



Texas Health and Human Services Commission

Vendor Drug Program Pharmacy Provider Handbook

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THE INFORMATION CONTAINED IN THE PHARMACY PROVIDER HANDBOOK INCLUDES CITATIONS FROM 1 TEXAS ADMINISTRATIVE CODE (TAC) §§354 AND 355. THE CITATIONS CAN BE FOUND ON THE INTERNET AT THE TEXAS SECRETARY OF STATE'S INTERNET WEB SITE WWW.SOS.STATE.TX.US, UNDER TITLE 1, ADMINISTRATION, PART 15, TEXAS HEALTH AND HUMAN SERVICES COMMISSION.

1000 Participation

As part of the Texas Medical Assistance Program, the Vendor Drug Program is intended to provide outpatient pharmaceutical services to eligible recipients. Payment is made on behalf of eligible recipients directly to the contracted pharmacy providing services according to the procedures outlined and the limitations included in this material.

1100 Requirements for Participation

§354.1801

- (a) Any pharmacy or pharmacist who has a current license or registration with the Texas State Board of Pharmacy or is licensed under the laws of his respective state and is free from any pharmacy board restriction may apply to become a provider in this program. Prescribing practitioners who are authorized and licensed to practice the healing arts, as defined and limited by federal and state laws, and choose to provide their own pharmaceuticals may also apply to become providers.
- (b) Except as stated in §354.1809 of this title (relating to Termination of Participation), the Commission maintains open enrollment for in-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy. Out-of-state pharmacies or pharmacies holding any other class of pharmacy license may be subject to special application procedures. These procedures are used to determine how Medicaid recipients benefit from contracts with specialized pharmacies. Contracts are not granted to applicants unless additional benefits to the recipient are established.

1200 Applications for Participation

§354.1802

- (a) Applications for participation must be made to Texas Health and Human Services Commission, Vendor Drug Program, Pharmacy Contracts and Rebates, using the address provided on the cover letter to the application package.
- (b) When an application is approved, the provider or his authorized representative must enter into a written contract with the Commission to acquire participating status. The provider is advised by letter of the effective date of his contract, and his vendor number. A contracted provider agrees to provide pharmaceutical services to Medicaid recipients in the same manner and to the same degree as they are provided to the general public.
- (c) The Commission may enter into special negotiated reimbursement arrangements with other state or local entities for purposes of maximizing federal financial

participation in state or locally funded programs. If a state or local entity is unwilling to participate in this kind of an arrangement, a contract may be denied.

1300 Confidentiality

§354.1803

The provider must not reveal to the public the identity of any recipient of medical assistance. State law provides a criminal penalty for violation.

1400 Access to Records

§354.1804

On request, the provider must allow Commission, the Texas Attorney General Medicaid Fraud Control Unit, and the Department of Health and Human Services or their designees immediate access to the prescription files and to the drug acquisition records that pertain to the Title XIX Medical Assistance (Medicaid) Program for review or audit. These staff must be given access to and a sample of the prescription files of the provider's non-Medicaid customers to determine the provider's usual and customary price. The identification of the prescription file may be removed. The provider must cooperate in regular reviews (general audits and utilization reviews) of the records of each recipient covered under the Medicaid program.

1500 Nondiscrimination

§354.1805

The provider must provide services without discriminating on the basis of race, color, national origin, age, sex, or handicap.

1600 Disclosure of Criminal Convictions

§354.1807

On request, the provider must disclose to the Commission or to the United States Department of Health and Human Services the name of any person who has ownership or controlling interest in, or is an agent or managing employee of, the pharmacy when that person has been convicted of a criminal offense related to the person's involvement in any program under Title V, XVIII, XIX, or XX of the Social Security Act. The provider must also supply, on request, the ownership, management, control, and business transaction information required by 42 Code of Federal Regulations part 455, subpart B.

1700 Termination of Participation

§354.1809

- (a) The Commission reserves the right to reject any request for participation or to immediately terminate participation should the provider conduct his pharmaceutical practices in violation of the criteria of the Title XIX Vendor Drug Program, state or federal laws or the ethics adopted by the profession.
- (b) The Commission, on receipt of written request, provides a contract appeal to the provider if the Commission suspends or cancels the provider's participation in the program.

1800 Provider Sanctions

§354.1811

- (a) The Commission reserves the right to impose administrative sanctions on a provider who conducts his pharmaceutical practice in violation of the ethics adopted by the profession, any applicable federal or state laws, the criteria of the Vendor Drug Program, or the Commission's rules regarding fraud or abuse involving medical providers. Sanctions include, but are not limited to, termination or suspension from participation, suspension of payments, and recoupment of overpayments.
- (b) On receipt of a written request, the Commission provides a contract appeal to a provider who has had Commission sanctions placed on him.

1810 Definition of Placing a Pharmacy on Vendor Hold

§354.1813

In the context of this chapter, the term vendor hold means detaining accrued vendor payments from the effective date of the hold until the release date.

1820 Reasons for Placing a Pharmacy on Vendor Hold

§354.1815

Reasons for placing a pharmacy on vendor hold are as follows:

- (1) violation of the provisions of the Texas Title XIX Vendor Drug Program contract;
- (2) failure to pay, within the allotted period of time, the amount of restitution as revealed by the audit of the pharmacy;
- (3) request by the office of the investigator general, when that office is investigating a pharmacy for possible fraud;
- (4) failure to renew the pharmacy's permit with the Texas State Board of Pharmacy;

- (5) failure to file a required cost report. Failure by a provider who is required to file a cost report according to applicable instructions and within the prescribed time period results in a hold being placed on the provider's vendor payments. A hold remains in effect until all cost-reporting deficiencies are corrected. If the cost reporting deficiencies are not corrected within three months following the due date of the report, the contract of a provider required to file a cost report may be cancelled. The provider is notified of contract cancellation when this action is taken. Notice is considered to have been made as of the date of delivery to the United States Postal Service;
- (6) failure to allow access to financial and other records. Failure by a provider to allow Commission representatives or the attorney general's Medicaid fraud control unit staff access to financial and other records pertinent to Medicaid services results in the provider's vendor payments being placed on hold. A hold remains in effect until access to the requested records is allowed. If access to the requested records is not provided within 31 days of the refusal, a provider's contract may be cancelled. The provider is notified of contract cancellation when the action is taken.

1900 Correspondence Concerning Vendor Drug Program

Direct all correspondence regarding payment for services to:

Health and Human Services Commission
Medicaid/CHIP Division
Pharmacy Resolutions
1100 W. 49th St. MC H630
Austin, Texas 78756-3174

General information regarding the Vendor Drug Program may be obtained from the Commission's regional pharmacist serving the location. See the list of regional offices at the end of this Handbook. The regional pharmacist assists the Commission's state office staff in the administration of the Vendor Drug Program by providing consultant, management, and auxiliary services to contracted providers, eligible recipients, and other interested parties.

2000 Administration

2100 Covered Drugs

§354.1831

- (a) Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered by the program and are payable. Venosets, catheters, and other medical accessories are not covered and are not included when claiming for intravenous and irrigating solutions.
- (b) Except for vitamins K and D3, prenatal vitamins, fluoride preparations, and products containing iron in its various salts, the Commission does not reimburse for vitamins and legend and non-legend multiple ingredient antianemia products.
- (c) The Commission may limit coverage of drugs listed in the TDCI. Procedures used to limit utilization may include prior approval, cost containment caps, or adherence to specific dosage limitations recommended by manufacturers. Limitations placed on the specific drugs are indicated in the TDCI.

2200 Prior Authorization Procedures

§354.1832

- (a) Requests for prior authorization. Except as provided in subsection (b) of this section, a health care practitioner who prescribes a drug that is not included on the Preferred Drug List (PDL) for a Medicaid recipient must request prior authorization of the drug to HHSC or its designee. Specific procedures for the submission of requests for prior authorization will be available both on HHSC's Internet web site and in printed form. A health care practitioner may request a printed copy of the procedures and forms from HHSC.
- (b) New Medicaid recipients. The prior authorization requirement of this section does not apply to a newly enrolled Medicaid recipient until the 31st calendar day after the date of the determination of the recipient's Medicaid eligibility.
- (c) Disposition of requests for prior authorization. HHSC or its designee will notify the requesting practitioner of the approval or disapproval of the request within 24 hours of the receipt of the request.
- (d) Emergency requests for prior authorization. HHSC will authorize up to a 72-hour supply of a product subject to prior authorization if:
 - (1) The prescribing practitioner notifies HHSC of an emergency need for the product when submitting the request for prior authorization; and
 - (2) HHSC or its designee is unable to provide its approval or disapproval within 24 hours following the receipt of the request.

2300 Pharmacy Services

§354.1833

Under the Vendor Drug Program, pharmacy services include the dispensing to eligible recipients of covered legend and non-legend drugs that appear in the latest revision of the Texas Drug Code Index. For purposes of this chapter, dispensing is defined as preparation, packaging, compounding and/or labeling the medication. Pharmacy services under this chapter are limited to dispensing to recipients in outpatient settings.

2400 Prescriber Identification Numbers

§354.1835

Vendors must enter the identification number of the prescriber, as listed with the appropriate medical specialty board, on each claim.

2500 Evidence of Eligibility

§354.1837

Eligible individuals present the medical care identification card to the vendor each time a prescription is filled.

2510 Medical Care Identification Card

For **Medicaid** recipients, the Form 3087 Medical Care Identification Card is the usual documentation of eligibility, which recipients must present to the provider. Medical assistance benefits are available to a person only during the period of eligibility, which is certified on a month-to-month basis. At the beginning of each month, new identification cards are issued to replace the cards that expired at the end of the previous month. The Form 3087 certifies eligibility for medical benefits for only the period issued.

When a recipient's Form 3087 has been lost, stolen, or not yet received, a Form 1027 Medicaid Verification Letter is issued as documentation of eligibility.

Children's Health Insurance Program (CHIP) patients receive proof-of-eligibility cards from their health plan.

For **Children with Special Health Care Needs (CSHCN)** clients, the CSHCN Eligibility Card is the usual documentation that clients must present to the provider to confirm eligibility. Under certain circumstances, the eligibility card may not be valid at the time you see the client. Please verify a client's CSHCN eligibility by calling the CSHCN

Automated Inquiry System (AIS) at 800-568-2413 (24-hour access) or the CSHCN Customer Service line at 800-252-8023 during regular working hours.

The **Kidney Health Care (KHC)** Program does not issue eligibility cards. New KHC recipients get an Explanation of Benefits (EOB) that indicates if they are eligible for drug benefit, but updated EOB's are not issued on a regular basis or when drug benefits change. It is recommended that pharmacy providers call the KHC program at 1-800-222-3986 to verify recipient eligibility.

3000 Medications

3100 Substitution of One Drug for Another in a Prescription

§354.1851

- (a) Substitution is legal only if and when authorized by the prescribing physician.
- (b) When generic equivalents are dispensed, the estimated cost of the drug used is claimed.
- (c) Substitution authorization must be completely documented on the prescription.

4000 Limitations

4100 Availability of Funds

§354.1861

The Vendor Drug Program is limited by the availability of appropriated funds. Services may be adjusted periodically depending on current availability of funds.

4200 Prescription Requirements

§354.1863

- (a) Payment for pharmaceuticals can be made only when these pharmaceuticals are prescribed by a practitioner licensed to prescribe legend drugs.
- (b) The pharmacist must ensure that the original prescription conforms to the Texas State Board of Pharmacy rules concerning the records to be maintained by a pharmacy. A signed prescription must be maintained in the dispenser's file and available for audit at any reasonable time. Telephone orders, where legal, must be documented in writing. The name of the prescriber and the signature of the dispensing pharmacist must be documented. If a pharmacy maintains prescription records in a data processing system, a hard copy of the prescription must be retained on file unless the daily log includes all the information required in §351.1901 of this title (relating to Pharmacy Claims). The provider must conform to

all regulations issued by the Drug Enforcement Administration and Texas State Board of Pharmacy concerning the recording of prescriptions in a data processing system.

(c) The dispensing pharmacist must date the prescription and initial the refills.

Pharmaceuticals dispensed must be prescribed by the practitioner for a legitimate medical purpose while he or she is acting in the usual course of his or her professional practice.

This section refers to §351.1901, but should have referred to §354.1901

4300 Exemptions for Family Planning Drugs and Supplies

Family planning drugs and supplies related to pregnancy prevention/contraception are not subject to the number-of-prescriptions limit.

4310 Exemptions for Nursing Home Residents

Prescriptions for residents of Title XIX Nursing Facilities (NF's) are exempt from the three prescription limit. However, non-legend and nutritional products are not reimbursed through the Vendor Drug Program.

4400 Refill Limitations

§354.1867

As many as five refills may be authorized by the prescriber, but the total amount authorized must be dispensed within six months of the original prescription. Refills for controlled substances must conform to Drug Enforcement Administration and Texas State Board of Pharmacy rules. All refills are counted when determining compliance with the authorized refill limitation. In the absence of specific refill instructions, the prescription must be interpreted as not refillable. If a prescription notes specific refill instructions, any future dispensings must be considered refills of the original prescription, unless the prescriber has been contacted for authorization to dispense a new supply of medication. If authorization is granted, a new and separate prescription is prepared.

4500 Quantity Limitations

§354.3047

The quantity of drugs prescribed depends on the prescribing practice of the prescriber and the needs of the patient. For recipients with monthly prescription limitations, the

Vendor Drug Program reimburses the provider for the prescribed quantity, provided the quantity does not exceed a six-month supply. For recipients with access to unlimited prescriptions, the Vendor Drug Program reimburses the provider dispensing a medication for a quantity that does not exceed a one-month (thirty-four day) supply. Except for medications that may be too unstable to be dispensed as a one-month supply, the Commission requires that the same drug in the same strength be dispensed no more than once per month. The dispensing of authorized refills must be consistent with the prescribed dosage schedule and existing federal and state laws. To be reimbursed by the Vendor Drug Program, a refill must be dispensed only after 75% of a previous dispensing of the same prescription would have been used if taken according to the accompanying prescriber's orders. A higher percentage limit may be required for a drug that has been determined to be subject to abuse or overuse. A recipient may obtain an early medication refill for a justifiable reason. A justifiable reason includes, but is not limited to, a dosage increase or an anticipated prolonged absence from the community. The reason must be noted on the prescription. Unless specific authorization is obtained from the prescriber, breakage, spillage, or loss of a medication are not considered justifiable reasons. The prescription obtained under this authorization is considered a new prescription

4600 Advertising

§354.1871

- (a) No advertising is used to influence a recipient's free choice of a pharmacy and no advertising is used that, in the opinion of the Commission, is designed to or has the effect of promoting the volume of prescriptions provided under the Vendor Drug Program.
- (b) Advertisements should convey only participation in the program.
- (c) The sign supplied by the Commission may be used at the discretion of the pharmacy. Announcements of the participation in the Vendor Drug Program may be made on radio, on television, in newspapers, or in the media. Bargains, premiums, or other considerations on prescriptions may not be advertised in any manner that would increase the provider's volume of Medicaid prescriptions.

4700 Freedom of Choice

§354.1873

Medicaid recipients may obtain pharmaceutical services from any qualified pharmacy that contracts with the Commission to provide services through the Vendor Drug Program.

4800 Limitations on Provider Charges to Recipients

§354.1875

- (a) A provider of Medicaid Vendor Drug services agrees to accept the vendor payment as payment in full for pharmaceutical services provided each recipient.
- (b) The provider may neither charge nor take other recourse against Medicaid recipients, their family members, or their representatives for any claims denied or reduced by the Commission because of the provider's failure to comply with any Commission rule, regulation, or procedure.

5000 Audits

5100 Vendor Drug Providers Subject to Audit

§354.1891

- (a) All providers participating in the Vendor Drug Program are subject to periodic audit. When information from regional pharmacists or from computerized program management reports indicate a provider may have deviated from the standards of the Vendor Drug Program, an audit of that provider is considered top priority.
- (b) Audits determine provider compliance with the program policies, procedures, and limitations outlined in these rules and the provider's contract. Data for transactions selected for audit are compared with data on the corresponding prescriptions. Erroneous payments and overpayments that occur because of noncompliance with program requirements are considered exceptions subject to restitution to the Commission.
- (c) If a provider disagrees with the initial findings of an audit, the provider may present additional documentation to the Commission's auditor for review. Also, on written request, the Commission provides an opportunity for audit resolution for a provider who wants to present documentation not available at the time of audit. If the provider still disagrees and wants to appeal, the Commission, upon receipt of written request to the Manager of Contracts and Rebates, provides either an informal hearing or additional desk review. The Commission must receive the request for an informal hearing or desk review within 15 calendar days of the provider's receipt of the Commission's Notice of Overpayment letter. The Manager of the Vendor Drug Program will appoint reviewers for the informal hearing or desk review at the time the review is requested.

5200 Exception Notification

§354.1892

The Commission advises the vendor by certified letter of the audit results, detailing the exceptions and requesting payment within 30 days. If restitution is not received within this time period, a vendor hold is placed on the payment claims. If the vendor is no longer participating in the program, all unpaid claims are held and payments are placed on vendor hold until restitution is made. If no unpaid claims that can be held exist and restitution is not made, the case is referred for collection action.

Audits may include extrapolation methods on statistically valid sampling.

6000 Reimbursement

§355.201

- (a) Definitions. Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:
- (1) "Commission" means the Health and Human Services Commission.
 - (2) "Medical assistance" means a medical or health care related service, item, or supply that is delivered to a Medicaid recipient and is approved and authorized for payment or reimbursement by the Commission or a health and human services agency pursuant to state and federal law.
 - (3) "Program" means a specific component of the Medicaid program for which the Commission establishes either a methodology to reimburse a provider or a specific fee, payment rate, or charge that is paid to a provider for medical assistance in accordance with state and federal law.
 - (4) "Provider" means a health care practitioner, institution, or other entity that is enrolled in the medical assistance program and is authorized to submit claims for payment or reimbursement of medical assistance.
- (b) Purpose. This section implements the provisions of §531.021(d) and (e), Government Code and applies to all programs that provide medical assistance and to all reimbursement methodologies prescribed under this chapter.
- (c) Establishment of fees, rates, and charges. The Commission establishes fees, rates, and charges to be paid for medical assistance in accordance with:
- (1) the formulas, procedures, or methodologies prescribed in this chapter;
 - (2) the requirements of state and federal law, including:
 - (A) legislative or Congressional enactments that change state or federal laws in a manner that affects such fees, rates, and charges;
 - (B) changes in federal regulations, and policies that affect such fees, rates, and charges; and
 - (C) judicial orders, opinions, or interpretations regarding state or federal law that affect such fees, rates, and charges;

- (3) the consideration of economic factors that, in the Commission's determination:
 - (A) have or may have a significant and measurable effect on provider participation; or
 - (B) have or may have a significant and measurable effect on providers' ability to deliver services in accordance with state and federal law; and
 - (4) levels of appropriated state and federal funds or state or federal laws or enactments that limit, restrict, or condition the availability of appropriated funds for medical assistance.
- (d) Adjustment of fees, rates, and charges. Notwithstanding any other provision of this chapter, the Commission may adjust fees, rates, and charges paid for medical assistance if:
- (1) state or federal law is enacted, amended, or judicially interpreted to:
 - (A) require the Commission to increase or reduce a fee, rate, or charge paid to a provider for medical assistance;
 - (B) change the amount, scope, or type of allowable or unallowable costs for providers of medical assistance that are required to report costs to the Commission or a health and human services agency for purposes of establishing a reimbursement rate for medical assistance;
 - (C) require all providers within a program or category of providers to incur additional costs to provide medical assistance, other than unallowable costs, that are not currently recognized in the reimbursement methodology established by the Commission for the program; or
 - (D) restrict, limit, or condition the availability of appropriated funds to the Commission for payment or reimbursement of medical assistance;
 - (2) economic conditions that prevail among all providers within a specific program or category of providers and:
 - (A) result in a demonstrable increase in the cost of providing services beyond amounts recognized in the Commission's established reimbursement methodology; or
 - (B) require providers within a program or category of providers to incur costs, other than unallowable costs, that are not currently recognized in the reimbursement methodology established by the Commission for the program.
- (e) Notice of adjustment of fees, rates, and charges. If the Commission adjusts fees, rates, or charges under this section, the Commission or its designee will publish notice of the proposed adjustment at the earliest feasible date but not later than 10 state working days before the effective date of the adjustment. If the adjustment is required by the enactment or amendment of state or federal law, such notice may be published before the effective date of such enactment or amendment, but the adjustment to fees, rates, or charges will not take effect before the effective date of the enactment or amendment. The notice must be published either by publication on the Commission's Internet web site, or in the *Texas Register*. In addition, the Commission may issue written or electronic communication to providers, if economically feasible.
- (f) Contents of notice. The notice required under subsection (e) of this section will include the following:
- (1) a description of the specific increase or reduction of fees, rates, and charges;

- (2) the date on which such adjustment will take effect and the period during which the adjustment will be in effect;
- (3) a description of the legal and factual bases for the adjustment;
- (4) a description of the specific requirements of the rate setting methodology established under this chapter that cannot effectively be implemented as a result of the adjustment;
- (5) instructions for interested parties to submit written comments to the Commission regarding the proposed adjustment; and
- (6) The date, time, and location of a public hearing in accordance with §32.0282, Human Resources Code.

6100 Legend and Non-Legend Medication

§355.8541

For all medication, legend and non-legend, covered by the Vendor Drug Program and appearing in the Texas Drug Code Index (TDCI) and updates, the following requirements must be met.

- (1) Reimbursement. A pharmaceutical provider is reimbursed based on the lesser of the HHSC's best estimate of acquisition cost (EAC) plus the HHSC's currently established dispensing fee per prescription; or the usual and customary price charged the general public.
- (2) Estimated acquisition cost (EAC) is defined as wholesale estimated acquisition cost (WEAC); direct estimated acquisition cost (DEAC), according to the pharmacist's usual purchasing source and the pharmacist's usual purchasing quantity; or maximum allowable cost (MAC) for multi-source drugs. EAC is verifiable by invoice audit conducted by the HHSC to include necessary supporting documentation that will verify the final cost to the provider. All drug purchases through a central purchasing agreement or from a central purchasing entity must be billed to the HHSC as warehouse purchases.

The WEAC is established by the HHSC using market sources, which include, but are not limited to the current Redbook; Redbook Update; First Databank; First Alert; audit, or reported manufacturer pricing. The WEAC may not exceed wholesaler cost, as supplied by the drug manufacturers plus an amount representing wholesaler operating costs and profits under current market conditions. Market conditions will be examined at least every two years. Market conditions will be determined from information supplied to the department by reliable sources, which include, but are not limited to the manufacturer, the wholesaler, and contracted providers. Exceptions to general pricing determinations may be made on certain drugs and/or drug categories based on information from these same market sources.

The DEAC is established by the HHSC using direct price information supplied by drug manufacturers. Providers are reimbursed only at the DEAC on all drug products that are available from select manufacturers/distributors who actively seek and encourage direct purchasing.

The TDCI is used as the reference for drugs included in the scope of benefits and for allowable package sizes. No acquisition cost is billed to the HHSC for samples dispensed.

- (3) Reimbursement for non-legend drugs is based on the lesser of the usual and customary price charged to the general public; or EAC, plus 50% of the EAC. No dispensing fee is added to the price of non-legend drugs, and 50% of the EAC may not exceed the assigned dispensing fee.
- (4) Public Hearing. Notice of a public hearing to receive comments on proposed changes to general pricing determinations derived under these rules shall be published in the Texas Register.
- (5) Definitions. As used in the previous section, these terms shall be defined as follows:
 - (A) Reported Manufacturer Price--Information on pricing submitted to VDP by the manufacturer, including Average Wholesale Price, Average Manufacturer Price, wholesaler costs, direct prices and institutional or contract prices.
 - (B) Reliable Sources--Sources including other state/federal agencies and pricing services, as well as verifiable reports by contracted pharmacists and VDP field staff.
 - (C) Market Conditions--Conditions within the overall retail and wholesale pharmacy drug market place.
 - (D) Wholesaler Costs--The net cost of a product to a drug wholesaler or distributor.

Purchases from a central purchasing agency should be billed using code "9" in field 423 to indicate the source of purchase.

6200 Pricing

Providers use the current Texas Drug Code Index, as shown on the VDP Internet web site, as the reference for allowable package sizes of reimbursable drugs.

The provider's purchasing pattern should be consistent with economical and prudent purchasing practices. The agency conducts periodic drug surveys to determine the provider's quantity purchasing pattern. If the purchase is current (within 60 days before the service date), the agency permits variation from an established pattern. A copy of an invoice may be necessary to justify or allow the variation.

Acquisition cost for drugs not listed in the Redbook or unavailable through a full-service drug wholesaler is the cost shown on the pharmacy provider invoice.

6210 Price Changes

§355.8542

Price changes for legend and non-legend drugs are effective 30 days after receipt of the latest edition of the Redbook or Redbook Update in the Vendor Drug Program.

6220 Non-legend Drug Restrictions

§355.8543

Except insulin, non-legend drugs and nutritional products are not reimbursed when dispensed to recipients in nursing facilities and other institutions where those drugs are included in the reimbursement formula. Also, these drugs are not allowed to be charged to a recipient or a person authorized to act for the recipient.

6300 Usual and Customary Price

§355.8544

- (a) The usual and customary price is the price the provider most frequently charges the general public for the same drug. If the department cannot determine a most frequent price, the median price is used. Items that the provider must consider when determining the usual and customary price include the following:
- (1) The term general public does not include any person whose prescriptions are paid by third-party payors, including health insurers, governmental entities, and the Texas Medical Assistance (Medicaid) Program.
 - (2) When a discount is given (including, but not limited to, cash rebate, monetary price discount, coupon of value) or advertised for any segment of the general public, the discount must be included in the usual and customary price determination for Medicaid prescriptions if the Medicaid recipient would otherwise have qualified as a member of that same segment of the general public. Some providers give discounts to non-Medicaid customers based on requirements similar to those specified in subparagraphs (A) and (B) of this paragraph. Providers must not use the following types of requirements as reasons to disqualify Medicaid recipients as members of the same segment of the general public receiving the discount:
 - (A) possessing or presenting a special identification card or document, or making a verbal request for a discount;
 - (B) paying for the prescription by a particular method.
- (b) If a provider utilizes one pricing policy for cash recipient and a different pricing policy for charge recipient, the lower of the two pricing policies is the provider's usual and customary price.

- (c) The provider must keep adequate records showing how the usual and customary charge to the general public was determined according to the requirements as stated in this section. On request, the provider must disclose the records to representatives of the following agencies: Texas Department of Health, Texas Attorney General's Medicaid Fraud Control Unit, and United States Department of Health and Human Services. The identification (name and address of non-Medicaid customers) may have been removed from these records. If the provider does not keep the records for the time period specified in his contract with the department, then the usual and customary price determination includes all discounts given or advertised by the provider, regardless of whether the Medicaid recipient would or would not have qualified as a member of the general public receiving the discount.

6400 Texas Maximum Allowable Cost

§355.8545

- (a) Multisource drugs included in the Vendor Drug Program's formulary, the Texas Drug Code Index (TDCI), are subject to Texas maximum allowable cost (TMAC) reimbursement limits. Multisource drugs are sorted into therapeutic categories based on the drug and strength, and in some cases, on the dosage form and package size. Drug products exempt from the drug substitution provisions of the Texas Pharmacy Act and drug products that the Federal Food and Drug Administration does not consider to be therapeutically equivalent to other pharmaceutically equivalent products are exempt from TMAC requirements limits. The department may choose to exempt other multisource drug categories from TMAC reimbursement limits.
- (b) The TMAC reimbursement limit selected for each therapeutic category is determined using the wholesale estimated acquisition cost (WEAC) of all the drugs in the respective category. When a multisource drug is not available through a bona fide full-service drug wholesaler or is reimbursable only on a DEAC basis, as defined by the department, then the direct estimated acquisition cost (DEAC) of that drug is included in the calculation of the TMAC reimbursement limit. The Commission retains the right to adjust the reimbursement limit in any category on an individual basis.
- (c) The TMAC reimbursement limits are maximum reimbursement limits. If a pharmacy provider dispenses a drug with a WEAC or DEAC below the TMAC limit, reimbursement is made at the lower cost, based on the provider's source of purchase of the drug. If a drug is subject to both TMAC limits and federal maximum allowable cost limits, the lower of the two limits is the maximum reimbursement limit.
- (d) A pharmacy provider that dispenses a drug that is subject to a TMAC limit and bills the department for the service must accept Medicaid reimbursement as payment in full. No additional dispensing fee or product cost amounts may be billed to the Medicaid recipient.

6410 Reimbursement for Brand Name Drugs

§355.8546

- (a) Physicians, who want to dispense a brand name on a prescription for a multisource drug with a maximum allowable cost, handwrite the phrase "Brand necessary" on the face of the prescription. This procedure enables payment for the drug at the more expensive brand name estimated acquisition cost. To indicate this certification (override) on the pharmacy claim form, the provider must enter "6" in the field for "Dispense as Written." For telephone orders involving physician overrides, a written prescription must be obtained from the prescribing physician within 30 days from the time the order was placed.
- (b) A physician override for a prescription is valid only for the life of the prescription. The life of the prescription is defined as the original dispensing and any authorized refills, not to exceed five refills or a six-month supply. The physician override cannot be forwarded or transferred to any other prescription for the same drug.

6500 Reimbursement for Compound Prescriptions

§355.8547

Reimbursement for compounded prescriptions is based on estimated acquisition cost of the ingredients used, verifiable by invoice audit, plus the department's currently established dispensing fee per prescription or the usual and customary price charged to the general public, whichever is lower. Only drugs listed in the latest revision of the Texas Drug Code Index are considered for reimbursement. There is no provision for a compounding fee over and above the dispensing fee.

6600 Hospitals, Nursing Homes, and Governmental Institutions

§355.8548

Government institutions, including tax-supported hospitals, are reimbursed on the basis of actual invoice cost, verifiable by audit, plus an assigned fee for medications dispensed to eligible recipients. Reimbursement is based on an agreement between the institution and the department.

6700 Reimbursement to Hospitals and Physicians Who Dispense Drugs

§355.8549

Reimbursements to licensed physicians who dispense their own drugs and to hospitals with outpatient pharmacies are based on actual invoice cost, verifiable by audit, plus a

dispensing fee assigned by the department or the provider's usual and customary charge to the general public, whichever is lower.

6800 Third Party Resources

§355.8550

The Texas Vendor Drug Program assumes liability after Medicare or other third-party benefits are exhausted. Benefits available under the Texas Medical Assistance (Medicaid) Program are reduced to the extent that they are payable through other federal, state, or local programs, insurance coverage, or third-party coverage to which the eligible recipient may be entitled, or to the extent coverage is provided under federal or state law. When these benefits are available, they are considered a resource. In agreement with the department, exceptions must be on an individual claim basis. Free benefits to recipients from other sources are considered a resource when determining what benefits, if any, are available under the Medicaid program.

When a Medicaid recipient has coverage for prescription drugs through another third party, other than Medicare, providers should bill the third party resource or other insurance before billing Medicaid. Prescriptions reimbursable by Medicare Part D (Medicare Rx) are not eligible for additional reimbursement through Medicaid. Deductibles or co-payments for dually eligible Medicaid participants will not be made through the Vendor Drug Program.

Drugs that are excluded from coverage through Medicare Part D are still fully reimbursable through VDP, and coinsurance payments for drugs reimbursed through Medicare Part B are still eligible for VDP payment.

6900 Dispensing Fee

§355.8551

The Texas Health and Human Services Commission (Commission) reimburses contracted Medicaid pharmacy providers according to the dispensing fee formula defined in this section. The dispensing fee is determined by the following formula:

Dispensing Fee = [(Estimated Drug Ingredient Cost + Estimated Dispensing Expense) divided by (1 - Inventory Management Factor) - Estimated Drug Ingredient Cost] + Delivery Fee, where;

- (1) The estimated drug ingredient costs are defined in §355.8541 of this title (relating to Legend and Non-legend Medication) and §355.8545 of this title (relating to Texas Maximum Allowable Cost).

- (2) The estimated dispensing expense is \$5.27 for state fiscal year 1997. This will be adjusted annually, subject to the availability of funds, to account for general inflation.
- (3) The inflation adjustment will be made, subject to the availability of funds, on the first day of the state fiscal year. The projected rate of inflation for the upcoming state fiscal year shall be based upon a forecast of the Implicit Price Deflator - Personal Consumption Expenditures produced by a nationally recognized forecasting firm.
- (3) The inventory management factor is 2%.
- (4) The total dispensing fee shall not exceed \$200 per prescription.
- (5) A delivery incentive shall be paid, subject to the availability of funds, to approved providers who certify in a form prescribed by the Commission that the delivery services meet minimum conditions for payment of the fee. These conditions include: making deliveries to individuals rather than just to institutions, such as nursing homes; offering no-charge prescription delivery to all Medicaid recipients requesting delivery in the same manner as to the general public; and, publicly displaying the availability of prescription delivery services at no charge. The delivery incentive is \$0.15 per prescription and is paid on all Medicaid prescriptions filled. This delivery incentive is not to be paid for over-the-counter drugs, which are prescribed as a benefit of this program.
- (6) Notwithstanding other provisions of this section, the Commission may adjust the dispensing fee to address budgetary constraints in accordance with the provisions of 1 TAC §355.201.

As a result of §355.201 (see above), the dispensing fee was reduced by 2.5%, to \$5.14. The Inventory Management Factor was changed to 1.95%, effective October 16, 2003.

Criteria for Pharmacy Delivery

- The pharmacy advertises to Medicaid recipients the availability of prescription delivery service at no charge. The accepted minimum is the displaying of the delivery sign provided by the Commission in a prominent place in the store (window/door).
- Deliveries are made to Medicaid recipients in the same manner and degree as to the general public. Delivery available only to nursing homes or other similar group facilities does not constitute delivery.
- The pharmacy provides delivery service without requiring retention of the Medicaid recipient's Form 3087.

7000 Billing and Payment

The Commission pays providers for outpatient pharmaceuticals dispensed to eligible recipients according to the limitations and procedures outlined in this handbook.

Providers must use the forms specified by the Commission to return rejected claims, send special claims, or request research.

7100 Submission of Claims

§354.1901

- (a) To receive payment from the Commission, the provider must submit a pharmacy claim through the electronic adjudication system. A separate entry is submitted for each prescription or refill. For the original dispensing and each subsequent refill, the provider indicates on the prescription the price and reimbursement method (wholesale estimated acquisition cost, direct estimated acquisition cost, or maximum allowable cost) and National Drug Code number (NDC), which is submitted to the Commission on the corresponding pharmacy claim. Claims received over 90 days after the date of service are rejected. For claims on behalf of an individual who has applied for Medicaid coverage but has not yet been assigned a recipient number on the date of service, the filing period does not commence until the date the individual has been assigned a number. The requirements in §354.1863 of this title (relating to Prescription Requirements) are also waived for retroactive claims. The provider must ensure, however, that a prescription for a prior eligibility claim conform to Texas State Board of Pharmacy and Texas Health and Human Services Commission regulations on the date of service, or a claim cannot be submitted.
- (b) Providers must dispense the quantity prescribed or ordered by the prescriber except as limited by the policies and procedures described in the Commission's Pharmacy Provider Handbook. Where actual quantity dispensed deviates from the prescribed quantity, the provider must bill for the amount actually dispensed. The quantity of drugs must be entered in the metric decimal quantity field. The quantity shown as the metric decimal quantity unit must be calculated after referencing the pricing unit shown in the Texas Drug Code Index.
- (c) If all necessary information is not supplied, a claim cannot be processed or paid.
- (d) The provider must submit claims as the prescription is dispensed through the on-line system; however, some providers who supply a large volume of medications to nursing facility recipients may submit these claims through their data transmission company after the point of sale.
- (e) Overcharged prescription claims are not denied. The appropriate drug cost (wholesale acquisition cost, direct acquisition cost, or maximum allowable cost) listed in the computer drug file, plus the provider's assigned dispensing fee, is paid. The amount claimed and the amount paid are shown on the payment register.

Please refer to the Prescription Drug Claims Procedures Manual for a complete listing of information required while submitting a claim.

Since nursing facility prescriptions are already subject to drug regimen review, an exception can be allowed to the point of sale claims adjudication and prospective Drug Utilization Review (DUR) requirements.

Prospective DUR is a review of the patient's medication record and prescription drug orders prior to dispensing. The on-line system will assist the pharmacist in the

prospective review for Medicaid recipients by providing on-line information on prescriptions paid by the Medicaid program within the defined time period. Examples of DUR messages include the clinically significant drug/drug interactions and therapeutic duplications

7200 Claims Adjustments

§354.1905

The pharmacy provider must completely reverse the original submission and resubmit the claims to receive an adjustment for an overpayment or underpayment of a pharmacy claim. The Commission must receive an adjustment within 90 days of the date of adjudication.

Underpayments or overpayments may result because of errors in reporting the quantity of the drug dispensed, the National Drug Code (NDC) number, a price change for the drug, the source of purchase (wholesale or direct), or a physician override.

7300 Unacknowledged Claims

§354.1907

The Commission must receive a request for research on unacknowledged claims within the 90-day filing deadline.

The pharmacy provider must call Pharmacy Resolution at 1-800-435-4165 on claims for which the provider has received neither payment nor final determination of rejection. This phone number is for **PHARMACIES ONLY**, and should not be given to clients.

7400 Submittal of Special Claims

§354.1909

Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Providers may bill for up to ten ingredients through the on-line system. Payment requests for ingredients exceeding ten must be submitted to the Vendor Drug Program help desk.

Post payment review will also be performed for all claims over \$1000. Systems limitations prevent submission of total payment for claims in excess of \$10,000. These claims should be submitted electronically for \$9,999. The correct quantity should be indicated. Additional payment for these claims must be requested through Vendor Drug Program help desk.

7500 Electronic Data Transmission Vendors (Switches)

§354.1911

Providers must use contracted data transmission companies (switches) to send claims to the Commission. The provider is responsible for the information supplied to the Commission through the switch.

7600 Preferred Drug List (PDL)

§354.1924

- (a) Purpose. This section implements the provisions of §531.072, Government Code, which directs the Health and Human Services Commission (HHSC) to develop and implement a preferred drug list (PDL) for the Texas Medical Assistance Program.
- (b) Applicability. This section applies to drugs included in the Texas Drug Code Index (TDCI) established under §354.1921 of this title.
- (c) Selection of drugs for the PDL. HHSC will include a drug listed on the TDCI in the PDL on the basis of:
 - (1) The recommendations of the Pharmaceutical and Therapeutics Committee (P&T committee) established under §354.1928 of this title;
 - (2) The clinical efficacy of the drug, consistent with the determination of the Food and Drug Administration and the recommendations of the P&T committee;
 - (3) Comparison of the price of the drug and the price of competing drugs. For purposes of this section, the price of a drug is determined by reference to the reimbursement for the drug established under 1 TAC §355.8541 and after deducting Texas and federal rebates;
 - (4) A program benefit offered by the manufacturer or labeler of the drug and accepted by HHSC in accordance with §531.070, Government Code; and
 - (5) Written evidence offered by a manufacturer or labeler supporting the inclusion of a product on the PDL.
- (d) Distribution of PDL. HHSC will publish the PDL on its Internet website (<http://www.hhsc.state.tx.us/>). A health care provider may also request a copy of the PDL from HHSC by sending a written request to the HHSC or its designee.
- (e) Revisions to the PDL. Within 10 days following HHSC's decision on the recommendations of the P&T committee, HHSC will publish the revised PDL.

- (f) Exclusion of a drug from the PDL. A drug that is not included in the PDL will be subject to prior authorization by HHSC or its designee in accordance with section §354.1832 of this title.
- (g) Agreement on supplemental rebate necessary. HHSC will only include on the PDL drugs provided by a manufacturer or labeler that reaches an agreement on a supplemental rebate with HHSC in accordance with §531.070 of the Government Code. Such agreement may provide for a program benefit offered by the manufacturer or labeler of the drug and accepted by HHSC in accordance with §531.070, Government Code.

7700 Pharmaceutical and Therapeutics (P&T) Committee

§354.1928

- (a) The Pharmaceutical and Therapeutics (P&T) committee will develop recommendations for preferred drug lists to be adopted by the Commission. In accordance with the provisions of §531.074, Government Code, the P&T committee is appointed by the governor and consists of six physicians and five pharmacists.
- (b) In accordance with §531.074(f) of the Government Code, the P&T committee shall meet at least quarterly to consider products in categories recommended for consideration by the Commission or its designee.
- (c) In developing its recommendations for a Preferred Drug List (PDL), the P&T committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product. The P&T committee shall inform the Commission of its reasons for recommending drugs for the PDL.
- (d) The P&T committee shall maintain confidentiality of information used in considering their recommendations, including any information deemed confidential by law.
- (e) HHSC will publish notice of meetings of the P&T committee. The notices will include the categories to be considered at the upcoming meeting and instructions concerning filing of written comments and application to provide public testimony before the committee. Testimony will be provided in a public forum. The committee will not discuss or disclose information deemed confidential under §531.071, Government Code, in a public session.
- (f) Subject to HHSC's approval, the P&T committee will develop by-laws governing the conduct of P&T committee meetings, including the receipt of public testimony and procedures by which it makes its advisory recommendations. HSC or its designee will publish these by-laws on the Internet and make hard copies available upon request.

The Vendor Drug Program implemented the PDL with prior authorization effective February 23, 2004 pursuant to House Bill 2292, 78th Legislature, Regular Session, 2003. The preferred drug list will be updated continually as new therapeutic categories of drugs are reviewed by the P&T Committee and will be posted on the Vendor Drug Program web site at www.hhsc.state.tx.us/HCF/vdp/PT/PT.html. All pharmacies are encouraged to check the web site often for updates to the PDL.

A Medicaid claim for a new or refill prescription of a non-preferred drug will not pay unless prior authorization has been granted for the prescription covered by the claim. In some cases, the Vendor Drug Program will already have claims data that indicates that the patient has met the prior authorization criteria for the non-preferred drug requested. In those cases, the prescription will be prior authorized without the necessity of a phone call. In other cases, the prescriber or one of their staff representatives will have to call the Texas Prior Authorization Call Center Hotline's **toll free number** to obtain approval before the drug can be dispensed. Approved requests for prior authorization will be valid for one year.

Monday – Friday, 7:30 AM - 6:30 PM (CST)
1-877-PA-TEXAS
(1-877-728-3927)

****Prior authorization requests for non-preferred agents will not be handled via the Pharmacy Resolution Call Center.****

Pharmacies will receive a rejection code of 75E for a non-preferred drug that has not been prior authorized. The message will indicate that the drug is non-preferred and that the prescriber should call 1-877-728-3927.

In emergency situations after hours or on weekends pharmacists are authorized to dispense a 72-hour emergency supply of any non-preferred medication without prior approval. Pharmacies should submit an '8' in Field 461-EU 'Prior Authorization Type Code' and '00000000801' in Field 462-EV 'Prior Authorization Number Submitted' and a '3' in Field 404-D5 'Days Supply' in the claim segment of the billing transaction. The quantity dispensed and submitted in Field 442-E7 'Quantity Dispensed' should equal the quantity necessary for a 3-day supply according to the directions for administration given by the prescriber.