slip when approximately two weeks of the existing prescription remain.

Customer Support

Toll-free support for prescribers…………………………………………... 1-888-327-9791

Medco Health, 24-hours a day, 7 days a week
(except Thanksgiving and Christmas) toll-free support for clients……… 1-800-903-8639

Internet information for providers ………………………………........ www.medcohealth.com

MAA Customer Service Center, Olympia, 7 a.m.- 6 p.m., M-F………….. 1-800-562-3022

MAA Web site - explains this program, answers frequently
asked questions, and has downloadable forms ………………….. http://maa.dshs.wa.gov/rxbymail

This is a blank page.

Authorization

Authorization does not guarantee payment.
All administrative requirements (client eligibility, claim timeliness, etc.) must be met before MAA reimburses.

Who determines authorization status for drugs in MAA's drug file? [Refer to WAC 388-530-1200(1)]

MAA pharmacists, medical consultants, and the drug utilization review team evaluate drugs to determine authorization status on the drug file. MAA may consult with a drug evaluation unit, the Drug Utilization and Education (DUE) Council, and/or participating MAA providers in this evaluation.

How are drugs added to MAA's drug list?
[Refer to WAC 388-530-1200(2)(3)]

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the MAA pharmacist(s) a written request and the following supporting documentation:

- Background data about the drug;
- Product package information;
- Any pertinent clinical studies;
- Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process; and
- Any additional information the manufacturer considers appropriate.

MAA evaluates a drug based on, but not limited to, the following criteria:

- Whether the manufacturer has signed a federal drug rebate contract agreement;
- Whether the drug is a less-than-effective drug;
- The drug's risk/benefit ratio;
- Whether like drugs are on MAA's drug file list and there are less costly therapeutic alternative drugs;
- Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage;
- The drug's potential for abuse; and
- Whether outcome data demonstrate that the drug is cost effective.

Prior authorization/reject edit conflict codes

The following table indicates the type of Reject Edit/Conflict Code providers will receive if they submit a POS claim for a drug that requires a prior authorization (PA) number.

REJECT EDIT/ CONFLICT CODE	REASON REJECTED	ACTION
30 Missing/invalid MC code. PA Required	Expedited drugs requiring prior authorization.	Pharmacy must submit using appropriate EPA code or call MAA for PA.
75 PA Required	Medications that require prior authorization.	Pharmacy must call MAA for PA.

Prior authorization

When does MAA require prior authorization?
[Refer to WAC 388-530-1250(2)]

Pharmacists are required to obtain prior authorization for many drug products and items ***before*** providing them to the client. MAA reviews authorization requests for medical necessity. The requested service or item must be covered within the scope of the client's program.

Exception:

- In emergent situations, pharmacists may fill prescription drugs that require authorization without an authorization number. Justification for the emergency fill must be provided to MAA no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

How do I obtain prior authorization?

Prior authorization for drug products requiring prior authorization may be obtained by calling: **1-800-848-2842**

What information should a pharmacist have ready before calling MAA for an authorization number?

When calling for an authorization number, pharmacists must have the following information ready:

1. Previous prior authorization number, if available;
2. Pharmacy NABP #;
3. Client's Patient Identification Code (PIC;)
4. National Drug Code (NDC) being dispensed;
5. Prescriber's name and specialty (if known);
6. Justification for the requested service. Describe the medical need for the drug and/or dosing and diagnosis or condition of the client;
7. Date(s) of dispense.

MAA may request additional information, depending on the drug product.

Drugs that do not require prior authorization

To view MAA's current list of
Drugs that do not require prior authorization
go to:
http://maa.dshs.wa.gov/pharmacy

If you do not have access to the Internet, you may obtain a hard copy of MAA's Drugs that do not require prior authorization by:

Emailing:
Provider Relations Unit
providerinquiry@dshs.wa.gov

Faxing:
Provider Relations Unit
(360) 586-1209

Writing to:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562

Calling:
Provider Relations Unit
(800) 562-6188

Follow the link above to view a list of drugs that **do not** require prior authorization. The list is provided in alphabetical order.

IMPORTANT: Products on this list are **subject to all other coverage rules**.

If the product **is not** listed, be sure to check the following **before** calling for prior authorization:

- Is the drug listed in MAA's Expedited Prior Authorization list?
- Check the participating drug rebate manufacturer list and verify effective date. If the manufacturer/labeler is not on the list or the manufacturer is terminated, the drug is **not** reimbursable by MAA. *(See list of exceptions in the Reimbursement section under Drug Rebate of these billing instructions.)*
- Is this drug included in the nursing facility per diem?
- Is the drug designated less-than-effective by FDA?
- Is the drug obsolete or terminated?

For drugs requiring authorization, refer to Prior Authorization – page H.3.

Expedited prior authorization (EPA)
[Refer to WAC 388-530-1250(4)]

What is the EPA process?
MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

How is an EPA number created?
To bill MAA for drugs that meet the expedited prior authorization (EPA) criteria on the following pages, the pharmacist must create a 9-digit EPA number. The first six digits of the EPA number must be **850000.** The last 3 digits must be the code number of the diagnosis/condition that meets the EPA criteria.

BILLING: Enter the EPA in:

When Billing	Field
Point of Sale	*PA/Med Cert Code*
Electronically	*Authorization* or *Comments*
Hardcopy Pharmacy Statement	*Authorization Number*

Example: The 9-digit EPA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **850000002** (850000 = first six digits, 002 = diagnosis/condition code).

Pharmacists are reminded that EPA numbers are only for those drugs listed <u>on the following pages</u>. They are not valid for:

- Other drugs requiring prior authorization through the Prescription Drug Program;
- Waiving the MAC price; or
- Authorizing the third or fifth fill in the month.

Note: Use of an EPA code does not exempt claims from Therapeutic Consultation Services (TCS) edits. See Section F.

Expedited Prior Authorization Guidelines:

A. **Diagnoses -** Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet conditions for EPA. Drug claims submitted without an appropriate diagnosis/condition code for the dispensed drug are denied.

B. **Unlisted Diagnoses - If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EPA list, the pharmacist must call the Pharmacy Prior Authorization toll-free number at 1-800-848-2842 to request authorization.**

C. **Documentation** - Dispensing pharmacists must write on the original prescription the full name of the person who provided the diagnostic information and the diagnosis/condition and/or the criteria code from the attached table. Documentation must be kept on file for six (6) years.

Drug	Code	Criteria
Abilify® *(Aripiprazole)*	015	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **18** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Accutane® *(Isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while under-going treatment. The following conditions must be **absent:** a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
Actonel® *(Risendronate Sodium)*	142	Treatment of Paget's disease of the bone at doses of 30mg per day for two months. Retreatment may be necessary with same dose duration.
	143	Prevention of osteoporosis in post-menopausal women at doses of 5mg per day when hormone replacement is contraindicated.
	144	Treatment of osteoporosis in post-menopausal women at doses of 5mg per day.
	146	Prevention and treatment of glucocorticoid-induced osteoporosis in men and women at doses of 5mg per day.
	148	Prevention and treatment of osteoporosis in post-menopausal women at doses of 35mg per week.
Adderall® *(Amphetamine/ Dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Patient is **3** years of age or older.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.

Drug	Code	Criteria
Adderall XR® *(Amphetamine/ Dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Patient is **6** years of age or older; and c) Total daily dose is administered as a single dose.
Adeks® Multivitamins	102	For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all of the following: a) Patient is under medical supervision; and b) Patient is not taking oral anticoagulants; and c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.
Advil® Suspension *(Ibuprofen suspension)*	038	Diagnosis of chronic inflammatory disease or syndrome such as Juvenile Rheumatoid Arthritis (JRA).
	073	Diagnosis of chronic pain and all of the following: a) Patient is **12** years of age or older; and b) Cannot swallow tablets; and c) Is intolerant to aspirin drug therapy.
	074	Diagnosis of chronic pain or sustained fever and all of the following: a) Patient is between six months and **12** years of age; and b) The patient has tried and failed acetaminophen elixir.
Aggrenox® *(Aspirin/ Dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Allegra® *(Fexofenadine)*	061	Treatment of symptoms associated with allergic rhinitis.
Allegra D® *(Fexofenadine/ pseudoephedrine)*	062	Diagnosis of chronic idiopathic urticaria.
Ambien® *(Zolpidem tartrate)*	006	Short-term treatment of insomnia. Drug therapy is limited to a one month supply, after which the patient must be re-evaluated by the prescriber before therapy can be continued.

Drug	Code	Criteria
Amiodarone	010	Prescribed or recommended by a cardiologist/internist.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Atacand® (Candesartan cilexetil)
Atacand HCT® (Candesartan cilexetil/HCTZ)
Avalide® (Irbesartan/HCTZ)
Avapro® (Irbesartan)
Benicar® (Olmesartan medoxomil)
Cozaar® (Losartan potassium)
Diovan® (Valsartan)
Diovan HCT® (Valsartan/HCTZ)
Hyzaar® (Losartan potassium/HCTZ)
Micardis® (Telmisartan)
Micardis HCT® (Telmisartan/HCTZ)
Teveten® (Eprosartan mesylate)
Teveten HCT® (Eprosartan mesylate/HCTZ)

Drug	Code	Criteria
Anzemet® *(Dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Aredia® *(Pamidronate disodium)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases.
	016	Treatment of Paget's disease of the bone.
Aricept® *(Donepezil)*	022	Treatment of dementia of the Alzheimer's type according to the criteria established by the National Institute of Neurological Disorders and Stroke/Alzheimer's Disease Related Disorders Association (NINDS/ADRDA).
Avonex® *(Interferon beta 1-A)*	119	Prescribed by, or in consultation with a neurologist, for the treatment of relapsing multiple sclerosis (MS).
Azelex® *(Azelaic acid)*	101	Diagnosis of acne vulgaris in patients **12** years of age or older.
Betapace® *(Sotalol)*	010	Prescribed or recommended by a cardiologist/internist.
Betaseron® *(Interferon beta 1-B)*	012	Prescribed by, or in consultation with a neurologist, and clinically confirmed and/or laboratory/ imaging-confirmed diagnosis of relapsing/remitting multiple sclerosis (MS) and patient must be ambulatory.
Bextra® *(Valdecoxib)*		Before any code is allowed, there must be an absence of all of the following: a) Sulfa allergy; and b) Rash
	078	Diagnosis of osteoarthritis or rheumatoid arthritis in patients **18** years of age or older. Dose limited to 10mg per day.
	079	Treatment of primary dysmenorrhea in patients **18** years of age or older. Dose limited to 20mg per day.
Calcimar® *(Calcitonin-salmon)*	016	Treatment of Paget's disease of the bone.
	017	Treatment or prevention of postmenopausal osteoporosis.
	123	Treatment of hypercalcemia.

Drug	Code	Criteria
Calcium w/vitamin D	126	Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.
Celebrex® *(Celecoxib)*		Before any code is used, please confirm patient is not allergic to sulfa drugs.
	139	Diagnosis of osteoarthritis in patients **18** years of age or older. Dose limited to 200mg or less per day.
	140	Diagnosis of rheumatoid arthritis in patient **18** years of age or older. Dose limited to 400mg or less per day.
	145	Diagnosis of colorectal polyps. Dose limited to 400mg or less per day.
	147	Diagnosis of acute pain, including primary dysmenorrhea, in patients **18** years of age or older. Dose is limited to a maximum of 600mg the first day and a maximum of 400mg on subsequent days.
Children's Advil® *(Ibuprofen)*		See criteria for Advil® Suspension.
Clarinex® *(Desloratadine)*		See criteria for Allegra®.
Claritin® *(Loratadine)* **Claritin-D®** *(Loratadine/pseudoephedrine)*		See criteria for Allegra®.

Drug	Code	Criteria
Clonazepam	099	Prescribed by, or in consultation with, a health care professional with prescriptive authority for this class of drug for psychiatric disorders meeting DSM IV diagnostic criteria on Axis I or II disorder (exclusive of disorders related to substance abuse and childhood related disorders).
	100	Prescribed for neurologic disorders including Lennox Gastaut Syndrome, akinetic and myoclonic seizures, and absence seizures which have failed to respond to succinimides or when prescribed for restless leg syndrome.
	120	Prescribed in consultation with a pain specialist for neuropathic pain.
	121	Prescribed for withdrawal syndromes for up to 30 days when related to alcohol, benzodiazepine, or barbituate use.
Clozapine Clozaril®	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is **17** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Compazine® Spansules *(Prochlorperazine maleate)*	095	Treatment of nausea and vomiting due to oncology treatment. Patient must have tried and failed Compazine® tablets or suppositories.

Drug	Code	Criteria
Concerta® *(Methylphenidate)*	149	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber, and b) Patient is **6** years of age or older.
Copaxone® Injection *(Glatiramer acetate)*	013	Prescribed by, or in consultation with a neurologist, and clinically-confirmed and/or laboratory/imaging – confirmed diagnosis of relapsing/remitting multiple sclerosis (MS).
Cordarone® *(Amiodarone)*	010	Prescribed or recommended by a cardiologist/internist.
Cyanocobalamin Injection *(Vit. B-12 Injection)*	075	For the treatment of vitamin B-12 deficiency (pernicious anemia).
Danocrine® *(Danazol)*		Before any code is allowed, there must be an absence of all of the following: a) Pregnancy b) Breast feeding c) Undiagnosed genital bleeding d) Porphyria e) Impaired hepatic, renal, or cardiac function
	023	Diagnosis of laparoscopic-proven endometriosis.
	024	Diagnosis of fibrocystic breast disease with pain/tenderness/ nodularity.
	025	Diagnosis of hereditary angioedema in males or females.
Dexedrine® *(D-Amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-Amphetamine sulfate)*		See criteria for Adderall®.

Drug	Code	Criteria
Differin® *(Adapalene)*	055	Treatment of acne vulgaris.
Enemeez® *(Docusate sodium)*		See criteria for Therevac®.
Evista® *(Raloxifene Hcl)*	017	Treatment or prevention of postmenopausal osteoporosis.
	034	Prevention of postmenopausal osteoporosis when hormone replacement therapy is contraindicated.
Exelon® *(Rivastigmine tartrate)*		See criteria for Aricept®.
Focalin® *(Dexmethylphenidate)*		See criteria for Concerta®.
Fosamax® *(Alendronate sodium)*	016	Treatment of Paget's disease of the bone.
	017	Treatment or prevention of postmenopausal osteoporosis.
	106	Treatment of osteoporosis in males.
	122	Treatment of steroid-induced osteoporosis.

Drug	Code	Criteria
Geodon® *(Ziprasidone)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
***Note:**		Because Geodon® prolongs the QT interval (> Seroquel® > Risperdal® > Zyprexa®) it is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Ibuprofen Suspension		See criteria for Advil® Suspension.
INFeD® (*Iron dextran)*	028	Diagnosis of iron deficiency and all of the following: a) Inability to tolerate any oral form of iron therapy; and b) The rate of continuing blood loss exceeds the rate at which iron can be absorbed from oral ferrous sulfate.
	029	Diagnosis of iron deficiency and all of the following: a) Inability to tolerate any oral form of iron therapy; and b) Immediate iron replacement is necessary to avoid blood product transfusions.

Drug	Code	Criteria
Infergen® *(Interferon alfacon-1)*	134	Treatment of chronic hepatitis C viral (HCV) infection in patients **18** years of age or older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	033	Diagnosis of chronic hepatitis B in patients **1** year of age or older.
	107	Diagnosis of malignant melanoma in patients **18** years of age or older.
	109	Treatment of chronic hepatits C in patients **18** years of age or older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients **18** years of age or older.
Klonopin® *(Clonazepam)*		See criteria for Clonazepam.
Kytril® *(Granisetron)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with total body or abdominal radiotherapy.

Drug	Code	Criteria
Marinol® *(Dronabinol)*	035	Diagnosis of cachexia associated with AIDS.
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD®		See criteria for Concerta®.
Miacalcin® *(Calcitonin-salmon)* **Miacalcin Nasal Spray®** *(Calcitonin-salmon)*		See criteria for Calcimar®.
Miralax® *(Polyethylene glycol 3350)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Motrin® Suspension *(Ibuprofen suspension)*		See criteria for Advil® Suspension.
Naltrexone		See criteria for ReVia®.
Nembutal® Sodium *(Pentobarbital sodium)*		See criteria for Seconal Sodium®.
Nephrocaps® **Nephro-FER®** *(Ferrous Fumarate/ Folic acid)* **Nephro-Vite®** *(Vitamin B Comp W-C)* **Nephro-Vite RX®** *(Folic acid/Vitamin B Comp W-C)* **Nephro-Vite +FE®** *(Fe fumarate/FA/ Vitamin B Comp W-C)* **Nephron FA®** *(Fe fumerate/Doss/ FA/B Comp & C)*	096	Treatment of patients with renal disease.

Drug	Code	Criteria
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.

Ansaid® (Flurbiprofen)
Arthrotec® (Diclofenac/misoprostol)
Clinoril® (Sulindac)
Daypro® (Oxaprozin)
Feldene® (Piroxicam)
Ibuprofen
Indomethacin
Lodine®, **Lodine XL®** (Etodolac)
Meclofenamate
Mobic® (Meloxicam)
Nalfon® (Fenoprofen)
Naprosyn® (Naproxen)
Orudis®, **Oruvail®** (Ketoprofen)
Ponstel® (Mefenamic acid)
Relafen® (Nabumetone)
Tolectin® (Tolmetin)
Toradol® (Ketorolac)
Voltaren® (Diclofenac)

Oxandrin® *(Oxandrolone)*

Before any code is allowed, there must be an absence of all of the following:

a) Hypercalcemia
b) Nephrosis
c) Carcinoma of the breast
d) Carcinoma of the prostate
e) Pregnancy

Code	Criteria
110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
111	To compensate for the protein catabolism due to long-term corticosteroid use.
112	Treatment of bone pain due to osteoporosis.

Drug	Code	Criteria
Pacerone® *(Amiodarone)*	010	Prescribed or recommended by a cardiologist/internist.
PEG-Intron® *(Peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Pegasys® *(Peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Plavix® *(Clopidogrel bisulfate)*	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once a day aspirin therapy.
Pulmozyme® *(Deoxyribonuclease)*	053	Diagnosis of cystic fibrosis and the patient is **5** years of age or older.
Rebetron® *(Ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Rebif® *(Interferon beta-1A/albumin)*		See criteria for Betaseron®.
Reminyl® *(Galantamine hydrobromide)*		See criteria for Aricept®.

Drug	Code	Criteria
Rena-Vite® **Rena-Vite RX®** *(Folic Acid/Vit B Comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(Naltrexone)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.

Note: A certification form must be on file with the pharmacy before the drug is dispensed. *(Sample copy of form attached.)*

Drug	Code	Criteria
Rilutek® *(Riluzole)*	089	Confirmed diagnosis of Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease) and the prescription is written by, or in consultation with, a neurologist.

Drug	Code	Criteria
Risperdal® *(Risperidone)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
	104	Treatment of dementia-related disturbed behavior in patients **18** years of age or older.
Ritalin LA®		See criteria for Concerta®.
Roferon-A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Rythmol® *(Propafenone)*	010	Prescribed or recommended by a cardiologist/internist.
Sandostatin® *(Octreotide acetate)*	056	Diagnosis of severe diarrhea and flushing due to metastatic carcinoid tumor.
	057	Diagnosis of therapeutically unresponsive severe diarrhea due to vasoactive intestinal polypeptide tumor (VIPoma).
	058	Diagnosis of AIDS with refractory diarrhea.
	098	Reduction of blood levels of growth hormone and IGF-I in acromegaly patients who have inadequate response or cannot be treated by surgical resection, pituitary irradiation, or bromocriptine mesylate at maximum tolerated doses.
Seconal Sodium® *(Secobarbital sodium)*	090	Limited to a one-week supply for pregnant women in the third trimester immediately preceding delivery.
Seroquel® *(Quetiapine fumarate)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is **6** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.

Drug	Code	Criteria
Sonata® *(Zaleplon)*		See criteria for Ambien®.
Soriatane® *(Acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age or older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Synarel® *(Nafarelin acetate)*	059	Diagnosis of endometriosis amenable to hormonal management in patients **18** years of age or older. Treatment limited to six months. Patient must have an **absence** of all of the following: a) Pregnancy; and b) Breast-feeding; and c) Hypersensitivity to GnRH.
	060	Diagnosis of central precocious puberty (CPP).
Talacen® *(Pentazocine/ acetaminophen)* **Talwin NX®** *(Pentazocine)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Tambocor® *(Flecainide acetate)*	010	Prescribed or recommended by a cardiologist/internist.

Drug	Code	Criteria
Therevac Plus® *(Docusate sodium benzocaine)* **Therevac SB®** *(Docusate sodium)*	065	Diagnosis of any of the following and the patient has tried and failed at least 3 other agents/modalities: a) Quadriplegia or paraplegia; b) Severe cerebral palsy; or c) Severe muscular dystrophy.
Ticlid® *(Ticlopidine)*	066	Diagnosis of stroke or stroke precursors, or for patients who have had a thrombotic stroke. The patient must be intolerant to aspirin.
Tonocard® *(Tocainide)*	010	Prescribed or recommended by a cardiologist/internist.
Vancomycin®	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vancomycin® IV/Inj.	103	Treatment of patients with methacillin resistant staph aureaus infections.
Venofer® *(Iron sucrose complex)*		See criteria for INFeD®.
Vioxx® ***(Rofecoxib)***	050	Diagnosis of rheumatoid arthritis in patients **18** years of age or older. Dose limited to 25mg per day.
	051	Diagnosis of osteoarthritis in patients **18** years of age or older. Dose limited to 12.5 to 25mg per day.
	052	Diagnosis of acute pain, including primary dysmenorrhea, in patients **18** years of age or older. Dose limited to 50mg or less, once daily for 5 days.

Drug	Code	Criteria
Vitamin ADC Drops	093	The child is breast-feeding, and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin B-12 Injection	075	For the treatment of vitamin B-12 deficiency (pernicious anemia).
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Zenapax® *(Daclizumab)*	138	For prophylaxis of acute organ rejection in patients receiving renal transplants when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.
Zofran® *(Odansetron)*		See criteria for Kytril®
Zometa® *(Zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases.

Drug	Code	Criteria
Zovirax® Oint *(Acyclovir)*		Before any code is allowed, there must be an **absence** of pregnancy.
	070	Diagnosis of shingles or immunodeficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
	071	Diagnosis of herpes simplex, types 1 & 2; varicella-2 zoster; or immuno-deficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
	072	Diagnosis of non-life threatening mucocutaneous herpes simplex virus infection or immunodeficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®.
Zyprexa® **Zyprexa Zydis®** *(Olanzapine)*		See criteria for Risperdal®.
Zyrtec® *(Cetirizine)* **Zyrtec-D®** *(Cetirizine/pseudoephedrine)*		See criteria for Allegra®.

This is a blank page.

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA)

REVIA (NALTREXONE) AUTHORIZATION

AGENCY SECTION (TO BE COMPLETED BY THE COUNSELOR)

CERTIFIED TREATMENT AGENCY	AGENCY NUMBER

The certified treatment agency listed above certifies that the patient listed below is 18 years of age or older; alcohol or opiate dependent, with alcohol or opiate dependence as the primary addiction; and has been admitted to publicly funded chemical dependency treatment scheduled to be provided for a minimum of 12 weeks of continuous service.

COUNSELOR'S SIGNATURE	DATE	PRINT COUNSELOR'S NAME

PATIENT SECTION (TO BE COMPLETED BY THE COUNSELOR)

PATIENT NAME	MEDICAL ASSISTANCE ADMINISTRATION PATIENT IDENTIFICATION CODE (PIC) NUMBER	DATE ADMITTED TO TREATMENT	DEPENDENCY
			☐ Alcohol ☐ Opiate

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
(TO BE COMPLETED BY PATIENT)

I, ______________________________, authorize the certified treatment agency indicated above to disclose patient identifying information, my status as a patient and their treatment recommendation to my physician and the pharmacy indicated below for the purpose of acquiring a prescription for REVIA (naltrexone).

Physician: ______________________________

Pharmacy: ______________________________

I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR Part 2 and Washington Administrative Code (WAC) 440-22) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall expire 90 days from the date signed. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Patient's signature: **Date:**

PHARMACY SECTION (TO BE COMPLETED BY THE PHARMACY)

I have received a prescription for REVIA (naltrexone) for the patient named above from the patient's physician and have filled the prescription as authorized. I understand that reimbursement from the Medical Assistance Administration (MAA) for REVIA (naltrexone) shall only be made under the following condition:

1. The medication is provided as part of a comprehensive treatment program as verified by the certification provided above.
2. Payment for the medication is limited to 12 weeks of continuous use. The medication is limited to a 34 day supply on each fill not to exceed three fills.
3. The pharmacy shall include the prescribing physician's MAA Medical Provider Number on the MAA billing form.
4. Record of this certification shall be kept on file at the pharmacy for MAA audit purposes. Prescriptions reimbursed by the MAA for naltrexone without this certification record on file shall be considered an overpayment.

Pharmacist's signature: **Date:**

See back of form for prohibition on redisclosure of information concerning the patient or information on this form.

COPIES TO: Pharmacy Physician Treatment Agency

Limitation extensions (LE)

What is a Limitation Extension?

A Limitation Extension (LE) is a request to exceed stated limitations or other restrictions on covered services. LE is a form of prior authorization. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165. Providers must be able to verify that it is medically necessary to provide more units of prescription drugs than allowed in MAA's billing instructions and Washington Administration Code (WAC).

Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I get LE authorization?

Limitation extensions may be requested by calling MAA's Drug Utilization and Review at 1-800-848-2842.

Limitation Extensions DO NOT APPLY to noncovered prescription drugs. See page C.4 for information on Exception to Rule.

Reimbursement

Drug Rebate Program

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates that states claim Federal Financial Participation (FFP) *only* for outpatient prescription drugs supplied by a drug manufacturer who has entered into a *drug rebate contract* with the Department of Health and Human Services (DHHS). As a result, MAA covers only outpatient prescription drugs supplied by contracted manufacturers.

Please Note: It is very important for pharmacy providers to bill the actual NDC for the drug dispensed and to accurately report the quantity filled when submitting claims for reimbursement. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause MAA to report false drug rebate calculations to manufacturers.

CONTRACT DRUGS:

Payable contract drugs are outpatient drugs supplied by a manufacturer who has entered into a drug rebate agreement with DHHS.

To download MAA's version of the Federal List of Drug Manufacturers Participating in the Centers for Medicare and Medicaid's (CMS) Drug Rebate Program, go to:
http://maa.dshs.wa.gov
Click on "Provider Publication/Fee Schedules," click "Accept" on the copyright agreement, then click on"Billing Instructions."
The Drug Rebate Manufacturer lists are located Prescription Drug Program Billing Instructions.

Estimated acquisition cost (EAC)
[Refer to WAC 388-530-1350]

First DataBank derives the Average Wholesale Price (AWP) of each product based on information they receive directly from each manufacturer or labeler. MAA determines the appropriate percentage of the AWP that represents the Estimated Acquisition Cost (EAC). Most drugs are reimbursed at the EAC plus a dispensing fee.

Effective with dates of service on and after August 1, 2002, the Medical Assistance Administration (MAA) increased the discount applied to the Average Wholesale Price (AWP) of drugs.

- For single source drugs and multiple source drugs with fewer than five manufacturers/ labelers, the discount from AWP increased from 11.0% to 14.0%.

- For multiple source drugs with five or more manufacturers/labelers, the discount from AWP increased from 11.0% to 50.0%.

Federal upper limits (FUL)
[WAC 388-530-1410]

In 1987, regulations limited the amount that Medicaid could reimburse for drugs with available generic drugs under the Federal Upper Limit program. These limits are intended to assure that the Federal government acts as a prudent buyer of drugs. The concept of the upper limits program is to achieve savings by taking advantage of the current market prices.

Until the passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Federal Upper Limit (FUL) could be established only if:

- ✓ All generic versions of a drug product had been classified as therapeutically equivalent (A-rate) by the FDA in its publication "Approved Drug Products with Therapeutic Equivalence Evaluations;" and
- ✓ At least three suppliers were listed in the current editions of published national compendia.

OBRA '90 expanded the criteria and permitted the establishment of a FUL for a drug product if there are:

- ✓ Three (or more) generic versions of the product rated therapeutically equivalent (A-rated) regardless of the ratings of other versions (B-rated); and
- ✓ At least three suppliers are listed in the current editions of published national compendia.

To view the Centers for Medicare and Medicaid's Federal Upper Limit List, go to: http://cms.hhs.gov/medicaid/drugs .

Drugs on this list are subject to coverage rules (e.g., prior authorization) contained in these billing instructions.

Please remember that if any of the drugs on the FUL list also appear on MAA's Maximum Allowable Cost (MAC) list, MAA reimburses the lower of EAC, MAC, FUL, or usual and customary charge.

Bill MAA your usual and customary charge using the complete 11-digit NDC from the dispensing container.

☞ **Note:** The unit cost relates to the form in which the drug is distributed (e.g., per tablet or capsule, milliliter, gram, packet, or vial). The reimbursement rate listed for each drug entity applies to brand as well as generic products. Pharmacists who dispense the MAC'd product without prior authorization (based on medical necessity) will receive the lower of EAC, MAC, FUL, or usual and customary charge.

Maximum Allowable Cost (MAC) Program

Automated Maximum Allowable Cost (AMAC) Program

AMAC is applied to all multisource drugs not currently on the state Maximum Allowable Cost (MAC) list. There must be at least two drugs in a Generic Code Number (GCN) sequence, and at least one of the manufacturers/labelers must participate in the federal rebate contract program. Drug products are paid at the Estimated Acquisition Cost (EAC) of the second lowest priced product in that sequence, or at the EAC of the lowest priced contract drug in that sequence, whichever is more. If the price established in this way exceeds the federal upper limit, the price will be set at the federal upper limit. If the EAC of the specific product dispensed is lower than the AMAC, the product will be paid at EAC.

Bill MAA your usual and customary charge. Reimbursement will be the lower of the billed charge or the maximum allowable fee.

State Maximum Allowable Cost Program (SMAC)
[WAC 388-530-1400]

Maximum allowable cost reimbursement for prescription drug products applies to a listing of specific, therapeutically equivalent multiple-source drugs.

For these specific drug forms and strengths, MAA will reimburse a maximum allowable cost (MAC). Brand name and generic drugs with a MAC established are reimbursed at the MAC price. Prior authorization from MAA must be obtained to exceed MAC. Prior authorization for brand name drugs is based on clinically documented medical necessity. If prior authorized, reimbursement is made at the appropriate percent of AWP (i.e., the Estimated Acquisition Cost [EAC]).

The MAC fee schedule is provided for pricing information only. The price shown is the maximum allowable cost per unit. The unit cost relates to the form in which the drug is distributed (e.g., per tablet or capsule, milliliter, gram, packet, or vial).

The reimbursement rate listed for each drug entity includes brand as well as generic products. Pharmacists who dispense a MAC'd product without prior authorization will receive the MAC reimbursement.

Bill MAA your usual and customary charge. Reimbursement is the billed charge or the maximum allowable fee, whichever is less.

IMPORTANT: Drugs listed in the MAC fee schedule are subject to prior authorization and other coverage rules contained in these billing instructions.

The MAC list beginning on page I.9 is in effect as of February 1, 2003.

For the most up-to-date MAC list, go to:
http://maa.dshs.wa.gov/pharmacy

Tax

Tax is computed on items determined to be taxable according to the Washington State Department of Revenue.

Dispensing fees

[Refer to WAC 388-530-1450]

MAA uses a three-tier dispensing fee structure with an adjusted fee allowed for pharmacies that participate in the Modified Unit Dose and/or True Unit Dose programs.

Listed below are the MAA dispensing fee allowances **(effective 7/1/02)** for pharmacies:

High-volume pharmacies (over 35,000 Rx/yr).............................. $4.20/Rx
Mid-volume pharmacies (15,001-35,000 Rx/yr)........................... $4.51/Rx
Low volume pharmacies (15,000 Rx/yr and under)...................... $5.20/Rx
Unit dose systems.. $5.20/Rx

A provider's dispensing fee is determined by the volume of prescriptions the pharmacy fills for MAA clients ***and*** the general public as indicated on the MAA annual prescription count survey completed by the pharmacy.

Return the annual prescription count survey to:

Provider Enrollment Unit
Division of Customer Support
PO Box 45562
Olympia, WA 98504-5562

REMEMBER to include MAA clients ***and*** the general public in your total prescription count.

Note: Sale or transfer of business ownership will invalidate your Core Provider Agreement. The new owner must call the Provider Enrollment Unit (see Important Contacts) to acquire a Core Provider Agreement.

Payment

Bill MAA only **after** you provide a service to an eligible client. Delivery of a service or product does not guarantee payment. For example, MAA does not make payment when:

- The request for payment is not presented within the 365 day billing limit.
- The service or product is not medically necessary or is not covered by MAA;
- The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product;
- The service or product is covered in the managed care capitation rate;
- It is included in the Nursing Home per diem rate; or
- The client is no longer eligible for Medical Assistance.

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
ACEBUTOLOL HCL	200MG		CAPSULE	$0.73320
ACEBUTOLOL HCL	400MG		CAPSULE	$0.95750
ACETAMINOPHEN	160MG/5ML		ELIXIR	$0.00900
ACETAMINOPHEN	325MG		TABLET	$0.01670
ACETAMINOPHEN	500MG		CAPSULE	$0.02200
ACETAMINOPHEN	500MG		TABLET	$0.02200
ACETAMINOPHEN	650MG		TABLET	$0.02200
ACETAMINOPHEN/CAFFEINE/BUTALBITAL	325-40-50		TABLET	$0.18859
ACETIC ACID	2%		EAR SOLUTION	$0.12500
ACETIC ACID			SOLUTION	$0.42750
ACETIC ACID HCL	2-1%		EAR DROP	$1.65521
ACETOHEXAMIDE	250MG		TABLET	$0.23630
ACYCLOVIR	800MG		TABLET	$1.68300
ACYCLOVIR	400MG		TABLET	$0.86560
ACYCLOVIR	200MG		CAPSULE	$0.33820
ALBUTEROL	90MCG	17	AEROSOL	$0.59000
ALBUTEROL	90MCG	17	AER REFILL	$0.43940
ALBUTEROL SULFATE	2MG/5ML		SYRUP	$0.03180
ALBUTEROL SULFATE	2MG		TABLET	$0.04500
ALBUTEROL SULFATE	4MG		TABLET	$0.07313
ALBUTEROL SULFATE	0.83MG/ML		SOLUTION	$0.19900
ALLOPURINOL	100MG		TABLET	$0.07250
ALPRAZOLAM	0.25MG		TABLET	$0.03830
ALPRAZOLAM	0.5MG		TABLET	$0.04560
ALPRAZOLAM	1MG		TABLET	$0.04920
ALPRAZOLAM	2MG		TABLET	$0.15380
ALUMINUM HYDROXIDE	320MG/5ML		ORAL SUSP	$0.00936
ALUMINUM HYDROXIDE	600MG/5ML		ORAL SUSP	$0.00422
ALUMINUM HYDROXIDE/MINERAL OIL			ORAL SUSP	$0.00422
AMANTADINE HCL	50MG/5ML		SYRUP	$0.06230
AMANTADINE HCL	100MG		CAPSULE	$0.28000
AMILORIDE HCL/HCTZ	5-50MG		TABLET	$0.06420
AMINOPHYLLINE	100MG		TABLET	$0.03440
AMINOPHYLLINE	200MG		TABLET	$0.03530
AMITRIPTYLINE HCL/PERPHENAZINE	50-4MG		TABLET	$0.19430
AMOXAPINE	100MG		TABLET	$0.97200
AMOXAPINE	150MG		TABLET	$1.52970
AMOXAPINE	25MG		TABLET	$0.36060
AMOXAPINE	50MG		TABLET	$0.58620
AMOXICILLIN TRIHYDRATE	50MG/ML		DROP RECON	$0.18000
AMOXICILLIN TRIHYDRATE	250MG		CAPSULE	$0.07350
AMOXICILLIN TRIHYDRATE	125MG/5ML	80	SUSP RECON	$0.01290
AMOXICILLIN TRIHYDRATE	125MG/5ML	100	SUSP RECON	$0.01650
AMOXICILLIN TRIHYDRATE	125MG/5ML	150	SUSP RECON	$0.02810
AMOXICILLIN TRIHYDRATE	250MG/5ML	80	SUSP RECON	$0.01850
AMOXICILLIN TRIHYDRATE	250MG/5ML	100	SUSP RECON	$0.02250
AMOXICILLIN TRIHYDRATE	250MG/5ML	200	SUSP RECON	$0.05400
AMOXICILLIN TRIHYDRATE	250MG/5ML	150	SUSP RECON	$0.02370
AMOXICILLIN TRIHYDRATE	500MG		CAPSULE	$0.15460
AMPICILLIN ANHYDROUS	250MG		CAPSULE	$0.05320
AMPICILLIN TRIHYDRATE	500MG		CAPSULE	$0.17000
AMPICILLIN TRIHYDRATE	250MG		CAPSULE	$0.06273
AMPICILLIN TRIHYDRATE	125MG/5ML		SUSP RECON	$0.02250

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
AMPICILLIN TRIHYDRATE	250MG/5ML		SUSP RECON	$0.02470
ANTIHEMOPHILIC FACTOR, HUM REC	310U(+/-)		VIAL	$0.85000
ANTIHEMOPHILIC FACTOR, HUM REC	600U (+/-)		VIAL	$0.85000
ANTIHEMOPHILIC FACTOR, HUM REC	1020U (+/-)		VIAL	$0.85000
ANTIHEMOPHILIC FACTOR, HUM REC (Helixate FS)	500 (+/-)U	1	KIT	$1.11000
ANTIHEMOPHILIC FACTOR, HUM REC (Helixate FS)	1000(+/-)U	1	KIT	$1.11000
ANTIHEMOPHILIC FACTOR, HUM REC (Helixate FS)	250 (+/-)U	1	KIT	$1.11000
ANTIHEMOPHILIC FACTOR, HUM REC (Kogenate FS)	250 (+/-)U	1	KIT	$0.81000
ANTIHEMOPHILIC FACTOR, HUM REC (Kogenate FS, Refacto)	500 (+/-)U	1	KIT	$0.81000
ANTIHEMOPHILIC FACTOR, HUM REC (Kogenate FS, Refacto)	1000(+/-)U	1	KIT	$0.81000
ANTIHEMOPHILIC FACTOR,HUMAN (Koate-dvi)	1000(+/-)U		KIT	$0.69000
ANTIHEMOPHILIC FACTOR,HUMAN (Koate-dvi)	250 (+/-)U		KIT	$0.69000
ANTIHEMOPHILIC FACTOR,HUMAN (Koate-dvi)	500 (+/-)U		KIT	$0.69000
ANTIHEMOPHILIC FACTOR,HUMAN	850 (+/-)U		VIAL	$0.69000
ANTIHEMOPHILIC FACTOR,PORCINE	550 (+/-)U		VIAL	$0.81000
ANTI-INHIBITOR COAGULANT COMP.(Feiba)	600 UNIT		VIAL	$0.69000
ASA/CALCIUM CARB/MAGNESIUM/ALH	325MG		TABLET	$0.02000
ASPIRIN	650MG		TABLET DR	$0.03890
ASPIRIN	325MG		TABLET	$0.00990
ASPIRIN	325MG		TABLET DR	$0.01740
ASPIRIN/CAFFEINE/BUTALBITAL	325-40-50		CAPSULE	$0.53140
ASPIRIN/CAFFEINE/BUTALBITAL	325-40-50		TABLET	$0.35280
ASPIRIN/CALCIUM CARBONATE/MAGNESIUM	324MG		TABLET	$0.02000
ATENOLOL	100MG		TABLET	$0.05900
ATENOLOL	50MG		TABLET	$0.04350
ATENOLOL	25MG		TABLET	$0.08250
ATENOLOL/CHLORTHALIDONE	50-25MG		TABLET	$0.30980
ATENOLOL/CHLORTHALIDONE	100-25MG		TABLET	$0.44830
AZATHIOPRINE	50MG		TABLET	$1.04920
BACITRACIN	500 UNIT/G		OINT.(GM)	$0.03366
BACITRACIN	500 UNIT/G		OINT.(GM)	$0.57714
BACLOFEN	10MG		TABLET	$0.21000
BACLOFEN	20MG		TABLET	$0.39140
BENZOYL PEROXIDE	10%		GEL	$0.13600
BENZOYL PEROXIDE	5%		GEL	$0.14260
BENZTROPINE MESYLATE	0.5MG		TABLET	$0.08940
BENZTROPINE MESYLATE	1MG		TABLET	$0.10000
BENZTROPINE MESYLATE	2MG		TABLET	$0.12597
BETAMETHASONE DIPROPIONATE	0.05%		CREAM(GM)	$0.15016
BETAMETHASONE DIPROPIONATE	0.05%		OINT.(GM)	$0.15016
BETAMETHASONE DIPROPIONATE	0.05%		LOTION	$0.15016
BETAMETHASONE VALERATE	0.1%	45	CREAM(GM)	$0.12000
BETAMETHASONE VALERATE	0.1%	45	OINT.(GM)	$0.16500
BETAMETHASONE VALERATE	0.1%	15	CREAM(GM)	$0.07330
BETAMETHASONE VALERATE	0.1%	15	OINT.(GM)	$0.11630
BETAMETHASONE VALERATE	0.1%		LOTION	$0.11120
BISACODYL	10MG		SUPP.RECT	$0.18770
BROMPHENIRAMINE MALEATE	2MG/5ML		ELIXIR	$0.01253
BUMETANIDE	0.5MG		TABLET	$0.17180
BUMETANIDE	1MG		TABLET	$0.27750
BUMETANIDE	2MG		TABLET	$0.51780
BUPROPION HCL	75 MG		TABLET	$0.25000
BUPROPION HCL	100 MG		TABLET	$0.29560

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
CALCITONIN,SALMON,SYNTHETIC	200 U/ML		VIAL	$17.35500
CALCIUM CARB/MAG HYDROX/SIMETH	280-128-20		TAB CHEW	$0.03560
CALCIUM CARBONATE	1.25G		TABLET	$0.03372
CALCIUM CARBONATE	1.5G		TABLET	$0.02839
CALCIUM CARBONATE	650MG		TABLET	$0.05570
CALCIUM CARBONATE	350MG		TAB CHEW	$0.03560
CALCIUM CARBONATE	420MG		TAB CHEW	$0.03560
CALCIUM CARBONATE	500MG		TAB CHEW	$0.03560
CALCIUM CARBONATE	750MG		TAB CHEW	$0.03560
CALCIUM CARBONATE	850MG		TAB CHEW	$0.03560
CALCIUM CARBONATE/GLYCINE	420-180MG		TAB CHEW	$0.03560
CALCIUM CARBONATE/MAG CARB	520-400MG		TABLET	$0.03560
CALCIUM CARBONATE/MAG CARB			ORAL SUSP	$0.00422
CALCIUM CARBONATE/MAG HYDROX	400-135/5		ORAL SUSP	$0.00422
CALCIUM CARBONATE/SIMETHICONE	420-21MG		TAB CHEW	$0.03560
CALCIUM CARBONATE/SIMETHICONE	500-20		ORAL SUSP	$0.00422
CAPTOPRIL	100MG		TABLET	$0.18830
CAPTOPRIL	25MG		TABLET	$0.05850
CAPTOPRIL	50MG		TABLET	$0.09900
CAPTOPRIL	12.5MG		TABLET	$0.03750
CARBAMAZEPINE	200MG		TABLET	$0.08500
CARBAMAZEPINE	100MG		TAB CHEW	$0.14500
CARBIDOPA/LEVODOPA	50-200MG		TABLET SA	$1.22000
CARBIDOPA/LEVODOPA	10-100MG		TABLET	$0.25530
CARBIDOPA/LEVODOPA	25-100MG		TABLET	$0.27540
CARBIDOPA/LEVODOPA	25-250MG		TABLET	$0.32550
CEFACLOR	250MG		CAPSULE	$0.80250
CEFACLOR	500MG		CAPSULE	$1.38900
CEFACLOR	125MG/5ML	75	SUSP RECON	$0.12900
CEFACLOR	125MG/5ML	150	SUSP RECON	$0.14200
CEFACLOR	250MG/5ML	75	SUSP RECON	$0.25530
CEFACLOR	250MG/5ML	150	SUSP RECON	$0.27200
CEFACLOR	187MG/5ML	50	SUSP RECON	$0.20250
CEFACLOR	187MG/5ML	100	SUSP RECON	$0.21300
CEFACLOR	375MG/5ML	50	SUSP RECON	$0.38300
CEFACLOR	375MG/5ML	100	SUSP RECON	$0.40800
CEFUROXIME AXETIL	250MG		TABLET	$3.05000
CEFUROXIME AXETIL	500 MG		TABLET	$5.15000
CEPHALEXIN MONOHYDRATE	125MG/5ML	100	SUSP RECON	$0.08652
CEPHALEXIN MONOHYDRATE	125MG/5ML	200	SUSP RECON	$0.05932
CEPHALEXIN MONOHYDRATE	250MG/5ML	100	SUSP RECON	$0.10300
CEPHALEXIN MONOHYDRATE	250MG/5ML	200	SUSP RECON	$0.08555
CEPHALEXIN MONOHYDRATE	250MG		CAPSULE	$0.11030
CEPHALEXIN MONOHYDRATE	500MG		CAPSULE	$0.29990
CEPHALEXIN MONOHYDRATE	500MG		TABLET	$0.63510
CEPHALEXIN MONOHYDRATE	250MG		TABLET	$0.29990
CEPHRADINE	250MG		CAPSULE	$0.80000
CEPHRADINE	500MG		CAPSULE	$0.52690
CHLORAL HYDRATE	500MG/5ML		SYRUP	$0.01500
CHLORAL HYDRATE	500MG		CAPSULE	$0.07010
CHLORDIAZEPOXIDE HCL	10MG		CAPSULE	$0.03150
CHLORDIAZEPOXIDE HCL	25MG		CAPSULE	$0.03718
CHLORDIAZEPOXIDE HCL	5MG		CAPSULE	$0.02968

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
CHLOROTHIAZIDE	500MG		TABLET	$0.05760
CHLOROTHIAZIDE	250MG		TABLET	$0.03400
CHLORPHENIRAMINE MALEATE	4MG		TABLET	$0.01260
CHLORPROMAZINE HCL	50MG		TABLET	$0.18150
CHLORPROMAZINE HCL	100MG		TABLET	$0.25250
CHLORPROMAZINE HCL	25MG		TABLET	$0.15860
CHLORPROMAZINE HCL	200MG		TABLET	$0.31450
CHLORPROMAZINE HCL	10MG		TABLET	$0.03420
CHLORTHALIDONE	25MG		TABLET	$0.02631
CHLORTHALIDONE	50MG		TABLET	$0.02710
CHLORTHALIDONE	100MG		TABLET	$0.05040
CHLORZOXAZONE	500MG		TABLET	$0.08480
CHOLESTYRAMINE/ASPARTAME			POWDER	$0.15875
CHOLESTYRAMINE/ASPARTAME	4G		PACKET	$1.03826
CHOLESTYRAMINE/SUCROSE	4G		PACKET	$1.03832
CHOLESTYRAMINE/SUCROSE	4G		POWDER	$0.08322
CIMETIDINE	200MG		TABLET	$0.13650
CIMETIDINE	300MG		TABLET	$0.15530
CIMETIDINE	400MG		TABLET	$0.17700
CIMETIDINE	800MG		TABLET	$0.41550
CIMETIDINE HCL	300MG/5ML		LIQUID	$0.21610
CLEMASTINE FUMARATE	2.68MG		TABLET	$0.35860
CLINDAMYCIN PHOSPHATE	1%		LOTION	$0.55210
CLINDAMYCIN PHOSPHATE	1%	30	SOLUTION	$0.11950
CLINDAMYCIN PHOSPHATE	1%	60	SOLUTION	$0.17600
CLOBETASOL PROPIONATE	0.05%		OINT.(GM)	$0.70000
CLOBETASOL PROPIONATE	0.05%		CREAM(GM)	$0.70000
CLOMIPRAMINE HCL	25MG		CAPSULE	$0.58800
CLOMIPRAMINE HCL	50MG		CAPSULE	$0.76000
CLOMIPRAMINE HCL	75MG		CAPSULE	$1.02000
CLONAZEPAM	0.5MG		TABLET	$0.18000
CLONAZEPAM	1MG		TABLET	$0.22000
CLONAZEPAM	2MG		TABLET	$0.94310
CLOTRIMAZOLE	1%	10	SOLUTION	$0.40000
CLOTRIMAZOLE	1%	30	SOLUTION	$0.69000
CLOTRIMAZOLE	1%		CREAM/APPL	$0.16306
CLOTRIMAZOLE	1%		CREAM(GM)	$0.35678
CLOXACILLIN SODIUM	250MG		CAPSULE	$0.15530
CLOXACILLIN SODIUM	500MG		CAPSULE	$0.29930
CLOZAPINE	25MG		TABLET	$0.64940
CLOZAPINE	100MG		TABLET	$1.44000
CODEINE PHOSPHATE/ACETAMINOPHEN	12-120MG/5		ELIXIR	$0.01610
CODEINE PHOSPHATE/ACETAMINOPHEN	12-120MG/5		ORAL SUSP	$0.01610
CODEINE PHOSPHATE/ASPIRIN	30-325MG		TABLET	$0.07170
CODEINE PHOSPHATE/ASPIRIN	60-325MG		TABLET	$0.12000
CODEINE PHOS/BROMODIPH.-DPHA HCL	10-12.5/5		SYRUP	$0.01862
CYANOCOBALAMIN	1000MCG/ML		VIAL	$0.12780
CYCLOBENZAPRINE HCL	10MG		TABLET	$0.08910
DESIPRAMINE HCL	100MG		TABLET	$0.60140
DESIPRAMINE HCL	150MG		TABLET	$0.81370
DESIPRAMINE HCL	25MG		TABLET	$0.18360
DESIPRAMINE HCL	10MG		TABLET	$0.17470
DESIPRAMINE HCL	50MG		TABLET	$0.34000

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
DESIPRAMINE HCL	75MG		TABLET	$0.44280
DESONIDE	0.05%	15	CREAM(GM)	$0.38900
DESONIDE	0.05%	90	CREAM(GM)	$0.50000
DESONIDE	0.05%	15	OINT.(GM)	$0.38900
DESONIDE	0.05%	60	OINT.(GM)	$0.50000
DESONIDE	0.05%	60	CREAM(GM)	$0.43520
DESOXIMETASONE	0.05%		CREAM(GM)	$0.52400
DESOXIMETASONE	0.25%		CREAM(GM)	$0.69000
DEXAMETHASONE	0.5MG/5ML		ELIXIR	$0.06137
DEXAMETHASONE	4MG		TABLET	$0.13850
DIAZEPAM	10MG		TABLET	$0.06000
DIAZEPAM	5MG		TABLET	$0.04480
DIAZEPAM	5MG/ML		AMPUL	$1.60549
DIAZEPAM	5MG/ML		DISP SYRIN	$1.62626
DIAZEPAM	2MG		TABLET	$0.01557
DIAZEPAM	5MG/ML		VIAL	$0.70132
DICLOFENAC SODIUM	25MG		TABLET DR	$0.44010
DICLOFENAC SODIUM	50MG		TABLET DR	$0.65000
DICLOFENAC SODIUM	75MG		TABLET DR	$0.80000
DICLOXACILLIN SODIUM	500MG		CAPSULE	$0.53420
DICLOXACILLIN SODIUM	250MG		CAPSULE	$0.19430
DICYCLOMINE HCL	10MG		CAPSULE	$0.17630
DICYCLOMINE HCL	20MG		TABLET	$0.20930
DIFLUNISAL	500MG		TABLET	$0.67280
DIGOXIN	125MCG		TABLET	$0.09000
DIGOXIN	250MCG		TABLET	$0.09000
DIHYDROXYALUMINUM SODIUM CARBONATE	334MG		TAB CHEW	$0.03560
DILTIAZEM HCL	30MG		TABLET	$0.08180
DILTIAZEM HCL	60MG		TABLET	$0.13800
DILTIAZEM HCL	90MG		TABLET	$0.19410
DILTIAZEM HCL	120MG		TABLET	$0.23790
DILTIAZEM HCL	90MG		CAP.SR 12H	$0.70488
DILTIAZEM HCL	120MG		CAP.SR 12H	$0.92782
DILTIAZEM HCL	60MG		CAP.SR 12H	$0.61944
DIPHENHYDRAMINE HCL	25MG		CAPSULE	$0.02250
DIPHENHYDRAMINE HCL	12.5MG/5ML		ELIXIR	$0.00610
DIPHENHYDRAMINE HCL	50MG		CAPSULE	$0.02060
DIPHENHYDRAMINE HCL	12.5MG/5ML		SYRUP	$0.00466
DIPIVEFRIN HCL	0.1%		DROPS	$1.95000
DIPYRIDAMOLE	50MG		TABLET	$0.09600
DIPYRIDAMOLE	25MG		TABLET	$0.02520
DIPYRIDAMOLE	75MG		TABLET	$0.16000
DISOPYRAMIDE PHOSPHATE	100MG		CAPSULE	$0.57000
DISOPYRAMIDE PHOSPHATE	150MG		CAPSULE	$0.44000
DOCUSATE SODIUM	250MG		CAPSULE	$0.03880
DOCUSATE SODIUM	100MG		CAPSULE	$0.02170
DOXEPIN HCL	10MG/ML		ORAL CONC.	$0.13620
DOXYCYCLINE HYCLATE	100MG		CAPSULE	$0.08520
DOXYCYCLINE HYCLATE	100MG		TABLET	$0.08910
DOXYCYCLINE HYCLATE	100MG		CAPSULE DR	$0.96000
DOXYCYCLINE HYCLATE	50MG		CAPSULE	$0.08730
DOXYCYCLINE MONOHYDRATE	100MG		CAPSULE	$1.43325
DOXYCYCLINE MONOHYDRATE	50MG		CAPSULE	$0.87789

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
ENALAPRIL MALEATE	20 MG		TABLET	$0.30000
ERGOLOID MESYLATES	1MG		TAB SUBL	$0.06375
ERYTHROMYCIN BASE	2%		SOLUTION	$0.05700
ERYTHROMYCIN BASE	250MG		CAPSULE DR	$0.17930
ERYTHROMYCIN BASE	333MG		TABLET DR	$0.17280
ERYTHROMYCIN BASE	250MG		TABLET	$0.07350
ERYTHROMYCIN BASE	250MG		TABLET DR	$0.07350
ERYTHROMYCIN BASE	500MG		TABLET	$0.15720
ERYTHROMYCIN BASE	500MG		TABLET DR	$0.15720
ERYTHROMYCIN BASE/ETHANOL	2%	30	GEL	$0.45111
ERYTHROMYCIN BASE/ETHANOL	2%	60	GEL	$0.52470
ERYTHROMYCIN BASE/ETHANOL	2%		MED. SWAB	$0.28220
ERYTHROMYCIN ESTOLATE	125MG/5ML		ORAL SUSP	$0.04500
ERYTHROMYCIN ESTOLATE	250MG/5ML		ORAL SUSP	$0.07660
ERYTHROMYCIN ETHYLSUCCINATE	200MG/5ML	150	ORAL SUSP	$0.02530
ERYTHROMYCIN ETHYLSUCCINATE	200MG/5ML	480	ORAL SUSP	$0.06970
ERYTHROMYCIN ETHYLSUCCINATE	400MG		TABLET	$0.23450
ERYTHROMYCIN ETHYLSUCCINATE	400MG/5ML		ORAL SUSP	$0.04360
ERYTHROMYCIN ETHYLSUCCINATE	200MG/5ML	200	ORAL SUSP	$0.04500
ERYTHROMYCIN STEARATE	500MG		TABLET	$0.24180
ERYTHROMYCIN STEARATE	250MG		TABLET	$0.13500
ESTAZOLAM	1MG		TABLET	$0.79020
ESTAZOLAM	2MG		TABLET	$0.88040
ESTRADIOL	1MG		TABLET	$0.23740
ESTRADIOL	2MG		TABLET	$0.33490
ESTRADIOL	0.5MG		TABLET	$0.18720
ESTROPIPATE	0.75MG		TABLET	$0.31320
ESTROPIPATE	1.5MG		TABLET	$0.41930
ESTROPIPATE	3MG		TABLET	$1.09400
ETHAMBUTOL HCL	400MG		TABLET	$1.33000
ETODOLAC	400MG		TAB.SR 24H	$0.81500
ETODOLAC	200MG		CAPSULE	$0.92140
ETODOLAC	300MG		CAPSULE	$1.02150
ETODOLAC	400MG		TABLET	$1.70500
ETOPOSIDE (NDC 55390-0291-01)	20 MG/ML	5	VIAL	$3.34000
FAMOTIDINE	20MG		TABLET	$0.18000
FAMOTIDINE	40MG		TABLET	$0.35000
FENOPROFEN CALCIUM	600MG		TABLET	$0.17600
FERROUS GLUCONATE	320MG		TABLET	$0.01680
FERROUS GLUCONATE	325MG		TABLET	$0.01680
FERROUS GLUCONATE	240MG		TABLET	$0.01680
FERROUS SULFATE	220MG/5ML		ELIXIR	$0.00776
FERROUS SULFATE	325(65)MG		TABLET	$0.01020
FERROUS SULFATE	325(65)MG		TABLET DR	$0.01020
FLUNISOLIDE	0.025%		SPRAY	$1.10000
FLUOCINOLONE ACETONIDE	0.01%	60	CREAM(GM)	$0.04130
FLUOCINOLONE ACETONIDE	0.025%	15	CREAM(GM)	$0.05750
FLUOCINOLONE ACETONIDE	0.025%	425	CREAM(GM)	$0.10500
FLUOCINOLONE ACETONIDE	0.025%	15	OINT.(GM)	$0.05750
FLUOCINOLONE ACETONIDE	0.025%	30	OINT.(GM)	$0.10500
FLUOCINOLONE ACETONIDE	0.01%	20	SOLUTION	$0.09380
FLUOCINOLONE ACETONIDE	0.01%	60	SOLUTION	$0.17630
FLUOCINOLONE ACETONIDE	0.025%	60	OINT.(GM)	$0.15000

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
FLUOCINOLONE ACETONIDE	0.01%	425	CREAM(GM)	$0.08400
FLUOCINOLONE ACETONIDE	0.025%	60	CREAM(GM)	$0.09900
FLUOCINONIDE	0.05%	15	CREAM(GM)	$0.12550
FLUOCINONIDE	0.05%	30	CREAM(GM)	$0.13450
FLUOCINONIDE	0.05%	60	CREAM(GM)	$0.18100
FLUOCINONIDE	0.05%	120	CREAM(GM)	$0.20360
FLUOCINONIDE	0.05%	15	OINT.(GM)	$0.60000
FLUOCINONIDE	0.05%		SOLUTION	$0.24200
FLUOCINONIDE	0.05%	30	OINT.(GM)	$0.54400
FLUOCINONIDE/EMOLLIENT	0.05%		CREAM(GM)	$0.45298
FLUOXETINE HCL	10MG		CAPSULE	$0.09530
FLUOXETINE HCL	20MG		CAPSULE	$0.09466
FLUOXETINE HCL	40MG		CAPSULE	$2.32780
FLUOXETINE HCL	10MG		TABLET	$0.09430
FLUOXETINE HCL	20MG/5ML		SOLUTION	$0.65800
FLUOXETINE HCL	20MG		TABLET	$0.60590
FLUPHENAZINE HCL	1MG		TABLET	$0.18810
FLUPHENAZINE HCL	2.5MG		TABLET	$0.26910
FLUPHENAZINE HCL	5MG		TABLET	$0.35210
FLUPHENAZINE HCL	5MG/ML		ORAL CONC.	$0.72987
FLUPHENAZINE HCL	10MG		TABLET	$0.50250
FLURAZEPAM HCL	15MG		CAPSULE	$0.04489
FLURAZEPAM HCL	30MG		CAPSULE	$0.05771
FLURBIPROFEN	100MG		TABLET	$0.34750
FLURBIPROFEN	50MG		TABLET	$0.50417
FOLIC ACID	1MG		TABLET	$0.01010
FUROSEMIDE	10MG/ML	60	SOLUTION	$0.09600
FUROSEMIDE	10MG/ML	120	SOLUTION	$0.13330
GEMFIBROZIL	600MG		TABLET	$0.18000
GENTAMICIN SULFATE	0.3%	5	OINT.(GM)	$3.54430
GENTAMICIN SULFATE	0.3%	15	DROPS	$0.30700
GENTAMICIN SULFATE	0.3%		DROPS	$0.48000
GENTAMICIN SULFATE	0.1%		CREAM(GM)	$0.13500
GENTAMICIN SULFATE	0.1%		OINT.(GM)	$0.13500
GLIPIZIDE	5MG		TABLET	$0.06350
GLIPIZIDE	10MG		TABLET	$0.11270
GLYBURIDE	5MG		TABLET	$0.18000
GLYBURIDE	1.25MG		TABLET	$0.13121
GLYBURIDE	2.5MG		TABLET	$0.25267
GRISEOFULVIN,MICROSIZE	500MG		TABLET	$1.25180
GUAIFENESIN/DM HB/P-EPHEDRINE/APAP	10-30-250		CAPSULE	$0.18814
GUAIFENESIN/DM HB/P-EPHEDRINE/APAP			CAPSULE	$0.18814
GUAIFENESIN	100MG/5ML		SYRUP	$0.00620
GUAIFENESIN/CODEINE PHOSPHATE	100-10MG/5		SYRUP	$0.01120
GUAIFENESIN/D-METHORPHAN HB	100-15/5ML		SYRUP	$0.00890
GUAIFENESIN/P-EPHEDRINE HCL/CODEINE	200-60-20		SYRUP	$0.04996
GUANABENZ ACETATE	4MG		TABLET	$0.41250
GUANABENZ ACETATE	8MG		TABLET	$0.58130
GUANFACINE HCL	1MG		TABLET	$0.61300
GUANFACINE HCL	2MG		TABLET	$0.84090
HALOPERIDOL	10MG		TABLET	$0.13204
HALOPERIDOL	0.5MG		TABLET	$0.01880
HALOPERIDOL	1MG		TABLET	$0.02100

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
HALOPERIDOL	2MG		TABLET	$0.02030
HALOPERIDOL	20MG		TABLET	$0.12000
HALOPERIDOL	5MG		TABLET	$0.02930
HALOPERIDOL DECANOATE	50MG/ML		VIAL	$16.12000
HALOPERIDOL DECANOATE	100MG/ML		VIAL	$22.73000
HALOPERIDOL LACTATE	2MG/ML		ORAL CONC.	$0.13130
HYDROCORTISONE/MINERAL OIL/PETROLAT,WHT	1%		OINT.(GM)	$0.06450
HYDRALAZINE HCL/HCTZ	25-25MG		CAPSULE	$0.06750
HYDRALAZINE HCL/HCTZ	50-50MG		CAPSULE	$0.08450
HYDRALAZINE HCL/HCTZ	100-50MG		CAPSULE	$0.23930
HYDROCHLOROTHIAZIDE	12.5MG		CAPSULE	$0.26000
HYDROCHLOROTHIAZIDE	50MG		TABLET	$0.01193
HYDROCHLOROTHIAZIDE	100MG		TABLET	$0.04430
HYDROCHLOROTHIAZIDE	25MG		TABLET	$0.01070
HYDROCODONE BITARTRATE/ACETAMINOPHEN	5-500MG		TABLET	$0.06390
HYDROCODONE BITARTRATE/ACETAMINOPHEN	7.5-650MG		TABLET	$0.16430
HYDROCODONE BITARTRATE/ACETAMINOPHEN	7.5-750MG		TABLET	$0.16350
HYDROCODONE BITARTRATE/ACETAMINOPHEN	2.5-500MG		TABLET	$0.24980
HYDROCODONE BITARTRATE/ACETAMINOPHEN	7.5-500MG		TABLET	$0.23030
HYDROCORTISONE	2.5%		LOTION	$0.45470
HYDROCORTISONE	0.5%	14	CREAM(GM)	$0.02200
HYDROCORTISONE	0.5%	30	CREAM(GM)	$0.10600
HYDROCORTISONE	1%		CREAM(GM)	$0.06450
HYDROCORTISONE	2.5%		CREAM(GM)	$0.17410
HYDROCORTISONE	2.5%		OINT.(GM)	$0.27380
HYDROCORTISONE	0.5%	60	LOTION	$0.03980
HYDROCORTISONE	0.5%	120	LOTION	$0.04000
HYDROCORTISONE	1%	75	LOTION	$0.05060
HYDROCORTISONE	1%	118	LOTION	$0.07250
HYDROCORTISONE	1%	120	LOTION	$0.09160
HYDROCORTISONE	0.5%	15	CREAM(GM)	$0.05700
HYDROCORTISONE	1%	60	LOTION	$0.04390
HYDROCORTISONE	1%		OINT.(GM)	$0.04966
HYDROCORTISONE ACETATE	0.5%		CREAM(GM)	$0.04680
HYDROCORTISONE ACETATE	1%		OINT.(GM)	$0.04960
HYDROXYCHLOROQUINE SULFATE	200MG		TABLET	$0.77630
HYDROXYZINE HCL	10MG		TABLET	$0.34910
HYDROXYZINE HCL	25MG		TABLET	$0.52000
HYDROXYZINE HCL	50MG		TABLET	$0.62800
HYDROXYZINE HCL	10MG/5ML		SYRUP	$0.01414
HYDROXYZINE PAMOATE	100MG		CAPSULE	$0.22430
HYDROXYZINE PAMOATE	25MG		CAPSULE	$0.07680
HYDROXYZINE PAMOATE	50MG		CAPSULE	$0.09830
HYOSCYAMINE SULFATE	0.375MG		CAP.SR 12H	$0.38220
IBUPROFEN	600MG		TABLET	$0.03990
IBUPROFEN	800MG		TABLET	$0.05630
IBUPROFEN	400MG		TABLET	$0.03380
INDAPAMIDE	2.5MG		TABLET	$0.22840
INDOMETHACIN	75MG		CAPSULE SA	$0.55637
INDOMETHACIN	25MG		CAPSULE	$0.02990
INDOMETHACIN	50MG		CAPSULE	$0.04260
INSULIN INJECTION (REGULAR) HUMAN	100 UNITS/ML		VIAL	$2.39000
30% INSULIN INJECTION (REGULAR) HUMAN	100 UNITS/ML		VIAL	$2.39000

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
IPRATROPIUM BROMIDE	0.2MG/ML		SOLUTION	$0.62700
ISONIAZID	300MG		TABLET	$0.05250
ISOSORBIDE DINITRATE	40MG		TABLET SA	$0.00000
ISOSORBIDE DINITRATE	10MG		TABLET	$0.01664
ISOSORBIDE DINITRATE	2.5MG		TAB SUBL	$0.02504
ISOSORBIDE DINITRATE	5MG		TAB SUBL	$0.02870
ISOSORBIDE DINITRATE	20MG		TABLET	$0.01430
ISOSORBIDE DINITRATE	5MG		TABLET	$0.01440
ISOPHANE INSULIN INJECTION SUSPENSION (NPH) HUMAN	100 UNITS/ML		VIAL	$2.39000
70 %ISOPHANE INSULIN INJECTION SUSPENSION (NPH) HUMAN	100 UNITS/ML		VIAL	$2.39000
KETOCONAZOLE	2%		CREAM(GM)	$0.66000
KETOPROFEN	50MG		CAPSULE	$0.43835
KETOPROFEN	75MG		CAPSULE	$0.46967
LACTULOSE	10G/15ML		SYRUP	$0.02280
LEVOBUNOLOL HCL	0.5%	2	DROPS	$1.93500
LEVOBUNOLOL HCL	0.5%	5	DROPS	$2.03100
LEVOBUNOLOL HCL	0.5%	10	DROPS	$2.07500
LEVOBUNOLOL HCL	0.25%	5	DROPS	$2.75100
LEVOBUNOLOL HCL	0.25%	10	DROPS	$3.00000
LEVOBUNOLOL HCL	0.5%	15	DROPS	$2.18112
LEVONORGESTREL-ETH ESTRA	0.15-0.03		TABLET	$0.87000
LEVONORGESTREL-ETH ESTRA	0.1-0.2 MG		TABLET	$0.77000
LIDOCAINE HCL	5%		OINT.(GM)	$0.25000
LIDOCAINE HCL	20MG/ML		SOLUTION	$0.02700
LIDOCAINE HCL	40MG/ML		SOLUTION	$0.20100
LINDANE	1%		SHAMPOO	$0.09988
LINDANE	1%		LOTION	$0.07500
LISINOPRIL	5 MG		TABLET	$0.43260
LISINOPRIL	10 MG		TABLET	$0.22000
LISINOPRIL	20 MG		TABLET	$0.35000
LISINOPRIL	30 MG		TABLET	$0.61000
LISINOPRIL	40 MG		TABLET	$0.41000
LITHIUM CARBONATE	300MG		CAPSULE	$0.12500
LITHIUM CITRATE	8MEQ/5ML		SYRUP	$0.02700
LOPERAMIDE HCL	2MG		CAPSULE	$0.14550
LOPERAMIDE HCL	2MG		TABLET	$0.24850
LORAZEPAM	0.5MG		TABLET	$0.09815
LORAZEPAM	1MG		TABLET	$0.10300
LORAZEPAM	2MG		TABLET	$0.16810
LOVASTATIN	20 MG		TABLET	$1.12000
LOVASTATIN	40 MG		TABLET	$1.95000
LOXAPINE SUCCINATE	10MG		CAPSULE	$0.53400
LOXAPINE SUCCINATE	25MG		CAPSULE	$0.82770
LOXAPINE SUCCINATE	5MG		CAPSULE	$0.43430
LOXAPINE SUCCINATE	50MG		CAPSULE	$1.03560
MAG CARB/AL HYDROX/ALGINIC AC	131-31.7/5		ORAL SUSP	$0.00936
MAG CARB/AL HYDROX/ALGINIC AC	358-95/15		ORAL SUSP	$0.00936
MAG CARB/AL HYDROX/ALGINIC AC			ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	200-200-20		ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	400-400-30		ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	200-200-25		ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	400-400-40		ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	200-225-25		ORAL SUSP	$0.00936

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
MAG HYDROX/AL HYDROX/SIMETH	450-500-40		ORAL SUSP	$0.00936
MAG HYDROX/AL HYDROX/SIMETH	200-200-20		TAB CHEW	$0.03560
MAG HYDROX/AL HYDROX/SIMETH	200-200-25		TAB CHEW	$0.03560
MAG HYDROX/AL HYDROX/SIMETH	400-400-40		TAB CHEW	$0.03560
MAGALDRATE	540MG/5ML		ORAL SUSP	$0.00936
MAGALDRATE/SIMETHICONE	540-40		ORAL SUSP	$0.00940
MAGNESIUM HYDROXIDE/AL HYDROX	200-225/5		ORAL SUSP	$0.00936
MAGNESIUM HYDROXIDE/AL HYDROX	200-200		TAB CHEW	$0.03560
MAGNESIUM HYDROXIDE/AL HYDROX	75-248		TAB CHEW	$0.03560
MAGNESIUM HYDROXIDE/AL HYDROX	300-600/5		ORAL SUSP	$0.00422
MECLIZINE HCL	12.5MG		TABLET	$0.02400
MECLIZINE HCL	25MG		TABLET	$0.02550
MECLIZINE HCL	25MG		TAB CHEW	$0.02540
MECLOFENAMATE SODIUM	100MG		CAPSULE	$0.25790
MECLOFENAMATE SODIUM	50MG		CAPSULE	$0.15830
MEDROXYPROGESTERONE ACETATE	2.5MG		TABLET	$0.26548
MEDROXYPROGESTERONE ACETATE	10MG		TABLET	$0.32560
MEDROXYPROGESTERONE ACETATE	5MG		TABLET	$0.28270
MEGESTROL ACETATE	40MG		TABLET	$0.67070
METAPROTERENOL SULFATE	10MG/5ML		SYRUP	$0.01340
ME-TESTOSTERONE/ESTROGEN,ESTER	1.25-0.625		TABLET	$1.05000
ME-TESTOSTERONE/ESTROGEN,ESTER	2.5-1.25MG		TABLET	$1.29000
METFORMIN HCL	500MG		TABLET	$0.16923
METFORMIN HCL	850MG		TABLET	$0.22887
METFORMIN HCL	1000MG		TABLET	$0.28100
METHAZOLAMIDE	50MG		TABLET	$0.42120
METHAZOLAMIDE	25MG		TABLET	$0.31002
METHOCARBAMOL	500MG		TABLET	$0.20800
METHOCARBAMOL	750MG		TABLET	$0.28950
METHOCARBAMOL/ASPIRIN	400-325MG		TABLET	$0.14450
METHOTREXATE SODIUM	25MG/ML		VIAL	$1.89000
METHYLDOPA	500MG		TABLET	$0.12150
METHYLDOPA	250MG		TABLET	$0.06750
METHYLPHENIDATE HCL	10MG		TABLET	$0.37130
METHYLPHENIDATE HCL	5MG		TABLET	$0.28470
METHYLPHENIDATE HCL	20MG		TABLET	$0.58280
METHYLPHENIDATE HCL	20MG		TABLET SA	$0.95550
METHYLPREDNISOLONE	4MG		TABLET	$0.43820
METHYLPREDNISOLONE ACETATE	40MG/ML		VIAL	$4.77000
METOCLOPRAMIDE HCL	10MG		TABLET	$0.10950
METOCLOPRAMIDE HCL	5MG		TABLET	$0.09870
METOCLOPRAMIDE HCL	5MG/5ML		SOLUTION	$0.02470
METOPROLOL TARTRATE	100MG		TABLET	$0.11610
METOPROLOL TARTRATE	50MG		TABLET	$0.07650
METRONIDAZOLE	250MG		TABLET	$0.05000
METRONIDAZOLE	500MG		TABLET	$0.10000
MEXILETINE HCL	150MG		CAPSULE	$0.61623
MEXILETINE HCL	200MG		CAPSULE	$0.73175
MEXILETINE HCL	250MG		CAPSULE	$0.85137
MG TRISILICATE/AL HYDROX			TAB CHEW	$0.03560
MG TRISILICATE/ALH/NAHCO3/AA	20-80MG		TAB CHEW	$0.03560
MG TRISILICATE/ALH/NAHCO3/AA	40-160MG		TAB CHEW	$0.03560
MINOCYCLINE HCL	100MG		CAPSULE	$0.80850

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
MINOCYCLINE HCL	50MG		CAPSULE	$0.40430
MINOXIDIL	2.5MG		TABLET	$0.19320
MINOXIDIL	10MG		TABLET	$0.28000
MISOPROSTOL	200MCG		TABLET	$0.95000
NA PHOS,M-B/NA PHOS,DI-BA			ENEMA	$0.00658
NADOLOL	160MG		TABLET	$1.10910
NADOLOL	40MG		TABLET	$0.50930
NADOLOL	80MG		TABLET	$0.65930
NADOLOL	20MG		TABLET	$0.47250
NAPHAZOLINE HCL	0.1%		DROPS	$0.31500
NAPROXEN	250MG		TABLET	$0.10750
NAPROXEN	375MG		TABLET	$0.14020
NAPROXEN	500MG		TABLET	$0.17010
NAPROXEN SODIUM	275MG		TABLET	$0.15310
NAPROXEN SODIUM	550MG		TABLET	$0.24130
NEOMYCIN SULFATE/GRAMICID/POLYMXIN			DROPS	$1.71200
NEOMYCIN SULFATE	500MG		TABLET	$0.00000
NIACIN	250MG		TABLET	$0.02759
NIACIN	500MG		TABLET	$0.02990
NIACIN	500MG		TABLET	$0.02990
NICARDIPINE HCL	30MG		CAPSULE SA	$0.68100
NICARDIPINE HCL	20MG		CAPSULE	$0.42420
NIFEDIPINE	10MG		CAPSULE	$0.05550
NIFEDIPINE	20MG		CAPSULE	$0.17480
NITROFURANTOIN MACROCRYSTAL	100MG		CAPSULE	$1.16300
NITROFURANTOIN MACROCRYSTAL	50MG		CAPSULE	$0.65400
NITROGLYCERIN	0.4MG/HR		PATCH TD24	$1.39430
NITROGLYCERIN	0.2MG/HR		PATCH TD24	$1.24260
NITROGLYCERIN	0.6MG/HR		PATCH TD24	$1.53230
NITROGLYCERIN	2.5MG		CAPSULE SA	$0.03350
NITROGLYCERIN	6.5MG		CAPSULE SA	$0.03620
NITROGLYCERIN	0.1MG/HR		PATCH TD24	$1.21433
NITROGLYCERIN	9MG		CAPSULE SA	$0.06050
NORETHINDRONE-ETHINYL ESTRAD	0.5-0.035		TABLET	$0.90000
NORETHINDRONE-ETHINYL ESTRAD	1-0.035MG		TABLET	$0.82400
NORGESTREL-ETHINYL ESTRADIOL	0.3-0.03MG		TABLET	$0.83770
NORGESTREL-ETHINYL ESTRADIOL	0.5-0.05MG		TABLET	$1.24000
NORTRIPTYLINE HCL	25MG		CAPSULE	$0.14960
NORTRIPTYLINE HCL	50MG		CAPSULE	$0.18300
NORTRIPTYLINE HCL	75MG		CAPSULE	$0.23420
NYSTATIN	100K U/ML		ORAL SUSP	$0.12500
NYSTATIN	500000 U		TABLET	$0.51000
NYSTATIN	100000 U/G	15	CREAM(GM)	$0.07250
NYSTATIN	100000 U/G	30	OINT.(GM)	$0.12000
NYSTATIN	100000 U/G	30	CREAM(GM)	$0.09700
NYSTATIN	100000 U/G	15	OINT.(GM)	$0.09700
NYSTATIN/TRIAMCIN	100000-0.1	15	CREAM(GM)	$0.07320
NYSTATIN/TRIAMCIN	100000-0.1	30	CREAM(GM)	$0.09800
NYSTATIN/TRIAMCIN	100000-0.1	15	OINT.(GM)	$0.08000
NYSTATIN/TRIAMCIN	100000-0.1	30	OINT.(GM)	$0.09750
NYSTATIN/TRIAMCIN	100000-0.1	60	OINT.(GM)	$0.09900
NYSTATIN/TRIAMCIN	100000-0.1	60	CREAM(GM)	$0.12500
OXACILLIN SODIUM	250MG		CAPSULE	$0.18596

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
OXACILLIN SODIUM	500MG		CAPSULE	$0.36035
OXACILLIN SODIUM	250MG/5ML		SUSP RECON	$0.04521
OXAZEPAM	10MG		CAPSULE	$0.32000
OXAZEPAM	30 MG		CAPSULE	$0.84027
OXAZEPAM	15MG		TABLET	$0.06670
OXYBUTYNIN CHLORIDE	5MG		TABLET	$0.15900
OXYCODONE HCL/ACETAMINOPHEN	5-325MG		TABLET	$0.09530
OXYCODONE HCL/ACETAMINOPHEN	5-500MG		CAPSULE	$0.28340
OXYCODONE/ASPIRIN	4.88-325MG		TABLET	$0.17630
PAPAVERINE HCL	150MG		CAPSULE SA	$0.03909
PENICILLIN V POTASSIUM	125MG/5ML		SUSP RECON	$0.01389
PENICILLIN V POTASSIUM	250MG/5ML		SUSP RECON	$0.01657
PENICILLIN V POTASSIUM	250MG		TABLET	$0.04137
PENICILLIN V POTASSIUM	500MG		TABLET	$0.06699
P-EPHED HCL/TRIPROLIDINE HCL	60-2.5MG		TABLET	$0.02730
P-EPHED HCL/TRIPROLIDINE HCL	30-1.25/5		SYRUP	$0.01030
PERMETHRIN	1%		LIQUID	$0.11300
PERPHENAZINE	2MG		TABLET	$0.22370
PERPHENAZINE	4MG		TABLET	$0.31010
PERPHENAZINE	8MG		TABLET	$0.36200
PERPHENAZINE	16MG		TABLET	$0.67130
PHENAZOPYRIDINE HCL	100MG		TABLET	$0.08540
PHENAZOPYRIDINE HCL	200MG		TABLET	$0.10680
PHENOBARBITAL	30MG		TABLET	$0.00750
PHENOBARBITAL	20MG/5ML		ELIXIR	$0.00600
PHENYLEPHRINE/PYRIL TAN/CP	5-12.5-2/5		ORAL SUSP	$0.16885
PHENYTOIN SODIUM EXTENDED	100MG		CAPSULE	$0.18000
PILOCARPINE HCL	1%		DROPS	$0.22578
PILOCARPINE HCL	2%		DROPS	$0.30316
PILOCARPINE HCL	6%		DROPS	$0.47002
PILOCARPINE HCL	4%		DROPS	$0.36210
PINDOLOL	10MG		TABLET	$0.21750
PINDOLOL	5MG		TABLET	$0.15750
PIROXICAM	10MG		CAPSULE	$0.03940
PIROXICAM	20MG		CAPSULE	$0.04230
POT BICARB/SODIUM BICARB/CITRIC ACID			TABLET EFF	$0.03560
POTASSIUM CHLORIDE	10MEQ		TABLET SA	$0.10000
POTASSIUM CHLORIDE	20MEQ		TAB PRT SR	$0.36000
POTASSIUM CHLORIDE	8MEQ		TABLET SA	$0.07650
POTASSIUM CHLORIDE	40MEQ/15ML		LIQUID	$0.00490
POTASSIUM CHLORIDE	20MEQ/15ML		LIQUID	$0.00300
POTASSIUM CHLORIDE	10MEQ		CAPSULE SA	$0.10840
POTASSIUM CHLORIDE	20MEQ		PACKET	$0.19980
POTASSIUM CHLORIDE	25MEQ		PACKET	$0.19240
PRAZOSIN HCL	5MG		CAPSULE	$0.30000
PRAZOSIN HCL	1MG		CAPSULE	$0.11500
PRAZOSIN HCL	2MG		CAPSULE	$0.22010
PREDNISOLONE	5MG		TABLET	$0.02710
PREDNISOLONE ACETATE	1%		DROPS SUSP	$0.95241
PREDNISONE	1MG		TABLET	$0.10352
PREDNISONE	5MG		TABLET	$0.01907
PREDNISONE	50MG		TABLET	$0.17941
PREDNISONE	2.5MG		TABLET	$0.03640

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
PREDNISONE	10MG		TABLET	$0.02900
PREDNISONE	20MG		TABLET	$0.05000
PRENATAL VIT/FE FUMARATE/FA	27-0.8MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	29-1MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	60-1MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	65-1MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	66-1MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	27-0.5MG		TABLET	$0.05990
PRENATAL VIT/FE FUMARATE/FA	27-1MG		TABLET	$0.05990
PRENATAL VIT/FE GLUCONATE/FA	30-0.4MG		TABLET	$0.05990
PRENATAL VIT/FE GLUCONATE/FA	30-0.8MG		TABLET	$0.05990
PRENATAL VITS W-CA,FE,FA(<1MG)			TABLET	$0.05990
PRENATAL VITS W-CA,FE,FA(1MG)			TABLET	$0.05990
PROBENECID	500MG		TABLET	$0.46780
PROCAINAMIDE HCL	500MG		CAPSULE	$0.00000
PROCAINAMIDE HCL	500MG		TABLET SA	$0.00000
PROCAINAMIDE HCL	750MG		TABLET SA	$0.00000
PROCAINAMIDE HCL	250MG		CAPSULE	$0.05565
PROCAINAMIDE HCL	375MG		CAPSULE	$0.06351
PROCAINAMIDE HCL	250MG		TABLET	$0.11030
PROCHLORPERAZINE MALEATE	10MG		TABLET	$0.80930
PROCHLORPERAZINE MALEATE	5MG		TABLET	$0.53930
PROCHLORPERAZINE MALEATE	25 MG		SUPP.	$2.00000
PROMETHAZINE HCL	50MG		SUPP.RECT	$3.31000
PROMETHAZINE HCL	25MG		TABLET	$0.30000
PROMETHAZINE HCL	6.25MG/5ML		SYRUP	$0.01230
PROPANTHELINE BROMIDE	15MG		TABLET	$0.00000
PROPARACAINE HCL	0.5%		DROPS	$0.49900
PROPOXYPHENE HCL	65MG		CAPSULE	$0.23000
PROPOXYPHENE HCL/ACETAMINOPHEN	65-650MG		TABLET	$0.12760
PROPOXYPHENE HCL/ASA/CAFFEINE	65MG		CAPSULE	$0.12000
PROPOXYPHENE/ACETAMINOPHEN	100-650MG		TABLET	$0.16726
PROPRANOLOL HCL/HCTZ	40-25MG		TABLET	$0.05100
PROPRANOLOL HCL/HCTZ	80-25MG		TABLET	$0.07430
PSEUDOEPHEDRINE HCL	60MG		TABLET	$0.02730
PSEUDOEPHEDRINE HCL	30MG/5ML		SYRUP	$0.01045
PSEUDOEPHEDRINE HCL	30MG		TABLET	$0.02580
PSEUDOEPHEDRINE HCL	9.4MG/ML		DROPS	$0.00840
PSEUDOEPHEDRINE HCL	15MG/5ML		SYRUP	$0.00840
PSEUDOEPHEDRINE HCL/CHLOR-MAL	120-8MG		CAP.SR 12H	$0.24090
PSYLLIUM SEED/DEXTROSE			POWDER	$0.00771
QUINIDINE SULFATE	200MG		TABLET	$0.19400
QUINIDINE SULFATE	300MG		TABLET	$0.31980
QUININE SULFATE	325MG		CAPSULE	$0.21000
RANITIDINE HCL	150MG		CAPSULE	$0.43000
RANITIDINE HCL	300MG		CAPSULE	$0.74000
RANITIDINE HCL	150MG		TABLET	$0.08000
RANITIDINE HCL	300MG		TABLET	$0.30530
RESERPINE	0.25MG		TABLET	$0.01580
SALSALATE	750MG		TABLET	$0.09600
SELEGILINE HCL	5MG		TABLET	$1.79700
SELENIUM SULFIDE	2.5%		SHAMPOO	$0.03510
SILVER SULFADIAZINE	1%		CREAM(GM)	$0.11100

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
SIMETHICONE/SOD BICARB/TTA	460-420/G		GRAN. EFF.	$0.00422
SODIUM BICARBONATE	325MG		TABLET	$0.03560
SODIUM BICARBONATE	650MG		TABLET	$0.03560
SODIUM BICARBONATE/SODIUM CIT			GRAN. EFF.	$0.00422
SODIUM FLUORIDE	1MG		TAB CHEW	$0.01854
SODIUM FLUORIDE	2.2MG/ML		DROPS	$0.07988
SODIUM FLUORIDE	0.25MG		TAB CHEW	$0.00570
SODIUM FLUORIDE	0.5MG		TAB CHEW	$0.00570
SPIRONOLACTONE	100MG		TABLET	$0.89000
SPIRONOLACTONE	50MG		TABLET	$0.61000
SULFACETAMIDE SODIUM	10%		OINT.(GM)	$0.65420
SULFACETAMIDE SODIUM	10%	2.5	DROPS	$0.09700
SULFACETAMIDE SODIUM	10%	5	DROPS	$0.32400
SULFACETAMIDE SODIUM	10%	10	DROPS	$0.33380
SULFAMETHOXAZOLE/TRIMETHOPRIM	200-40MG/5		ORAL SUSP	$0.01260
SULFAMETHOXAZOLE/TRIMETHOPRIM	800-160MG		TABLET	$0.07720
SULFAMETHOXAZOLE/TRIMETHOPRIM	400-80MG		TABLET	$0.06110
SULFASALAZINE	500MG		TABLET	$0.11630
SULFATHIAZ/SULFACET/SULFABENZ			CREAM/APPL	$0.05100
SULINDAC	150MG		TABLET	$0.17540
SULINDAC	200MG		TABLET	$0.23310
TAMOXIFEN CITRATE	10MG		TABLET	$1.63000
TESTOSTERONE CYPIONATE (NDC 00009-0417-01)	200 MG/ML	1	VIAL	$16.73000
TESTOSTERONE CYPIONATE (NDC 00009-0417-02)	200 MG/ML	10	VIAL	$7.67800
TETRACYCLINE HCL	250MG		CAPSULE	$0.02792
TETRACYCLINE HCL	500MG		CAPSULE	$0.04490
TETRACYCLINE HCL	125MG/5ML		ORAL SUSP	$0.01754
THEOPHYLL/EPHED HCL/PHENOBARBITAL	130-24-8MG		TABLET	$0.01500
THEOPHYLL/EPHED HCL/PHENOBARBITAL			TABLET	$0.01500
THEOPHYLLINE ANHYDROUS	125MG		TABLET	$0.34140
THEOPHYLLINE ANHYDROUS	100MG		TAB.SR 12H	$0.07000
THEOPHYLLINE ANHYDROUS	200MG		TAB.SR 12H	$0.08500
THEOPHYLLINE ANHYDROUS	300MG		TAB.SR 12H	$0.10000
THEOPHYLLINE ANHYDROUS	80MG/15ML		ELIXIR	$0.00564
THIORIDAZINE HCL	100MG/ML		ORAL CONC.	$0.46110
THIORIDAZINE HCL	30MG/ML		ORAL CONC.	$0.10130
THIOTHIXENE	1MG		CAPSULE	$0.08440
THIOTHIXENE	10MG		CAPSULE	$0.23020
THIOTHIXENE	2MG		CAPSULE	$0.10900
THIOTHIXENE	5MG		CAPSULE	$0.15580
THIOTHIXENE HCL	5MG/ML		ORAL CONC.	$0.20940
TIMOLOL MALEATE	10MG		TABLET	$0.25680
TIMOLOL MALEATE	20MG		TABLET	$0.47837
TIMOLOL MALEATE	5MG		TABLET	$0.17355
TIZANIDINE HCL	4MG		TABLET	$1.06000
TOBRAMYCIN SULFATE	0.3%		DROPS	$0.80700
TOLAZAMIDE	250MG		TABLET	$0.08018
TOLAZAMIDE	500MG		TABLET	$0.15328
TOLMETIN SODIUM	400MG		CAPSULE	$0.39900
TOLMETIN SODIUM	600MG		TABLET	$0.54000
TOLMETIN SODIUM	200MG		TABLET	$0.67490
TRAMADOL HCL	50MG		TABLET	$0.15000
TRAZODONE HCL	100MG		TABLET	$0.09750

State of Washington
Maximum Allowable Cost List
2/1/03

NAME	STRENGTH	SIZE	FORM	MAC
TRAZODONE HCL	150MG		TABLET	$0.58430
TRETINOIN	0.01%		GEL	$1.15000
TRETINOIN	0.025%		GEL	$1.10000
TRETINOIN	0.025%		CREAM(GM)	$1.01000
TRETINOIN	0.05%		CREAM(GM)	$1.22000
TRETINOIN	0.10%		CREAM(GM)	$1.41000
TRIAMCINOLONE ACETONIDE	0.1%		CREAM(GM)	$0.07400
TRIAMCINOLONE ACETONIDE	0.5%		OINT.(GM)	$0.22220
TRIAMCINOLONE ACETONIDE	0.1%		LOTION	$0.11500
TRIAMCINOLONE ACETONIDE	0.1%		PASTE	$0.76500
TRIAMCINOLONE ACETONIDE	0.1%		OINT.(GM)	$0.07500
TRIAMCINOLONE ACETONIDE	0.025%		CREAM(GM)	$0.05670
TRIAMCINOLONE ACETONIDE	0.025%		OINT.(GM)	$0.05670
TRIAMTERENE/HCTZ	75-50MG		TABLET	$0.04580
TRIAMTERENE/HCTZ	37.5-25MG		TABLET	$0.23930
TRIAMTERENE/HCTZ	50-25MG		CAPSULE	$0.17700
TRIAMTERENE/HCTZ	37.5-25MG		CAPSULE	$0.30750
TRIAZOLAM	0.25MG		TABLET	$0.35081
TRIAZOLAM	0.125MG		TABLET	$0.32131
TRIFLUOPERAZINE HCL	10MG		TABLET	$0.47870
TRIFLUOPERAZINE HCL	2MG		TABLET	$0.32330
TRIFLUOPERAZINE HCL	5MG		TABLET	$0.38120
TRIMETHOBENZAMIDE HCL/B-CAINE	200MG		SUPP.RECT	$0.64525
TRIMETHOPRIM	100MG		TABLET	$0.33000
URSODIOL	300 MG		CAPSULE	$1.86830
VALPROATE SODIUM	250MG/5ML		SYRUP	$0.05940
VALPROIC ACID	250MG		CAPSULE	$0.15450
VERAPAMIL HCL	120MG		TABLET	$0.08000
VERAPAMIL HCL	80MG		TABLET	$0.04800
VERAPAMIL HCL	240MG		TABLET SA	$0.31130
VERAPAMIL HCL	180MG		TABLET SA	$0.35060
VERAPAMIL HCL	40MG		TABLET	$0.14640
WARFARIN SODIUM	10MG		TABLET	$0.35860
WARFARIN SODIUM	2MG		TABLET	$0.27590
WARFARIN SODIUM	1MG		TABLET	$0.25000
WARFARIN SODIUM	5MG		TABLET	$0.30000
WARFARIN SODIUM	2.5MG		TABLET	$0.28230
WARFARIN SODIUM	7.5MG		TABLET	$0.36500
WARFARIN SODIUM	4MG		TABLET	$0.29140
ZOFRAN (NDC 00173-0442-00)	2 MG/ML	20	VIAL	$11.41000

Billing

General information

MAA bases its prescription drug reimbursement on (1) the standard 11-digit National Drug Code (NDC) (5-4-2 format), and (2) the quantity filled.

MAA's total reimbursement for a prescription drug must not exceed the lowest of:

(a) Estimated acquisition cost (EAC) plus a dispensing fee;
(b) Maximum allowable cost (MAC) plus a dispensing fee;
(c) Federal Upper Limit (FUL) plus a dispensing fee;
(d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Services (PHS) Act and dispensed to medical assistance clients;
(e) Automated maximum allowable cost (AMAC) plus a dispensing fee;
(f) Certified average wholesale price (CAWP) plus a dispensing fee; or
(e) The provider's usual and customary charge to the non-Medicaid population.

[WAC 388-530-1300]

Bill your usual and customary charge (the charge you bill the general public) when billing MAA.

Note: This means:

- If the pharmacy provider offers a discount, rebate, promotion or other incentive that directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to MAA for the prescription. (Example: A $5.00 off coupon for purchases elsewhere in the store.)
- If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAA when giving the free product to a medical assistance client.

Drug quantities

Quantities must be billed using the metric quantity or metric decimal as appropriate.
See Section K: Point-of-Sale, NCPDP payor sheet (pages K.7-K.9).

National Association of Boards of Pharmacy (NABP) Number

- All claims must contain the NABP number.
- Do not use the 7-digit provider number assigned to you by MAA for claims submission. However, MAA's assigned provider number will appear on your Remittance and Status Reports.

NCPDP billing unit standards

Dosage Forms Billed as "Each"

- Solid Oral Dosage Forms
- Tablets
- Capsules
- Powder-filled vials, ampoules, and syringes are billed as a unit of "each" regardless of size or content of vial, ampoule or syringe in metric units.
- Suppositories must be billed as the number of individual suppositories dispensed, *not the number of packages, which may contain more than one suppository.*
- Convenience Packets, Therapy Packs and packs of Oral Contraceptive must be billed as the number of individual tablets or capsules (eaches) dispensed, *not the number of boxes or packages*.
- Non-filled Hypodermic Syringes must be billed as the actual number of syringes and/or hypodermic needles dispensed (eaches). *Do not bill the number of boxes or plastipaks*.
- Kits are defined as products with at least two (2) different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single National Drug Code (NDC). Kits are intended to be dispensed as a unit and should be billed as a unit of EACH kit dispensed.
- Blood Derivatives products have varying potencies from batch to batch. Therefore, antihemophilic products must be billed as an each using the number of UNITS dispensed (i.e. International units or micrograms).
- Prolastin must be billed as an each using the number of MILLIGRAMS dispensed (each).
- Transdermal Patches and Powder Packets must be billed as eaches, *not the number of boxes or packages*
- Unit-of-use packages with a quantity less than one should be billed as "one each". This rule does not apply to injectable products (see above). Examples of unit-of-use products with a quantity less than one include ointments in packets and eye drops in dropperettes.
- Powder-filled Blisters must be billed as the number of blisters, not by weight.

Dosage Forms Billed as "Milliliter" (ml)

- Liquid Oral Dosage Forms, Syrups, Elixirs, etc. must be billed as the total number of milliliters (ml) dispensed.
- Injectables that are liquid-filled vials, ampoules, and syringes must be billed as the total number of milliliters (ml) dispensed.
- Liquid Ophthalmic and Otic Products must be billed as the number of milliliters (ml) contained in the package according to manufacturer labeling.
- Reconstitutable Ophthalmic and Otic Products must be billed as the total number of milliliters (ml) dispensed after reconstitution; i.e., once the powder has been reconstituted with diluent, according to manufacturer instructions.
- Reconstitutable Oral Products must be billed as the total number of milliliters (ml) dispensed after reconstitution, according to the manufacturer's instructions.

Dosage Forms Billed as "Gram" (gm)

- Creams
- Ointments
- Ophthalmic ointments must be billed as the number of grams (gm) in the package according to the manufacturer's labeling.
- Bulk Powders must be billed as the number of grams (gm) dispensed.

Dosage Forms Billed as Either "Milliliter" or "Gram"

- Inhalers, inhaler refills and aerosols should be represented as the metric quantity contained in the packaging in grams (gm) or milliliters (ml) as specified by the manufacturer on the labeling.
- Topical Products - These products must be billed as the number of grams (gm) or milliliters (ml) in the container. *Do not bill the number of ounces dispensed or the number of packages dispensed.*

Dosage Forms Billed as "Exception"

Miscellaneous Products

Several products do not fit into any of the above categories. These products should use the billing unit type specified below.

- Cordran Tape (one each)
- TesTape (one each)
- EpiPen (one each)
- EpiPen Jr. (one each)
- Imitrex Kit Refill (one each)
- Ventolin Rotacaps with Rotahaler (100 each, 24 each)

[1] Materials reproduced with the consent of the National Council for Prescription Drug Programs, Inc. 1988, 1992, 2002 NCPDP. NCPDP is a registered trademark of the National Council for Prescription Drug Programs, Inc. The Billing Unit Standard and Implementation Guide are available from NCPDP at www.ncpdp.org. The documents are free to NCPDP members, and available for a fee to non-members.

Billing a client **[Refer to WAC 388-502-0160]**

Reminder

- A common billing complaint is the pharmacist misinterpreting a Point-of-Sale (POS) message as a denial and charging the client instead of calling MAA for prior authorization (PA). Please remember that it is the pharmacist's responsibility to call MAA for PA when the pharmacist receives a PA message from the POS system.

  The Point of Sale (POS) system does not solve the problem of identifying clients who are not currently on MAA's eligibility file. For clients whose DSHS Medical ID cards show that they are eligible, but their claims deny in the POS system for lack of eligibility, please take the following steps:

  1. **FAX** a copy of the client's DSHS Medical ID card to Claims Entry at (360) 586-1403; or
  2. Mail in a **completed** paper claim with a photocopy of the Medical ID card attached.

     Faxed copies of DSHS Medical ID cards will be updated within two working days in order for claims to be resubmitted. Please do not fax **claims** to this number.

☞ **See Washington Administrative Code on next page…**

Refer to WAC 388-502-0160

1. A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.

2. The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

3. A provider may bill a client only if one of the following situations apply:

    a. The client is enrolled in medical assistance managed care and the client and provider comply with the requirements in WAC 388-538-095;

    b. The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request.

       The agreement must include each of the following elements to be valid:

       i. A statement listing the specific service to be provided;
       ii. A statement that the service is not covered by MAA;
       iii. A statement that the client chooses to receive and pay for the specific service; and
       iv. The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.

    c. The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

    d. The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA. [Medical Assistance is not insurance.];

e. The provider has documentation that the client represented himself/herself as a private pay patient and not receiving Medical Assistance when the client is already eligible for and receiving benefits under an MAA medical program. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection 3.b. regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection 4 of this section for that service.

f. The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA; or

g. The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a $3.00 copayment may be imposed on the client by the hospital, except when:

i. Reasonable alternative access to care was not available;
ii. The "indigent person" criteria in WAC 246-453-040(1) applies;
iii. The client was 18 years of age or younger;
iv. The client was pregnant or within 60 days postpregnancy;
v. The client is an American Indian or Alaska Native;
vi. The client was enrolled in a MAA managed care plan, including Primary Care Case Management (PCCM);
vii. The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
viii. The client receives waivered services such as community options program entry system (COPES) and community alternatives program (CAP).

4. If a client becomes eligible for a covered service that has already been provided because the client:

a. Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;

b. Receives a delayed certification (see page K.2), the provider must:

   i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
   ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

c. Receives a retroactive certification (see page K.3), the provider:

   i. Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
   ii. May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

Note: Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.

If eligible, the client receives a DSHS Medical ID card dated the first of the month of application. The Medical ID card is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

5. Hospitals may not bill, demand, collect, or accept payment from a Medically Indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described in subsection 3.g. of this section.

6. A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

   This includes, but is not limited to:

   (a) Medical charts;
   (b) Radiological or imaging films; and
   (c) Laboratory or other diagnostic test results.

Hospice clients

Clients who have elected to receive hospice benefits are identified by an "**X"** in the hospice area on their DSHS Medical ID card.

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated by the designated hospice agency and attending physician **only**.

Services **not** related to the terminal illness may be provided to clients on a fee-for-service basis. When billing for hospice clients and the service is **not** related to the terminal illness, use the following billing procedures:

BILLING:

Electronic billers must enter "**K**" in the following position, accordingly:

Tape format .... in the 46th position of the HD record
EMC format........................... in the 54th position of the HD record
Multi-insurer format.............. in the 79th position of the P3 record

Hard copy billers must enter "**K**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers must enter "**11** " in the Customer Location field.

Healthy Options Managed Care clients

MAA will reimburse for drugs dispensed to clients enrolled in a Healthy Options managed care plan only if the drugs are outside the scope of the managed care plan and covered under fee-for-service.

Examples:

- Prescriptions written by **dentists** will be paid fee-for-service without any special comments when the dentist's MAA provider number is placed on the claim in the prescriber ID field.
- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed following abortion procedure are reimbursable on a fee-for-service basis for clients enrolled in a Healthy Options managed care plan.
- Over-the-counter contraceptives from a pharmacy that is not contracted with the clients managed care plan.
- HIV Anti-Retrovirals.

Healthy Options Clients Who Self-Refer

Healthy Options managed care clients may self-refer to any of the following entities and receive prescriptions related to the therapeutic classifications listed below. The prescriptions are reimbursable on a fee-for-service basis and, clients may take these prescriptions to any Medicaid-participating pharmacy.

Pharmacists must document the prescribing entity (i.e., mental health center, family planning clinic, or health department) on the original prescription. All other fee-for-service rules apply to claims for the therapeutic classes listed below, including prior authorization requirements.

Community Mental Health Centers may prescribe mental health drugs within the following therapeutic drug classes:

Attention Deficit Hyperactive Disorder (ADHD) drugs
Antianxiety
Anticonvulsants
Antidepressants
Antipsychotics
Central Nervous System (CNS) drugs

Healthy Options clients who self-refer (continued)

Pharmacies may bill MAA for the following Community Mental Health ancillary drugs. These drugs may be prescribed in addition to the therapeutic classes on the previous page: Any strength or dose form not listed below will not be covered under these provisions.

Akineton 2mg tab
Amantadine 100mg caps and 50mg/5ml liquid
Atenolol 25mg, 50mg, and 100mg tabs
Benztropine mesylate 0.5mg, 1mg, 2mg tabs
Clonidine 0.1mg, 0.2mg, and 0.3mg tabs (no patches)
Cytomel (T4) 5mcg, 25mcg, and 50mcg tabs
Diphenhydramine 25mg and 50mg caps
Guanfacine 1mg and 2mg tabs
Hydroxyzine Pamoate 25mg caps, 25mg/ml, 50mg caps, 50mg/ml, 100mg caps
Kemadrin 5mg tab
L-Thyroxine all strengths
Nadolol 20mg, 40mg, 80mg, 120mg, and 160mg tabs (no sustained action – SA)
Pindolol 5mg and 10mg tabs
Propranolol 10mg, 20mg, 40mg, 60mg, 80mg, and 90mg tabs (no sustained action – SA)
Trihexyphenidyl 2mg tabs, 5mg, SA, and tabs
Vitamin E (expedited prior authorization only for Tardive Dyskensia)

Family Planning Agencies may prescribe family planning related drugs for sexually transmitted diseases (STD) (excluding HIV), abortion-related drugs, and prescription contraceptives within the following therapeutic drug classes:

Analgesics
Antibiotics
Anti-emetics
Antifungals
Anti-infectives
Anti-inflammatories
Contraceptive drugs/devices
Oxytocics

Health Departments may prescribe drugs for STD (excluding HIV), tuberculosis, and prescription contraceptives within the following therapeutic drug classes:

Antibiotics
Anti-emetics
Anti-infectives
Contraceptive drugs/devices
Tuberculosis drugs

BILLING:

Electronic billers must enter "**X**" in the following position, accordingly:

Tape format .... in the 46th position of the HD record
EMC format........................... in the 54th position of the HD record
Multi-insurer format.............. in the 79th position of the P3 record

Hard copy billers must enter one of the following comments in the *Justification/ Comments* field on the Pharmacy Statement [DSS 13-714].

Prescribed by Family Planning Agency
Prescribed by Community Mental Health Center; or
Prescribed by Health Department

Point-of-Sale billers must enter "**2**" in the Medical Certification field.

Family Planning Only and TAKE CHARGE clients

Clients on the Family Planning Only or TAKE CHARGE Programs are identified by the statement "Family Planning Only" or "TAKE CHARGE" on their DSHS Medical ID card.

Qualified agencies may prescribe family planning related drugs for sexually transmitted diseases (STD) (excluding HIV), abortion-related drugs, and prescription contraceptives within the following therapeutic drug classes:

Analgesics
Antibiotics
Anti-emetics
Antifungals
Anti-infectives
Anti-inflammatories
Contraceptive drugs/devices
Oxytocics

Skilled Nursing Facility clients

Over-the-Counter (OTC) Drugs

MAA does not reimburse for OTC drugs when the client resides in a skilled nursing facility. Reimbursement for OTC drugs is included in the skilled nursing facility per diem.

Medications for skilled nursing facility clients on leave

Skilled nursing facility clients on leave should have their additional maintenance prescriptions filled for the duration of the leave. If client leaves weekly, prescriptions should be filled for a one-month supply.

Skilled nursing facilities should determine which of the following methods will be followed when a skilled nursing facility client goes on leave:

- The client may take the prescription medication home and keep it there for use during skilled nursing facility absences; or
- The client may return the prescription medication to the skilled nursing facility following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

  Both of these practices are in accord with state pharmaceutical regulations.

BILLING:

Electronic billers must enter "Q" as follows::

Tape format .... in the 46th position of the HD record
EMC format........................... in the 54th position of the HD record
Multi-insurer format.............. in the 79th position of the P3 record

Hard copy billers must indicate "weekend pass" or "take home/leave supply" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "8" in the Medical Certification Code field.

Emergency Kits

The *emergency kit* is a set of limited pharmaceuticals furnished to a skilled nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each skilled nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

Medications supplied from the emergency kit are to be replaced by an equivalent amount of medications from the client's prescription by the skilled nursing facility. No charge shall be made to MAA for such replacements.

Skilled Nursing Facility Unit Dose Delivery Systems
[Refer to WAC 388-530-1550]

MAA recognizes two types of **Unit Dose Delivery Systems** for skilled nursing facilities:

- ➨ **True Unit Dose Delivery System**
- ➨ **Modified Unit Dose Delivery System**

Participating True Unit Dose and Modified Unit Dose providers receive the "unit dose dispensing fee" when dispensing in-house unit dose prescriptions. The term *in-house unit dose* applies to bulk pharmaceutical products that are packaged by the pharmacy for true or modified unit dose delivery. Only True Unit Dose providers will receive the unit dose dispensing fee for drugs that are manufacturer packaged in unit dose form (e.g., blister packs, punch cards, etc.). Modified Unit Dose providers will receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to the Reimbursement Section of these billing instructions for MAA Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?
[Refer to WAC 388-530-1600(1)]

To be eligible for a unit dose dispensing fee from MAA, a pharmacy must:

1. Notify MAA in writing of its intent to provide unit dose service;
2. Specify the type of unit dose service to be provided;
3. Identify the nursing facility or facilities to be served;
4. Indicate the approximate date unit dose service to the facility or facilities will commence; and
5. Sign an agreement to follow department requirements for unit dose reimbursement.

For information on becoming a True Unit Dose or a Modified Unit Dose provider, please call Provider Enrollment at (866) 545-0544 or send a written request to:

Medical Assistance Administration
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

How do pharmacies bill MAA under a true or modified unit dose delivery system? [Refer to WAC 388-530-1600(2)(3)(4)]

Under a true unit dose delivery system, a pharmacy must bill MAA only for the number of drug units actually used by the MAA client in the skilled nursing facility.

Under a modified unit dose delivery system, a pharmacy must bill MAA for the number of drug units dispensed to the MAA client in the skilled nursing facility.

It is the unit dose pharmacy provider's responsibility to coordinate with the skilled nursing facilities to ensure that the unused drugs the pharmacy dispensed to the MAA client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of all unused drugs returned to the pharmacy from the skilled nursing facility on or before the 60th day following the date the drug was dispensed. This adjustment must conform to the skilled nursing facility's monthly log.

Exception:

- Unit dose providers do not have to credit MAA for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

BILLING:

Electronic billers must enter "3" as follows::

Tape format .... in the 46th position of the HD record
EMC format.......................... in the 54th position of the HD record
Multi-insurer format............. in the 79th position of the P3 record

Hard copy billers must indicate "In-house unit dose" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "3" in the Unit Dose Indicator field.

Who is responsible for the cost of repackaging client's bulk medications? [Refer to WAC 388-530-1600(5)]

The cost of repackaging is the responsibility of the skilled nursing facility when the repackaging is done:

- To conform with the nursing facility's delivery system; or
- For the nursing facility's convenience.

Pharmacies may not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form.

What records do pharmacies need to keep?
[WAC 388-530-1600(6)(7)]

The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each skilled nursing facility served, including, but not limited to the following information:

- Facility name and address.
- Client's name and patient identification code (PIC).
- Drug name/strength.
- National Drug Code (NDC).
- Quantity and date dispensed.
- Quantity and date returned.
- Value of returned drugs or amount credited.
- Explanation for no credit given or nonreusable returns; and
- Prescription number.

Upon request, the pharmacy must submit copies of these monthly logs to MAA. MAA may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to MAA?
[WAC 388-530-1600(8)]

When the pharmacy submits the completed annual prescription volume survey to MAA, it must include an updated list of skilled nursing facilities served under unit dose systems.

Third Party Liability

Clients with privately purchased HMO insurance will have an ***HI, HO, or HM*** identifier in the insurance column on their DSHS medical ID card. These clients are required to use the HMO facilities for their medical services (including pharmacy). If services are provided that are not covered by the HMO plan, the claim may be submitted to MAA for processing without first billing the HMO to receive a denial from them. Enter "Not covered by HMO" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714]. The pharmacy must maintain documentation of the non-HMO coverage.

The carrier code information is available on the DSHS/MAA website at http://maa.dshs.wa.gov, Click on "Downloadable Files." The information can be downloaded and printed, or used as an on-line reference.

For questions related to insurance, contact:

Coordination of Benefits Hotline
1-800-562-6136
or
Coordination of Benefits Program
Division of Customer Support
PO Box 45565
Olympia, WA 98504-5565

Billing

Pharmacy providers who submit their claims through the on-line Point of Sale (POS) system are not required to submit third party Explanations of Benefit (EOB) documents. However, documentation **must** be retained and kept by the provider for audit purposes.

Listed below are examples of third party situations and how they are processed in the POS system. All amounts billed to the insurance and DSHS must be usual and customary charges except for capitated copayments.

- **Billing for balances** – This is necessary when partial payment is received from the third party primary payor and the claim is being billed to DSHS as secondary. The usual and customary charge **must** be entered in the *Usual and Customary* field. The insurance payment amount **must** be entered in the *Other Payor Amount* field. When a third party payment is reported, there is no need to enter a numeric code in the *Other Coverage code* field. Leave *Other Coverage code* field blank.

  Note: In this instance, the normal 34-day supply limit may be exceeded.

- **Capitated contracted copayments** – This is for capitated service agreements that some providers have with insurance companies. Copayments are collected by the provider (fee-for-service payment is not applicable for this service). When the service being billed to the department is under a capitated service agreement, enter only the copayment amount in the *Usual and Customary* field and in the *Gross Amount Due* field. Because a fee-for-service amount was not paid by the third party carrier, **do not** enter an amount in the *Other payor amount* field. Enter a "2" in the *Other Coverage code* field. Hardcopy billers must enter other coverage code 2 in the *Justification/Comments* field. This is the only circumstance appropriate to use the "2". By entering a "2" you are certifying that this is a capitated amount and that a fee-for-service payment was not received for the service.

  Note: In this instance, the normal 34 day supply limit may be exceeded.

- **Insurance Denials and claims paid at $0 (zero)** – This is necessary when you bill the insurance carrier and receive a denial or your claim is paid at $0.00. A $0.00 payment occurs if the primary payor applies a deductible or is less than the copayment amount or other insurance conditions for nonpayment apply. Enter a "3" in the *Other Coverage code* field and the date the claim was denied (or paid at $0.00) in the *Primary Payor Denial Date* field. Hardcopy billers must enter the comment "Other Coverage Code 3" in the *Justification/Comments* field.

Primary insurance billing exceptions

Situations may occur when a client is out of the HMO service area or HMO coverage is not accessible. After making reasonable attempts to access the primary coverage, a pharmacy provider may proceed to meet the client's immediate needs.

An exception to regular POS insurance billing requirements is allowed for Medical Assistance clients whose insurance company requires the client to pay before receiving prescriptions. To enable these clients to receive their medications, MAA will pay the lesser of your billed amount or the Medicaid allowed amount. In these prepay situations **do not** bill the insurance company. Bill these claims directly to MAA.

In the instances described above, enter a "4" in the *Other Coverage code* field. Hardcopy billers must enter the comment "Other Coverage Code 4" in the *Justification/Comments* field.

Although all claims are subject to audit, post payment audit and review will be conducted on these conditions. MAA may recoup payments for services that do not meet the stated criteria.

How to bill for clients who are eligible for both Medicare and Medicaid

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Part B Medicare now cover some drugs and related supplies. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier ***first***. Medicare is the primary payor of claims.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's allowable or MAA's allowable, whichever is less.

An **X** in the *Medicare* column on the client's Medical ID card indicates Medicare eligibility.

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

After Medicare has processed your claim, and if Medicare has allowed the service(s), in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent*," appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

- If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, bill MAA.

You must submit your claim to MAA within
***six months* of the Medicare statement date.**

- If **Medicare denies** a service, bill MAA through the POS system using the appropriate DUR outcome code (see pages K.5 and K.6). Claims may also be billed on the Pharmacy Statement form and must have the Medicare denial letter or Explanation of Benefits (EOMB) attached. [Note: When Medicare denies a service that requires prior authorization, MAA waives the *prior* requirement, but authorization is still required.]

Do not bill MAA for Medicare's coinsurance and deductible
through the on-line POS system.
For detailed POS billing instructions, see Section K.

How do I bill for a baby who is using his/her parent's PIC?

🗁**BILLING**:

Electronic billers must enter "**B**" as follows::

Tape format .... in the 46th position of the HD record
EMC format.......................... in the 54th position of the HD record
Multi-insurer format............. in the 79th position of the P3 record

Hard copy billers must indicate "**Baby using parent's PIC**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "**2**" in the Eligibility Clarification Code field.

Point-of-Sale (POS)

What is Point-of-Sale (POS)?

The POS system is an on-line, real time, pharmacy claims processing system. Since the POS is online, each attempt to process a claim will appear on your weekly Remittance and Status Report (RA). Please be sure to track each transaction completely before contacting MAA. A claim that is rejected and subsequently paid on the same RA will have an Explanation of Benefits (EOB) 402 attached to the claim(s). The POS system uses the National Council for Prescription Drug Programs (NCPDP) version 3.2C format.

Any claim that requires a hard copy attachment must be submitted as a paper claim.

Do pharmacies have to use the on-line POS system?

No! Pharmacies that choose not to use the on-line POS system can submit their claims through hard copy billing (paper claims) or electronically using MAA's approved record formats. These claims will be processed by MAA through the POS system. All prescription drug claims are processed and edited through the POS system regardless of how they are submitted.

Do pharmacies need a separate agreement with MAA to use POS?

No! A separate agreement with MAA is not required to use POS. Simply contact your switch-vendor or software vendor.

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit initial claims and adjust prior claims in a timely manner. The following is MAA's timeliness standards for initial claims and for resubmitted claims for the Prescription Drug Program:

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note: If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

Medicare Crossover Claims: If Medicare allows the claim, the provider must bill MAA within six months of the date Medicare processes the claim. If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for the initial claim.

---

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- ✓ **MAA may grant exceptions to the 365 day time limit for** initial claims **when billing delays are caused by either of the following:**

  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

• Resubmitted Claims

MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within 15 months of the date the service was provided to the client. After 15 months, MAA does not accept a prescription drug claim for resubmission, modification, or adjustment.

• Overpayments that must be refunded to DSHS

The 15-month period for resubmitted claims above does not apply to overpayments that a prescription drug provider must refund to DSHS. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. **Do not do a claim adjustment.**

• Billing the Client

MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements in this section, resulting in the claim not being paid by MAA. **[See "Billing a Client," page J.4.]**

---

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

National Drug Code (NDC)

The NDC is the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

> **The provider must always use the actual, complete 11-digit NDC from the dispensing container.**

MAA accepts only the 5-4-2 NDC format. ***All 11 digits, including zeros, must be entered***. The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Prospective Drug Use Review (Pro-DUR)

MAA is providing a system-facilitated Prospective Drug Use Review screening as a part of the POS system. High dose and therapeutic duplication edits post and claims are rejected when potential drug therapy problems are identified. Once pharmacists have conducted their professional review, MAA-approved NCPDP DUR conflict, intervention, and outcome codes can be used to override the Pro-DUR edit.

When appropriate, enter one MAA-approved NCPDP DUR code from each of the categories on the next page. By placing the following information onto the claim, the provider is certifying that the indicated DUR code is true and documentation is on file:

1. Two byte alpha DUR Conflict Code, *followed by...*
2. Two byte alphanumeric DUR Intervention Code, *followed by...*
3. Two byte alphanumeric DUR Outcome Code

Electronic submitters may enter the DUR codes in the following fields:

TAPE FORMAT: in the 133-138 position of the DD record
EMC FORMAT: in the 149-154 position of the DD record
MULTI-INSURER FORMAT: in the 75-80 position of the P2 record.

An example of a valid entry would be **HDM∅1G**.

Paper claims must note the appropriate DUR Conflict Code in the *Justification/Comments* field, if applicable.

MAA-Approved NCPDP DUR Codes

DUR CONFLICT CODES

AT	Addictive toxicity
CH	Call Help Desk
DA	Drug allergy alert
DC	Inferred drug disease precaution
DD	Drug-drug interactions
DI	Drug incompatibility
DL	Drug lab conflict
DF	Drug good interaction
DS	Tobacco use precaution
ER	Overuse precaution
HD	High dose alert
IC	Iatrogenic condition alert
ID	Ingredient duplication
LD	Low dose alert
LR	Underuse precaution
MC	Drug disease precaution
MN	Insufficient duration alert
MX	Excessive duration alert
OH	Alcohol precaution
PA	Drug age precaution
PG	Drug pregnancy alert
PR	Prior adverse drug reaction
SE	Side effect alert
SX	Drug gender alert
TD	Therapeutic duplication

DUR INTERVENTION CODES

MØ (M, ZERO)	Prescriber interface
PØ (P, ZERO)	Patient interaction
RØ (R, ZERO)	Pharmacist reviewed

DUR OUTCOME CODES

1A	Filled, false positive
1B	Filled as is or filled for Medicare-Medicaid eligible client following Medicare denial
1C	Filled with different dose
1D	Filled with different directions
1F	Filled with different quantity
1G	Filled after prescriber approval obtained

Prospective Drug Use Review (Pro-DUR) Edits

The following charts outline potential reject edits. The description, reason for the edit, and necessary action are indicated.

REJECT EDIT/ CONFLICT CODE	REASON	ACTION
88 HD	High Dose Alert Any drug to be dispensed in excess of the maximum daily dose.	Pharmacist should verify that the quantity and/or day's supply was entered correctly. Pharmacist may need to contact the prescriber regarding appropriate prescribed quantity. NCPDP Pro-DUR codes can be used to certify the indicated situation exists.
88 TD	Therapeutic Duplication Alert Concurrent prescriptions for drugs in the same therapeutic class.	Pharmacist should use professional judgement or confer with prescriber to determine appropriateness of duplicate therapy.

Other Prospective Drug Use Review Edits

REJECT EDIT	REASON	ACTION
60	Age alert Client age inappropriate for drug.	Verify client age or call 1-800-848-2842 for authorization.
66	Age alert Client age exceeds maximum for drug.	Verify client age or call 1-800-848-2842 for authorization.
79	Refill too soon Previous supply dispensed has not been exhausted.	If increase in dose, enter appropriate NCPDP DUR codes. Otherwise, call 1-800-848-2842 for authorization.
83	Duplicate claim Previous claim paid for same drug.	If same drug, different strength, the pharmacist should check prescriber ID field and enter prescriber ID on each claim (for both strengths). If different prescribers, pharmacist must call 1-800-848-2842 for authorization.

NCPDP Payor Sheet for Washington Medicaid
Version 3.2C

Data Element	Format	Required Staus	Description/Valid Values
Required Transaction Header Section			
ANSI BIN	NCPDP	Required	Enter "**610084**"
Version Number	NCPDP	Required	Enter "**3C**"
Transaction Code	NCPDP	Required	Valid values: 00, 01, 02, 03, 04, 11, 24, 31, 32, 33, 34
Processor Control Number	10 A/N	Required	Definition: CICSWARX - Production Claims CICSACPT - Test Claims
Pharmacy ID	NCPDP	Required	Enter your seven-digit NABP Provider #.
Group Number	7 A/N	Required	Client ID is position 1-3 Group Number is position 4-7. For Washington Medicaid, use **2507850** for all claims.
Cardholder ID Number	14 A/N	Required	Use the client's 14-digit Patient Identification Code (PIC).
Person Code	NCPDP	Optional	Always "**01**" if an entry is required by your system.
Date of Birth	NCPDP	Required	8 digit format: CCYYMMDD
Sex Code	NCPDP	Required	
Relationship Code	NCPDP	Required	
Other Coverage Code	NCPDP	Conditional	0 – Not Specified 1 – No Other Coverage Identified 2 – Capitated Service Co-pay Only When filing for a situation where no fee for service is applicable to this claim, use code "2" & leave the Other Payor Amount field blank. 3 – Other Coverage Exists - This Claim Not Covered or Paid at $0. 4 – Other Coverage Exists - Payment Not Collected Due to Exclusive Network.
Date Filled	NCPDP	Required	

NCPDP Payor Sheet for Washington Medicaid
Version 3.2C

Data Element	Format	Required Staus	Description/Valid Values
Optional Header Information Section			
Customer Location	NCPDP	Conditional	Enter "**01**" to indicate client resides at home, in an Assisted Living Facility, group home, or Adult Family Home. Enter "**02**" to indicate an ITA Claim. Enter "**03**" for Skilled nursing facility residents. Enter "**11**" for Hospice patient whose prescription is unrelated to terminal condition.
Eligibility Clarification Code	NCPDP	Conditional	Enter code "**2**" to indicate baby is using the parent's PIC.
Patient First Name	NCPDP	Optional	
Patient Last Name	NCPDP	Optional	
Required Claim Header Information Section			
Rx Number	NCPDP	Required	
New/Refill Number	NCPDP	Required	
Metric Quantity	NCPDP	Conditional	Enter whole unit quantities only. (**Note:** Do not enter metric decimal quantities here, see Metric Decimal Qty on next page.)
Days Supply	NCPDP	Required	Enter Estimated Days Supply
Compound Code	NCPDP	Conditional	Enter Compound Code "**2**" for each ingredient used in the compound for the quantity dispensed. Bill each ingredient of a compounded prescription as a separate claim with the appropriate NDC and quantity used for that ingredient.
NDC Number	NCPDP	Required	
Dispense As Written (DAW) Code/Product Selection Code	NCPDP	Optional	This field is not used at this time.
Ingredient Cost	NCPDP	Required	
Prescriber ID	7 A/N	Required	Enter the DEA# or MAA provider number of the prescriber.
Date Rx Written	NCPDP	Required	
Usual & Customary Charge	NCPDP	Required	For Public Health Service entities, usual and customary is the "Actual Acquisition Cost."

NCPDP Payor Sheet for Washington Medicaid
Version 3.2C

Data Element	Format	Required Staus	Description/Valid Values
Optional Header Information Section			
Prior Authorization/ Medical Certification Code & Number	NCPDP	Conditional	If applicable, enter the prior authorization (PA) number. Enter Medical Certification Code "**2**" to indicate a self-referred Healthy Options client. Enter "**5**" to indicate a lost/stolen medication replacement or ITA. Enter "**8**" to indicate a supply for take home, school or camp, suicide risk, or monitoring.
Level of Service	NCPDP	Optional	This field is not used.
Diagnosis Code	NCPDP	Optional	Enter the ICD-9 diagnosis code, if known.
Unit Dose Indicator	NCPDP	Conditional	Enter "**3**" for prescriptions unit-dose packaged by the pharmacy.
Gross Amount Due	NCPDP	Required	Enter the gross amount due before subtracting any other insurance payments.
Other Payor Amount	NCPDP	Conditional	Enter the total amount of the payment(s) received from other payor(s).
Patient Paid Amount	NCPDP	Optional	
Incentive Amount Submitted	NCPDP	Optional	
DUR Conflict Code	NCPDP	Conditional	Enter the applicable DUR Conflict Code.
DUR Intervention Code	NCPDP	Conditional	Enter the applicable DUR Intervention Code.
DUR Outcome Code	NCPDP	Conditional	Enter the applicable DUR Outcome Code: **DUR 70** – 1B following Medicare denial for a Medicaid-covered drug. **DUR 79** – 1C for dosage changes only **DUR 88 –** Enter the appropriate DUR outcome code.
Metric Decimal Qty	NCPDP	Conditional	Enter metric decimal quantities only, up to third decimal. (**Note:** Do not enter whole unit quantities here - see Metric Quantity on K.8 page.)
Primary Payor Denial Date	NCPDP	Conditional	If applicable, enter the date in **CCYYMMDD** format that the other carrier denied this claim.

Other Information

- An optional data element means that the user should be prompted for the field but does not have to enter a value. A conditional data element means that certain situations may warrant an entry in order to avoid a claim rejection.
- Duplicate claims will be rejected with an "83" error (indicating claim has been previously paid).
- DUR information, if applicable, will appear in the message text of the response.
- POS claims coding is subject to MAA review/audit; documentation must be on file.

Completing the Pharmacy Statement [DSHS 13-714]

The boxes on the Pharmacy Statement [DSHS 13-714] will be referred to as *fields*. Only those fields that are required for billing will be addressed.

Provider Name and Address and NABP Number - Enter your name and address as recorded with the Division of Program Support. Enter your NABP (National Association of Boards of Pharmacy) number.

Patient Identification (PIC) - An alpha-numeric code assigned to each Medical Assistance client which consists of:

a) First and middle initials (or a dash (-) if the middle initial is not indicated)
b) Six-digit birthdate, consisting of MMDDYY.
c) First five letters of the last name (or blanks if less than five characters)
d) Alpha or numeric character (tiebreaker)

Patient Name And Address - Enter the client's last name, first name and middle initial. Enter the client's address.

Prescription Number - Assign in sequence with regular prescriptions filled by the pharmacy. The original prescription number may be used for refills, or a new number may be assigned. (MAA accepts a maximum of seven numeric characters for this purpose.)

Nursing Home - Check *Yes* if the prescription was provided to a client residing in a skilled nursing facility; otherwise, check *No*. Note: adult family homes, assisted living facilities or group homes are not considered skilled nursing facilities.

Date Written - Enter the date on which the prescriber wrote/ordered the prescription.

Date Filled - Enter the date the prescription was filled.

Quantity Filled - Enter quantity filled.

Est. Days Supply - Enter the estimated days' supply for the quantity dispensed.

National Drug Code (NDC) - Enter the manufacturer's complete 11-digit NDC from the dispensing container.

All digits, including zeros, must be entered. The three sections in the NDC field **must** have numbers entered in the correct section. The *labeler code* portion of the 11-digit NDC will always consist of five numeric characters; the *product code* portion consists of four numeric characters; and the *package size* will be two numeric characters.

SAMPLE NDC NUMBER: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Drug Name - Enter the drug name and strength.

Prescriber's ID - Enter the DEA #. If you do not have a DEA #, enter the 7-digit MAA provider identification number of the prescriber. Be sure to use the unique individual provider identification number. Do not complete with a group billing number. If this field is left blank, the claim will be denied. Pharmacists who have received approval from the Washington State Board of Pharmacy for Pharmacist Prescriptive Authority *will use the DEA # or the MAA provider number of the physician who has granted protocol authorization.*

Prescription (Directions For Use) - Enter the *Sig*.

Authorization Number - Enter the authorization number when required.

Generic - Enter an "X" under *Yes* or *No* to indicate if a generic substitution is permitted by the prescriber.

Justification/Comments - Enter any other information applicable to this prescription.

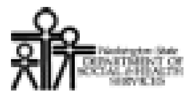
Total Charge - Enter your usual and customary charge, including your dispensing fee. Do not include tax.

Insurance Paid Amount - Enter any amount paid by insurance; do not enter co-pay amount here. (Refer to TPL section.)

Balance Due - Enter the amount due after deducting patient pay or insurance.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)
MEDICAL ASSISTANCE ADMINISTRATION (MAA)

INTERNAL CONTROL NUMBER (DSHS USE ONLY)



PHARMACY STATEMENT (525-106)

PRINT OR TYPE ALL INFORMATION

PROVIDER NAME AND ADDRESS	NABP NUMBER
Drug Store 100 Main Street Anytown, WA 98000	4900000

PATIENT IDENTIFICATION (COPY FROM MEDICAL IDENTIFICATION CARD)

FI	MI	BIRTHDATE	LAST NAME	TB
T	A	1 2 1 2 7 5	JONES	A

4. PATIENT NAME AND ADDRESS

Teri A. Jones
200 Main St.
Anytown, WA 98000

DETAIL CLAIM INFORMATION

1

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE	$3.00
1234567		☐ Yes ☒ No	01/02/2003	01/02/2003		3		
EST. DAYS SUPPLY: 7	NATIONAL DRUG CODE: 1 6 1 6 9 0 0 1 0 0 3		DRUG NAME: Kimono condom				PAYABLE BY PATIENT	
PRESCRIBER'S ID: 9777707	PRESCRIPTION (DIRECTIONS FOR USE): as needed				AUTHORIZATION NUMBER:		INSURANCE PAID AMOUNT	
GENERIC: ☐ Yes ☒ No	JUSTIFICATION/COMMENTS:						BALANCE DUE	$3.00

2

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE	$17.50
1234568		☐ Yes ☒ No	01/02/2003	01/02/2003		35.44		
EST. DAYS SUPPLY: 5	NATIONAL DRUG CODE: 0 0 1 6 8 0 2 0 4 3 7		DRUG NAME: Lidocaine 5% ointment				PAYABLE BY PATIENT	
PRESCRIBER'S ID: PE1234567	PRESCRIPTION (DIRECTIONS FOR USE): apply twice a day				AUTHORIZATION NUMBER:		INSURANCE PAID AMOUNT	
GENERIC: ☒ Yes ☐ No	JUSTIFICATION/COMMENTS:						BALANCE DUE	$17.50

3

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE	$6.92
1234569		☐ Yes ☒ No	01/02/2003	01/02/2003		500		
EST. DAYS SUPPLY: 30	NATIONAL DRUG CODE: 0 0 3 3 8 0 0 4 9 0 4		DRUG NAME: Sodium chloride 0.9% solution				PAYABLE BY PATIENT	
PRESCRIBER'S ID: PE1234567	PRESCRIPTION (DIRECTIONS FOR USE): 25 ml with 25 mg edecrin sodium 1-3 x wk IV				AUTHORIZATION NUMBER:		INSURANCE PAID AMOUNT	
GENERIC: ☒ Yes ☐ No	JUSTIFICATION/COMMENTS: compound						BALANCE DUE	$6.92

4

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE	$265.25
1234569		☐ Yes ☒ No	01/02/2003	01/02/2003		10		
EST. DAYS SUPPLY: 30	NATIONAL DRUG CODE: 0 0 0 0 6 3 6 2 0 5 0		DRUG NAME: Edecrin sodium				PAYABLE BY PATIENT	
PRESCRIBER'S ID: PE1234567	PRESCRIPTION (DIRECTIONS FOR USE): 25mg with 25 ml sodium chloride 1-3 x wk IV				AUTHORIZATION NUMBER: 12345678910		INSURANCE PAID AMOUNT	
GENERIC: ☐ Yes ☒ No	JUSTIFICATION/COMMENTS: compound						BALANCE DUE	$265.25

PROVIDER CERTIFICATION

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for t payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds race, creed, color, national origin or the presence of any sensory or mental handicap, and that the foregoing informatio true, accurate and complete.

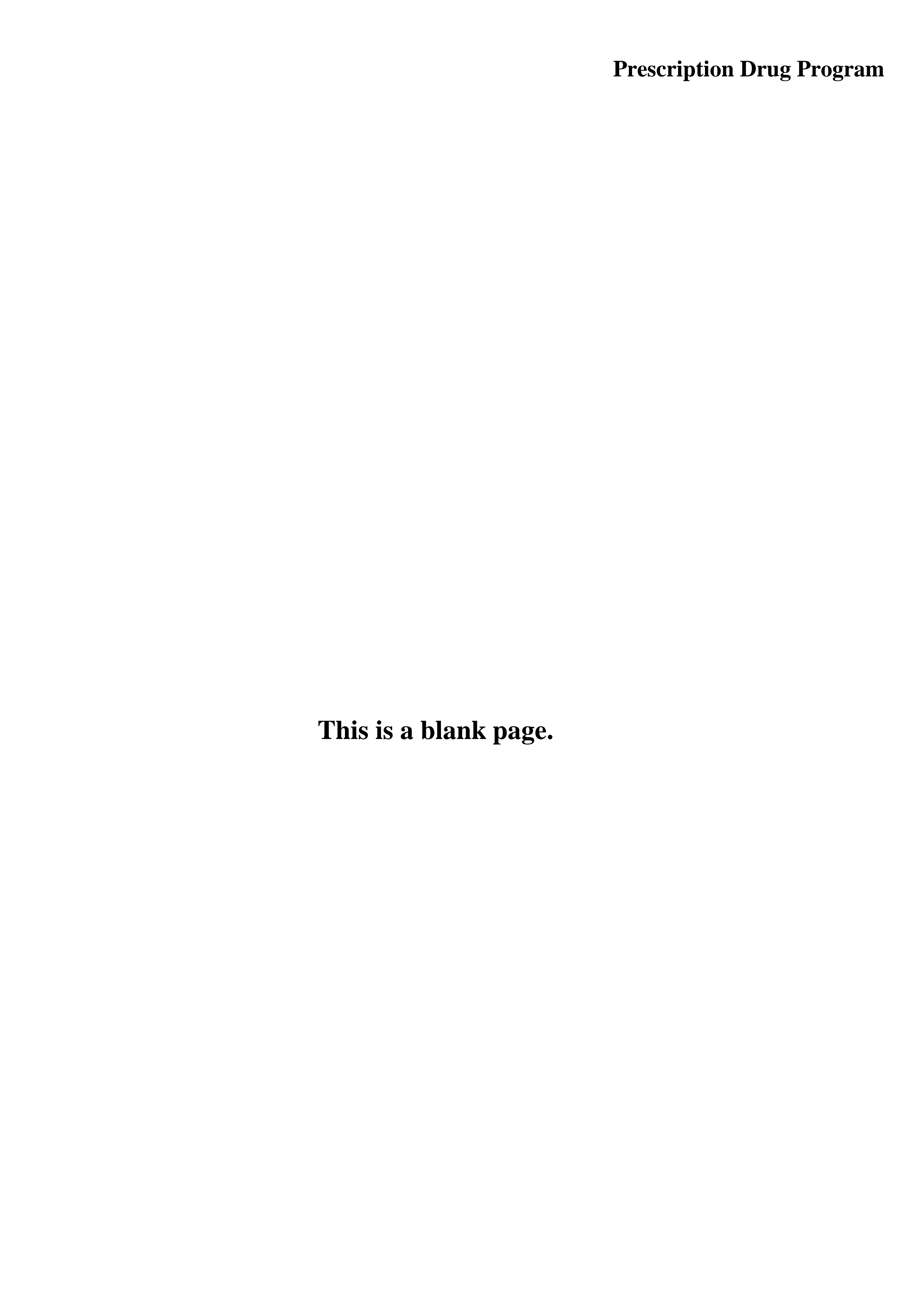
NET TOTAL BILLED $292.67

SIGNATURE OF PHARMACIST (IN INK) X

DATE

DSHS 13-714 (REV. 05/2002) (AC 10/2002)

MAIL TO: DIVISION OF PROGRAM SUPPORT, PO BOX 9245, OLYMPIA WA 98507-9245



This is a blank page.

Completing the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

Federal law requires a claim "paid" by Medicare to be submitted to Medicaid within six (6) months of the Medicare statement date.

When the words, "This information is being sent to either a private insurer or Medicaid fiscal agent," appear on your Medicare Remittance Notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be used in the Point of Sale (POS) system.

If you have received a payment from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

The Medicare/Medicaid billing form (HCFA-1500) must be submitted to MAA, Claims Processing Office:

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

General Instructions

- Use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (fields 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the HCFA-1500 claim form.
- Attach complete, legible Medicare EOMB or claim will be denied.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical IDentification card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

NOTE: The Medical ID card is your proof of eligibility.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medical Assistant client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.
9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

> **Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for field 9.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24a. **<u>Date(s) of Service</u>**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., February 4, 2003 = 020403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY)**

24b. **<u>Place of Service</u>**: Required. Enter a **9**.

24c. **<u>Type of Service</u>**: Required. Enter a **9**.

24d. **<u>Procedures, Services or Supplies CPT/HCPCS</u>**: Required. Enter **appropriate HCPCS**.

<u>Coinsurance and Deductible</u>: Required. Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24e. **<u>Diagnosis Code</u>**: Required. Enter appropriate diagnosis code for condition or use **V98.0.**

24f. **<u>$ Charges</u>**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24g. **<u>Days or Units</u>**: Required. Enter the appropriate units.

24k. **<u>Reserved for Local Use</u>**: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. **<u>Your Patient's Account No.</u>**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **<u>Accept Assignment</u>**: Required. Check **yes.**

28. **<u>Total Charge</u>**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **<u>Amount Paid</u>**: Required. Enter the <u>Medicare Deductible</u> here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **<u>Balance Due</u>**: Required. Enter the <u>Medicare Total Payment</u>. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **<u>Name and Address of Facility Where Services Are Rendered</u>**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **<u>Physician's, Supplier's Billing Name, Address, Zip Code and Phone #</u>**: Required. Enter the pharmacy's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit pharmacy provider number (which usually begins with six [6]) here. **Do not use your NABP number for Medicare/Medicaid crossover claims.**

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ______ . __
2. ______ . __
3. ______ . __
4. ______ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION