

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 4 PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED
DRUG ITEMS

8.324.4.1 ISSUING AGENCY: New Mexico Health Care Authority ([HCA](#)).
 [8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1/1/2014; A, 7/1/2024; A, xx/xx/xxxx]

8.324.4.2 SCOPE: The rule applies to the general public.
 [8.324.4.2 NMAC - Rp, 8.324.4.2 NMAC, 1/1/2014]

8.324.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
 [8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.4 DURATION: Permanent.
 [8.324.4.4 NMAC - Rp, 8.324.4.4 NMAC, 1/1/2014]

8.324.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
 [8.324.4.5 NMAC - Rp, 8.324.4.5 NMAC, 1/1/2014]

8.324.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
 [8.324.4.6 NMAC - Rp, 8.324.4.6 NMAC, 1/1/2014]

8.324.4.7 DEFINITIONS: [RESERVED]

8.324.4.8 MISSION STATEMENT: ~~[To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.]~~ We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
 [8.324.4.8 NMAC - Rp, 8.324.4.8 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.9 PHARMACY SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to MAP eligible recipients, including covered pharmacy services and practitioner administered drugs ~~[[42 CFR Section 440.120(a)]]~~, 42 CFR Section 440.120(a). Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD.
 [8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the ~~[HSD/MAD]~~ HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by ~~[HSD]~~ HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives ~~[instruction]~~ instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact ~~[HSD]~~ HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a

provider must adhere to the provisions of the MAD provider participation agreement (PPA), an agreement with ~~[a HSD]~~ an HCA contracted managed care organization (MCO) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply the necessary information ~~[in-order]~~ for payment to be made. Eligible providers include:

- (1) pharmacies licensed by the New Mexico ~~[pharmacy-board]~~ board of pharmacy;
- (2) clinics licensed for outpatient dispensing by the New Mexico ~~[pharmacy-board]~~ board of pharmacy;
- (3) institutional pharmacies licensed for outpatient dispensing by the New Mexico ~~[pharmacy-board]~~ board of pharmacy;
- (4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico ~~[pharmacy-board]~~ board of pharmacy;
- (5) prescribing practitioners practicing in communities more than 15 miles from a licensed pharmacy;
- (6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and
- (7) mail order pharmacies licensed to dispense in New Mexico.

B. When services are billed to and paid for by a MAD coordinated services contractor, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the medical assistance program (MAP) eligible recipient.

[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an MAP eligible recipient must comply with all federal, state, and local laws, rules, regulations, executive orders and the provisions of the provider participation agreement. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include but are not limited to supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if an MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.310.3 NMAC.

D. Retention and storage of the original prescription, electronic prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years. If the prescriber certifies that a specific brand is medically necessary, by handwriting "brand medically necessary" or "brand necessary" on the face of the prescription (or by an electronic alternative), the allowed ingredient cost is the ~~[estimated acquisition cost (EAC)]~~ lesser of pricing methodology of the national average drug acquisition cost (NADAC (brand)), Affordable Care Act federal upper limit (ACA/FUL), wholesale acquisition cost (WAC) or the submitted ingredient cost of the brand drug. The documentation of the provider's handwritten or electronic alternative certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512. "Brand necessary" prescriptions may be subject to prior authorization. Any claim for which "brand necessary" is claimed must be supported with documentation in the prescriber's medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

E. A pharmacy provider must discuss any matters with the MAP eligible recipient or their personal representative that in the provider's professional judgment are significant. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act. Pharmacy counseling services are subject to the standards for counseling established under

the state Pharmacy Practice Act. Counseling must be furnished unless declined by the MAP eligible recipient or ~~his or her~~ their authorized representative.

F. A pharmacy must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs.
[8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.12 COVERED SERVICES: MAD covers medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this section of this rule. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

A. ~~[For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin, diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculicides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over-the-counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over-the-counter products may be requested when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.]~~ For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin, diabetic test strips, prenatal vitamins, electrolyte replacements, certain insect repellants, ophthalmic lubricants, pediculicides and scabicides, sodium chloride for inhalation, topical anti-inflammatories, topical and vaginal antifungals, oral hormonal contraceptives, pregnancy test kits, emergency contraception, and naloxone nasal spray. The HCA/MAD website makes available additional MAD determined over-the-counter coverage. MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or their authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over-the-counter products may be requested when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.

B. When drugs are provided through a preferred drug list (PDL), drugs are subject to generic-first coverage provisions. The MAP eligible recipient must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition unless a brand drug is determined to be more economical to cover on the PDL over the generic. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered based on the agency's PDL, or upon approval by MAD, or its designee, including ~~[HSD]~~ HCA's contracted managed care organization (MCO), based upon medical justification by the prescriber. ~~[Generic-first]~~ Generic first provisions do not apply to injectable drug items. MAD covers the following for a non-institutionalized MAP eligible recipient and shall be included on the MCO's and agency's PDL:

(1) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings; and

(2) diabetic supplies: equipment, appliances, devices, diabetes technology and supplies for the management or treatment of diabetes. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(a) blood glucose monitors, including those for individuals with disabilities, including the legally blind;

(b) test strips for blood glucose monitors;

(c) visual reading urine and ketone strips;

(d) lancets and lancet devices;

(e) insulin;

- (f) injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;
- (g) syringes;
- (h) prescriptive oral agents for controlling blood sugar levels; and
- (i) glucagon emergency kits.

[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.13 COVERAGE REQUIREMENTS:

A. Legal requirements: All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to ~~his or her~~ their practice and ethics.

B. Rebate requirements: MAD pays only for the drugs of pharmaceutical manufacturers that have entered into and have in effect a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a MAP eligible recipient.

C. Prescribing: A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a MAP eligible recipient. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify ~~his or her~~ their MAP eligible recipients that ~~he or she~~ they cannot prescribe drug items for them.

[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.14 NONCOVERED SERVICES OR SERVICE RESTRICTIONS: Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

- A.** MAD does not cover the following specific pharmacy items:
- (1) medication supplied by state mental hospitals to a MAP eligible recipient on convalescent leave from the center;
 - (2) methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);
 - (3) personal care items such as non-prescription shampoos, soaps;
 - (4) cosmetic items, such as retin-A for aging skin, rogaïne for hair loss;
 - (5) drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;
 - (6) fertility drugs;
 - (7) antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service;
 - (8) long-term weight loss/weight control drugs;
 - (9) barbiturate hypnotic drugs whose primary action is to induce sleep unless the MAP eligible recipient resides in a nursing home;
 - (10) drug items used to treat sexual dysfunction;
 - (11) compounded drug items which lack an ingredient approved by the federal food and drug administration (FDA) for the indication for which the drug is intended;
 - (12) compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and
 - (13) cough and cold preparations for a MAP eligible recipient under the age of four.
- B.** MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a MAP eligible recipient who resides in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the MAP eligible recipient or billed to MAD, or a ~~HSD~~ HCA contracted managed care organization, by a provider:
- (1) diabetic testing supplies and equipment;
 - (2) aspirin and acetaminophen;
 - (3) routine ointments, lotions and creams, and rubbing alcohol; and

(4) other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

C. MAD does not cover drug items for a MAP eligible recipient who is eligible for medicare Part D when the drug item or class of drug meets the federal definition of a medicare Part D covered drug. MAD does not cover any copayment due from the MAP eligible recipient towards a claim paid by medicare Part D nor any ~~[medicare] of the annual out-of-pocket medicare cost cap. [Part D covered drug or class of drug where the MAP eligible recipient has a gap in medicare Part D coverage due to a medicare coverage limit.]~~ Items or drug classes specifically excluded by medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a MAP eligible recipient who is not ~~[dually-eligible]~~ dually eligible.
[8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the ~~[generic first]~~ generic first coverage provisions, applicable therapeutic “step” requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

A. **Prior authorization:** MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

D. **Drug utilization review:** The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the MAP eligible recipient’s service providers or governmental entities legally authorized to receive such information.

(1) **Prospective drug use review:** Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions, clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) **Counseling:** ~~[Pursuant to 42 CFR 456.705, each dispensing pharmacist or must offer to counsel each MAP eligible recipient or his or her authorized representative receiving services who presents a new prescription, unless the MAP eligible recipient or his or her authorized representative refuses such counsel. Pharmacists]~~ Pursuant to 42 CFR 456.705, each dispensing pharmacist or pharmacist intern must offer to counsel each MAP eligible recipient or their authorized representative upon receipt of a new prescription drug order. When counseling is refused by the MAP eligible recipient or their authorized representative, the pharmacist or pharmacist intern must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review ~~[has]~~ have taken place. A reasonable effort must be made to record and maintain the pharmacist’s comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a MAP eligible recipient ~~[access to a toll free number]~~ an alternative form of patient information to supplement patient counseling when appropriate. Examples include, but

[are not limited to: pictogram labels, written information leaflets, and quick-response \(QR\) codes that link to digital drug information.](#)

[8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.16 REIMBURSEMENT: Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor, see 8.302.2 NMAC and Section 17 of [\[this rule\] 8.324.4 NMAC](#).

A. General reimbursement methodology: The estimated ingredient cost will not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the actual acquisition cost of a 340B drug, or the federal upper limit (FUL).

(1) Estimated acquisition cost (EAC). MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs;

(b) the factors MAD considers in setting rates for drugs under this subparagraph include:

- (i)** product cost, which may vary among purchasing contracts;
- (ii)** clinical concerns;
- (iii)** MAD's budget limits;
- (iv)** the actual package size dispensed; and
- (v)** payments by other payers in New Mexico and other state MAD and

medicare pricing policies;

(c) MAD uses the EAC as its reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology;

(d) EAC is calculated using the current published average wholesale price (AWP) of a drug less a percentage established by MAD, the average manufacturer price (AMP) plus a percentage established by MAD, or the wholesale acquisition cost (WAC) plus a percentage established by [\[HSD\] HCA](#), and other pricing limits determined by other pricing information sources selected by MAD; and

(e) MAD uses the ingredient cost indicated in the ingredient cost field on the billing transaction as the EAC when that indicated ingredient cost is lower than the MAD EAC.

(2) Maximum allowable cost (MAC) MAC methodology. MAD establishes a MAC applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and for certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by arraying costs for the A-rated therapeutic equivalent drugs regardless of manufacturer, and selecting a reasonable price from the arrayed list in a manner consistent with the state plan or any waiver approved by CMS subjecting that price to cost factors and tests for reasonableness;

(c) When a state MAC price has not been calculated by MAD, a baseline price calculated by a national supplier of drug pricing information is used as the state MAC;

(d) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's billed usual and customary charge; and

(e) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in Subsection B of this section.

(3) Federal upper limit (FUL) methodology:

(a) MAD adopts the FUL that is set by CMS or recommended by the federal department of justice.

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) MAD will not use the individual drug FUL as MAD's reimbursement rate when the prescribing practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's usual and customary billed charge.

(4) 340B drug discount actual acquisition cost:

(a) The actual ingredient cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be placed in the ingredient cost field and indicated on the billing transaction as a 340B drug item.

(b) Drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be billed at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item with use of a “UD” modifier on medical claims or “08” on point-of-sale pharmacy claims. If a MAP eligible recipient with a prescription written at a 340B entity requests the item to be dispensed by a 340B pharmacy under contract to the 340B entity, then the pharmacist must dispense 340B purchased items when filling the prescription.

(5) Usual and customary charge:

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(c) Usual and customary charges must reflect discounts given to a MAP recipient for certain reasons, such as age or NF resident, when a MAP eligible recipient meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-MAP recipient.

(d) Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(6) Medicare reimbursement: Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in ~~[this Section Subsection A of this rule]~~ Subsection A of 8.324.4.16 NMAC.

(7) Practitioner administered drug items are reimbursed according to the MAD fee schedule.

B. Pricing information to set EAC and MAC: MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, federal agencies, drug data information clearinghouses and pharmacy invoices.

C. Assistance in establishing EAC and MAC: MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, or other consultants when establishing EAC or MAC.

D. Pharmacy price reductions: If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non- MAP recipient, the provider must similarly reduce its charge to MAD for the prescription.

E. No claims for free products: If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a MAP eligible recipient.

F. Solutions: Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

G. Non-drug items: Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies, see 8.310.2 NMAC.

[8.324.4.16 NMAC - Rp, 8.324.4.16 NMAC, 1/1/2014; A, xx/xx/xxxx]

8.324.4.17 POINT OF SALE: The point-of-sale system provides relevant drug utilization information that the pharmacist must consider before dispensing a drug. If utilization information indicates that a MAP eligible recipient has an adequate supply of the drug item or that the quantity being dispensed is excessive, the claim will initially be denied. The pharmacist is responsible for resolving the issue and obtaining an authorization to dispense the drug, if necessary.

A. General requirements: All MAD in-state and border area pharmacy providers are required to submit claims through the point-of-sale system.

B. Exceptions to general requirements: The following are exceptions to this general requirement:

- (1) the provider is out-of-state and is not a border area provider;
- (2) the provider is a family planning clinic dispensing prescriptions;

- (3) the provider submitted on average less than 50 claims per month to MAD for the preceding six-month period;
- (4) the claim requires an attachment or explanation; or
- (5) a required data element on the claim cannot be entered in the current standard point-of-sale format.

[8.324.4.17 NMAC - Rp, 8.324.4.17 NMAC, 1/1/2014]

8.324.4.18 PRESCRIPTIONS AND REFILLS:

A. Dispensing frequencies: MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same MAP eligible recipient.

- (1) The limitation is established individually for each drug.
- (2) Maintenance drugs are subject to a maximum of three times in 90 days with a 14-calendar day grace period to allow for necessary early refills.
- (3) Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.
- (4) The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.
- (5) Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

B. Refill requirements: Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the MAP eligible recipient has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.

C. Quantities dispensed: Maintenance drugs are those on the MAD-approved maintenance drug list.

- (1) For a MAP eligible recipient with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.
- (2) Prescriptions for non-maintenance drugs are limited to 34-day supplies.
- (3) Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the MAP eligible recipient has been established.
- (4) Controlled substances may not be refilled until 75 percent of the drug has been used based on the days supply of the previous prescription unless the prescriber has been notified and given approval. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

(5) Pharmacy providers shall not reduce prescriptions for maintenance drugs that are written for quantities larger than a 34-day supply and may dispense up to a 90-day supply. MAD considers prescription splitting to be fraudulent. Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill.

(6) Coverage may be limited by the end date of the MAP eligible recipient's span of eligibility at the time of dispensing.

(7) Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

(8) Controlled substances may have specific controls on the quantities dispensed.

D. Unit dose packaging: MAD does not pay additional for unit dose packaging.

E. Prevention of abuse: Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the MAP eligible recipient of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the MAP eligible recipient's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

F. Mail service pharmacy: MAD may provide a mail service pharmacy for a MAP eligible recipient use.

- (1) The mail service pharmacy is available as an option to all MAP eligible recipients.

(2) Retail pharmacies may mail, ship or deliver prescriptions to all MAP eligible recipients consistent with applicable state and federal statutes, rules and regulations.
[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1/1/2014]

HISTORY OF 8.324.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0700, Pharmacy Services, filed 2/29/1980.

ISD 310.0700, Drug Services, filed 2/10/1981.

ISD 310.0700, Drug Services, filed 7/8/1982.

ISD Rule 310.0700, Drug Services, filed 3/1/1983.

ISD Rule 310.0700, Drug Services, filed 2/15/1989.

ISD Rule 310.0700, Drug Services, filed 7/9/1984.

MAD Rule 310.07, Drug Services, filed 3/31/1989.

MAD Rule 310.07, Drug Services, filed 1/3/1992.

MAD Rule 310.07, Drug Services, filed 4/20/1992.

MAD Rule 310.07, Drug Services, filed 12-8-94.

History of Repealed Material:

MAD Rule 310.07, Drug Services, filed 12/8/1994 - Repealed effective 2/1/1995.

8 NMAC 4.MAD.753, Pharmacy Services, filed 1/18/1995 - Repealed effective 8/13/2004.

8.324.4 NMAC, Pharmacy Services, filed 8/2/2004 - Repealed effective 1/1/2014.