20. Pharmacy

20.1. General Information

Pharmacy Benefits: ~~Centennial~~ Turquoise Care Programs

Prescription drugs are a benefit under the Turquoise~~Centennial~~ Care program to be covered by the MCOs. MCOs shall support HCA~~SD~~ in promptly responding to public and legislative inquiries involving the design and management of the MCO's pharmacy benefit.

Preferred Drug List (PDL) and Formulary Requirements

MCOs shall comply with the NMAC 8.308.9.14 Pharmacy Services and the Pharmacy Services section of the Agreement.

MCOs shall comply with all new legislative requirements relating to medication formularies.

MCOs ~~-~~shall not impose step therapy requirements before authorizing coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of an autoimmune disorder, a behavioral health condition, cancer or a substance use disorder, pursuant to a medical necessity determination, except in cases in which a generic version is available. ~~including any statute on step~~

MCO~~'~~s shall not require prior authorization for any Medication Assisted Treatment (MAT) medications and shall comply with the following:~~.~~

- Medication Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. There are FDA approved medications to treat alcohol use disorder, smoking and opioid use disorder.
- MCOs are directed to cease requiring prior authorization for any FDA-approved MAT drugs, including but not limited to methadone, buprenorphine, naltrexone, and buprenorphine/naloxone combinations. New drugs, formulations and delivery routes for these medications are created frequently, and MCOs are directed to ensure that all MAT drugs and all forms of those drugs are available to Medicaid members without unnecessary barriers.
- Generic first policy for MAT drugs defined:

- An MCO can require a recipient to use a generic version of a drug prescribed as a brand name unless the prescriber specifically states on the prescription "brand medically necessary." When the "brand medically necessary" is written by hand on the prescription (not a rubber stamp), a pharmacy bills using a "dispense as written" indicator on the National Council for Prescription Drug Programs (NCPDP) transaction. In this case, the MCO must pay for the brand name version; this is a federal requirement. In this case, no step therapy may be required.

- No P~~p~~rior A~~a~~uthorizations On~~for~~ MAT D~~d~~rugs
  - No prior authorization is required for any MAT drug in any formulation when used to treat opioid use disorders. Any formulation of buprenorphine FDA approved for the treatment of opioid use disorders is exempt from the generic-first coverage provisions of 8.324.4.12 NMAC. Prescribers should specifically state on the prescription either in writing or electronic indication "brand medically necessary." The prescriber must maintain in the patient care notes the patient has failed the generic therapy or did not maintain a therapeutic response on the generic equivalent. The pharmacy then bills using the "dispense as written" indicator on the NCPDP claim submission. Best clinical practices when prescribing buprenorphine for the treatment of opioid use disorders (e.g. systematic checking of the prescription ~~monitorin~~monitoring program and periodic urine drug screening) should be addressed through a ~~proveder~~provider alert rather than a prior ~~authroizaiton~~authorization process.
  - MCOs must cover all vaccines as indicated on the CDC vaccine schedule. ~~flu shots, including the booster enhanced flu shots for members when prescribed for recipients 65 and older and for other conditions per CDC seasonal recommendations.~~
  -

Treatment Guidance for Chronic HCV Infection

MCOs shall establish a system to cover treatment of members over the age of 17 years old with active Hepatitis C infection for the appropriate amount of time that the therapy requires for the ~~member~~Member's diagnosis. The system will consist of:

- ~~The approval process of properly requested treatments for members with chronic HCV infection using the Uniform New Mexico HCV Checklist for Centennial Care (See MAD 634 Attached);~~

- ~~The development of a provider incentive plan to expand the number of practitioners treating HCV in New Mexico, including:~~
  - ~~Incentive(s) to receive training in the treatment of chronic HCV infection;~~
  - ~~Incentive(s) to begin treating such patients; and~~
  - ~~Incentives for treatment of each patient;~~
- Not using active alcohol or drug use as screening criteria for the treatment, approval or denial process;
- Not using the specialty of the requesting provider as screening criteria for treatment, approval or denial;
- ~~Referral of all members to a community health worker, Care Coordinator, or MCO specialty pharmacist at the time of a drug treatment request for guidance and treatment compliance;~~
- Quarterly data submission concerning number of requests, approvals, and denials for any ~~medicatins~~medications requiring prior approval. ~~by fibrosis stage (or equivalent) and genotype for all treatment requests;~~
- A comprehensive plan of outreach to the MCOs' referring providers requesting oral drug treatment for chronic HCV infected patients. This is to include patients who have a positive Hepatitis C Ribonucleic Acid (HCV RNA) test within the past two calendar years and have not received treatment.~~s;~~
- A comprehensive plan to expand HCV case finding efforts and screening efforts; and
- A comprehensive plan to expand HCV screening efforts to conform to USPSTF/CDC/ American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA) guidelines.

MCOs are to approve properly requested treatments for the following ~~Centennial Care~~Turquoise Care members with chronic HCV infection:

- Access to drug therapy, that does not include a prior authorization or step therapy for glecaprevir/pibrentasivir (Mavyret®) or sofosbuvir /velpatasvir (Epclusa®).
- All members over age 17, all HCV genotypes, with a positive Hepatitis C RNA level;
- ~~In all cases, t~~The MCOs shall ensure (using the AASLD/IDSA guidelines) that each treatment request is appropriate for any medication requests for the treatment of Hepatitis C other than glecaprevir/pibrentasivir (Mavyret®) or sofosbuvir /velpatasvir (Epclusa®). ~~with respect to:~~

- ~~HCV genotype and viral load;~~
- ~~Drug dose(s) and duration(s). The MCO's preferred formulary agent may be given preference if the level of evidence and effectiveness (as measured by Systemic Vascular Resistance) is equal or greater, and no drug interactions are of concern;~~
- ~~The presence or absence of advanced fibrosis or cirrhosis. For the purpose of making treatment decisions using the AASLD/IDSA guidance, "cirrhosis" can be considered to be present if any of the following are present:~~
  - ~~APRI >= 1.0;~~
  - ~~Fib-4 >= 3.25;~~
  - ~~Transient Elastography Score>= 12.5 kP (F4 equivalent);~~
  - ~~Fibrotest > = 0.73 (F4 equivalent) OR Fibrometer with F4 predominance;~~
  - ~~Radiographic imaging or physical exam findings consistent with cirrhosis; and~~
  - ~~Liver biopsy confirming a METAVIR Score of F4.~~
- ~~Prior HCV treatment experience:~~
  - Plans may require resistance associated substitutions testing, based on the American Association for the Study of Liver Disease (AASLD) guidance.

- Guidance regarding lost or stolen medications:
  - MCOs shall use the same criteria currently used for refills of other lost or stolen medications.~~;~~
  - ~~and~~
  - ~~MCOs shall use Care Coordination and other functions to minimize this occurrence.~~
- Guidance regarding requests for off label, experimental, and other forms of treatment that are not specified in the guidelines:
  - MCOs shall initiate a peer-to-peer consultation with the requesting physician to further understand the request and its rationale; and
  - MCOs shall present the case to Project ECHO before issuing a denial.

- ~~Note that a "properly requested treatment" as defined above means that:~~

~~The Uniform Checklist form is completed fully as directed and submitted;~~

-
- ~~Necessary lab data and copies of medical records are attached; and~~

- ~~The requested drug(s), dose(s), and length of treatment are consistent with AASLD/IDSA guidance as written (the level of evidence in the guidance should not be considered relevant to length of treatment decisions). If not consistent, MCOs shall provide an appropriate alternative.~~

- ~~MCOs are granted the option to expand their treatment criteria beyond these guidelines (e.g., to those 17 years of age and under), with advance notice to and approval by MAD.~~

Human Immunodeficiency Virus

- MCO's must maintain an appropriate formulary for HIV medications. MCO's must cover pre and post exposure prophylactic medications without a prior authorization.
- MCO's must cover all formulations of oral combination medications. MCO's must not mandate the use of individual oral therapies when a combination option is available.
- MCO's must offer a reasonable path for long acting injectable HIV medications to members.

Medical Aid in Dying

- Medical Aid in Dying (MAID) compounded prescription orders are not to be filled by the MCO's PBM. Any members requesting a MAID compound via appropriate channels are to have the compounded MAID prescription submitted to the FFS PBM.

~~Diabetes~~ Delivery of Necessary Diabetic Resources

- MCO's shall comply with 2023 Legislation (HB 53)~~.~~

  Absent a change in diagnosis or in a covered Member's management of diabetes treatment or its complications, ~~or treat ment or diabetes or its complicatioscomplications,~~ the MCO shall not require more than one prior authorization per policy period for any single drug or category of item prescribed as medically necessary by the covered ~~member~~Member's health care prescriber.

  - Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use ~~or operate~~or operate devices for which a covered ~~member~~Member has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the MCO. This does not construe required payment for diabetes resources that are not a covered benefit.

~~Indian Health Services~~Indian Health Service & Tribal 638 Outpatient Pharmacy Annual All Inclusive Rate (AIR) Reimbursement

MCOs shall follow federal requirements related to reimbursement to MCO contracted Indian Health Service (I.H.S.) and Tribal 638 outpatient pharmacies.

- Each year the MCOs are required to reimburse the AIR published annually by the Federal Register and must continue the rate assigned from the previous year until that new rate is published in the Federal Register. It is the MCO's responsibility to check the Federal Register's publication for the annual rate posted. All affected dates of service for pharmacy drug claims will be adjusted and reprocessed to reflect the new reimbursement rate annually.
- Pharmacy drug claims reimbursed at the AIR are not eligible for professional dispensing, pharmaceutical administration, and/or compounding fees.
- The AIR for pharmacy drug services may be billed in addition to billing an I.H.S. or Tribal 638 physical health, behavioral health, or dental encounter that is provided on the same day. I.H.S. or Tribal 638 outpatient pharmacies will continue to bill the MCOs pharmacy benefit managers (PBMs). Excluded from this reimbursement change are durable medical equipment, medical supplies, and over the counter orthotic items.
- MCOs are required to have their PBMs update their claims processing systems to allow payment of the AIR on outpatient pharmacy drug claims effective for dates of service since March 1, 2021 or beginning July 1, 2024 of the Turquoise Care contract.
- MCOs are required to have all adjustments completed within 120 days from the time notification is received. MCOs are required to provide 30-, 60-, and 90-day updates on the status of claims adjustment; and confirm within 120-days that all adjustments have been completed. No further updates are required once the final completion notification of claims adjustment has been received.
- ~~MCO's must notify HCASD when the new annual rate is updated and when all adjustments have been completed.~~

Community Pharmacy Reimbursement

MCOs shall ensure that reimbursement to community-~~-~~based pharmacies realistically reflect buying power, buying volume, and price negotiating potential. MCOs must ensure that payment for the ingredient cost of a drug at a value that is at least equal to the national average drug acquisition cost for the prescription drug at the time that the drug is administered or dispensed, or if data for the N~~n~~ational A~~a~~verage D~~d~~rug A~~a~~cquisition Cost (NADAC) is unavailable, the W~~w~~holesale A~~a~~cquisition C~~c~~ost (WAC) of the drug. ~~that the Maximum Allowed Cost (MAC) for ingredient cost generic drugs for community- based pharmacies is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the NDC for the drug item. The dispensing fees will be paid in accordance with the terms of the applicable pharmacies' contracts.~~

The professional dispensing fees (PDFs) paid to~~for~~ community-~~-~~based pharmacies will mirror the FFS PDF~~is~~ ~~$10.30~~ and shall comply with any future FFS PDF changes.

Where there is no NADAC or WAC price available, such as for certain OTC drug items, certain generic drugs that have few manufacturers, and some repackage products, the MAC must be no lower than the published Wholesaler's Average Cost (WAC) listed for the NDC ~~plus 6%~~. The WAC must come from a published national pharmacy pricing source such as Medispan or First Data Bank that is not associated with the MCO or PBM. This pricing methodology for certain OTC drug items aligns with the State's reimbursement structure under Medicaid FFS. Such pricing is in effect only for drug items that do not have a NADAC or WAC price available.

~~If the pharmacy submits an ingredient cost less than NADAC (or the WAC plus 6% when applicable), then the MCO's PBM may use that lower submitted amount as the ingredient cost.~~

- A community-based pharmacy is a pharmacy that has the following characteristics:
  - Is open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written. This includes multi-site pharmacy operations and franchises whose locations are in New Mexico;
  - Is located in New Mexico or near the state border, if the border town is a primary source of prescription drugs for Centennial Care members residing in the border area;
  - Is not government owned, not hospital~~l~~ owned or hospital based, not an extension of a hospital, not owned by a corporation owning hospitals, and not an extension of a medical practice or specialty facility;
  - Is not owned by a corporate chain with stores outside of New Mexico;

- Is not a mail order pharmacy; and
- Is not part of a national network of pharmacies or specialty pharmacies, including those primarily used for supplying IV admixtures.

- A list of pharmacies to which this section of this policy applies is included at the end of this policy. ~~HSD~~HCA develops and maintains the criteria for inclusion on the list and applies only to community-based pharmacies that participate in the MCOs' Centennial Care network. Inclusion of a pharmacy on the list does not mandate inclusion of the pharmacy in the MCOs' Centennial Care network. This does not supersede any credentialing requirements established by the MCO or its PBM. Pharmacies on the list that are not contracted for participation in the MCOs' Centennial Care network will be subject to the MCOs' out of network payment rules.
- The MCO is not obligated to adjust claims retroactively based on changes made by ~~HSD~~HCA/MAD to the list.

- Calculation of Payment:
  - A pharmacy cannot be required to submit a dispensing fee on the claim, nor shall the payer use a submitted dispensing fee to limit payment. MCOs must ensure that the contracted dispensing fee is used in the payment calculations including any applicable professional dispensing fees for Community Based Pharmacies, as directed by ~~HSD~~HCA; and
  - MCOs must ~~pay for~~pay compounding fees when a pharmacist must prepare a compound medication for a covered FDA approved drug/ingredient, for a dosage form or strength not already commercially available, as written in a clinician's prescription. Neither compounding fees nor reimbursement will apply to a compound that includes non-covered pharmacy products as defined by MAD regulations. MCOs must also pay ~~HSD~~HCA-required administration and incentive fees for pharmacist's prescribing/consultation services, when the pharmacist is enrolled with ~~HSD~~HCA, permitted by license, and credentialed by the MCO, such as may be done for vaccines, smoking cessation products, combined hormonal and injectable contraceptives, and Naloxone. When specifically established by MAD, MCOs will reimburse for administration fees for injections, including but not limited to injectable vaccines and injectable contraceptives; and MCOs will reimburse for the counseling fee for Naloxone, in all formulations/delivery methods. Other counseling for FDA approved drugs, and products, as required by OBRA 90, is a pharmacist's dispensing responsibility.
- Updating Prices:

- NADAC prices (or WAC prices ~~plus 6%~~ for ~~OTC~~ all drug items including OTC) must be implemented within seven calendar days of NADAC price changes. If a price increase is not made within seven calendar days, MCOs must ensure that pharmacy claims are adjusted to reflect the price increase for claims that were not paid at the increased price. A price decrease cannot be implemented retroactively.
- For MAC prices determined by an MCO (other than NADAC and WAC ~~plus 6%~~), the MCO must ensure all MAC payment levels are reviewed, at a minimum, once per week. If there is a price increase that took place during the week that resets the MAC price, an increase must be implemented within seven calendar days. If a price increase is not made within seven calendar days, the MCO must ensure that paid pharmacy claims are adjusted to reflect the price increase, if they were not paid at the increased price. A price decrease cannot be implemented retroactively.
- MAC prices must be established by evaluation a range of prices from sources with prices available in New Mexico. Documentation must be retained on how the price was selected and how it was determined that the price was available in New Mexico. If an MCO selects the lowest price available, documentation must be maintained showing that the source of the MAC price is available from wholesalers in New Mexico. Short term, special deal prices cannot be used to set a MAC price at the lowest available price.
- Medicaid Managed Care shall require all pharmacies, physicians, regional health centers, family planning organizations, state government and other clinics to bill the A~~a~~ctual ~~ingredient~~Acquisition C~~c~~ost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to an MCO eligible recipient at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item using the "UD" or "08" modifier. All claims submitted for pharmaceutical items obtained through the 340B program must be identified.
- Medicaid Managed Care claims shall require the manufacturer assigned NDC identifier, a valid HCPCS or CPT code, a "JW" (indicates waste) or "JZ" (no waste) modifier, and the unit of service for the HCPCS or CPT for informational purposes and does not dictate pricing.
- The Centers for Medicare and Medicaid Services (CMS) mandates that Medicare providers report either the "JG" (drug or biological acquired with 340B drug pricing program discount) or TB (drug or biological acquired with 340B drug pricing program discount, reported for

informational purposes) modifiers, and shall be accepted by Medicaid Managed Care; requiring the "UD" modifier to identify 340B drug claims.

~~MCOs must cover flu shots, including the booster enhanced flu shots for members when prescribed for recipients 65 and older and for other conditions per CDC seasonal recommendations.~~

- MCOs must follow MAD direction regarding the minimum amount of information that must be reported back to the pharmacy on a price challenge. When a MAC price challenge is made on the basis of failing to update a price within the applicable timeframes, and a pharmacy "wins" the challenge, MCOs must ensure that all pharmacy claims that were underpaid, due to the lack of a timely update, are adjusted.
- MCOs must require that if the pharmacy does not "win" the challenge, the response to the pharmacy shall state: the drug price that is in effect on the date of service; the date that the price was established as the MAC price; if the MAC price has subsequently changed since the date of the prescription and the current MAC price; the basis of that price (i.e., how the price was established); the NDC if the price is based on specific NDC; and how they concluded the price was available in New Mexico.
- MCOs must accept the price challenges directly from the pharmacy if the MCO's PBM is setting the price unless the pharmacy contract with the Pharmacy Services Administration Organization (PSAO) requires challenges to go through the PSAO, in which case the MCO must require the PSAO to forward challenges to the MCO within three business days of receipt from the pharmacy, and require the PSAO to forward any response to the pharmacy within three business days of receipt from the MCO.
- For a claim recoupment or payment reduction made more than seven calendar days after initial payment, a provider must be notified about the reason for the recoupment or reduction, the amount of the recoupment or reduction, and given an opportunity to appeal or file a grievance. There is no fair hearing right. This requirement does not apply if the pharmacy is reversing or rebilling the claim that results in a recoupment or payment reduction.
- If the pharmacy contract with the PSAO requires that notice of payment recoupment or reduction go through the PSAO, the MCO must require the PSAO to forward such notices including language regarding the opportunity to appeal the pharmacy within three business days of receipt from the MCO and the PSAO to forward any response to the MCO within three business days of receipt from the pharmacy.

Pharmaceutical Service Reimbursement Parity

Pharmacist Clinicians (Ph.C.s) shall be reimbursed for clinical services at the same rate that is paid to a licensed physician, physician assistant (PA), or advanced nurse practitioner (NP) for the same service. ~~Ph.C.s not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works (NMAC 8.310.3.11, Section C, 4). Pharmacists with independent prescriptive authority shall be reimbursed for clinical services at the same rate paid to the billing provider using the designated billing form.~~ Prescriptive authority shall be limited to those drugs and services, TB tests, Test to Treat and vaccines delineated within currently approved and future New Mexico Board of Pharmacy written prescriptive authority drug therapy protocols. ~~Ph.Cs. and Pharmacists with prescriptive authority must enroll with the New Mexico Medicaid program.~~

MCOs are required to have their PBMs update their claims processing systems to allow for billing and payment via pharmacy POS and the medical benefit based on information provided by the HCA. MCO's may alternatively accept CMS-1500 or UB-40 for pharmacist clinical services.

MCO Participation in the DUR Board and Submission of a DUR Annual Report

MCOs shall take part in a DUR program that complies with the requirements set forth in 42 C.F.R. § 438.3(s) and 42 CFR Part 456 Subpart K, and Section 1927(g) of the Social Security Act, to ensure prescriptions are appropriate, medically necessary, and minimize the potential for adverse medical results. ~~MCO representation on the DUR Board shall consist of one physician and one or two pharmacists.~~

DUR Reporting Requirements:

MCOs are contractually responsible for providing outpatient drug benefits and for conducting utilization review activities to promote the delivery of quality medically necessary care in a cost effective and programmatically responsible manner. To ensure all areas of section 1927(g) of the Act are met, MCOs must provide a detailed description of their DUR program activities to the State on an annual basis.

MCOs are required to take part in a DUR program and as part of this program, per CMS requirements, each MCO will be required to submit a DUR report to ~~HSD~~HCA that will be submitted to CMS. The report template is provided by CMS and at minimum shall contain the following:

- A description of the nature and scope of the prospective and retrospective drug review program;
- Detailed information on the specific criteria and standards in use;
- A summary of the educational interventions used and an assessment of the effect of ~~these~~these.
- interventions on the quality of care; and
- An estimate of the cost savings generated as the result of the program.

For your reference, the following are links to the CMS website for previous DUR reports:

All States:

https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/annual-reports/index.html

~~New Mexico:~~

~~https://www.medicaid.gov/MedicaidCHIPProgramInformation/ByTopics/PrescriptionDrugs/Downloads/2016_New-Mexico_DUR.pdf~~

MCO requirements regarding the Drug Rebate Analysis and Management System (DRAMS) and drug rebate dispute resolution

~~HSD~~HCA's PBM will continue to send drug rebate invoices to manufacturers based on the encounter data for pharmacy and medical claims submitted by the MCOs. ~~HSD~~HCA's PBM will receive copies of the manufacturers' checks. If the manufacturer does not pay the invoice in full because the manufacturer disputes some of the data on the invoice, ~~HSD~~HCA's PBM will refer the manufacturer dispute to the appropriate MCO staff.

Typically, when the manufacturer disputes the invoice based on incorrect data on the claims, the manufacturer will request claim level detail (CLD). ~~HSD~~HCA's PBM will send the CLD to the manufacturer.

After the manufacturer reviews the CLD, the manufacturer may issue a dispute in the form of an email or letter, and request that the payer review the claims.

When a dispute is reported to the MCO, the MCO is responsible for reviewing their pharmacy claims data to determine if the data needs to be corrected or if the data is correct. This entails reviewing claims and possibly contacting pharmacy and medical providers to obtain information to resolve the dispute.

The MCO must report the resolution of the dispute to ~~HSD~~HCA's PBM within 30 calendar days from the date of receiving the notice of the dispute.

A smaller number of disputes are initiated after the manufacturer has already paid the invoice. These disputes will be handled in the same manner as other disputes.

~~HSD~~HCA's PBM will review the MCO pharmacy and medical drug claims data prior to printing invoices in an attempt to minimize disputes. Often, for specific drug items, reporting the correct number of units is a common problem and the correction may be obvious to ~~HSD~~HCA's PBM. In such cases it will make the change prior to printing invoices. Usually, the problem occurs when the standard billing units differ from the units that CMS expects to be used on the rebate invoices. A problem also may occur when an MCO allows a provider to bill incorrect units. ~~HSD~~HCA's PBM will notify an MCO of any situation where the MCO continues to make the same error in data and the MCO will be required to implement corrections in their processing of claims.

Common Dispute Reasons

Disputes frequently result from recurring circumstances and often for the same drug items each quarter. When the error that will likely lead to a dispute originates with the provider and the MCO does not detect the error when processing the claim, the MCO will be asked to correct their claims processing editing to avoid continual disputes.

The following sections identify the most common reasons for disputes.

Unit Type Discrepancy

A provider bills a claim utilizing a unit type that differs from the unit type that was utilized in calculating the rebate. Most claims processing systems allow providers to utilize only three unit types when billing claims. Common claim processing system unit types

- Each (caps, tabs, kits, and vials)
- Milliliters (liquids)
- Grams (solids)

CMS has eight unit types for claims:

- AHF (refers only to injectable Anti-Hemophilic Factor units)
- CAP (capsule)
- SUP (suppository)

- GM (grams)
- ML (milliliter)
- TAB (tablet)
- TDP (transdermal patch)
- EA (each, refer to drugs not identifiable by any other unit type as given in program instructions)

Staff of ~~HSD~~HCA's PBM will convert the common claims processing unit types before preparing manufacturer invoices. If a dispute occurs based on unit conversion or for units that were not converted, ~~HSD~~HCA's PBM will make the correction in order to resolve the dispute.

If the unit type appears to be incorrect on the original encounter claim, the dispute will be sent to the MCO DRAMS contact for resolution.

Data Entry Errors Regarding the Quantity

Incorrect quantities are sometimes entered on the claims by the provider. If the MCO does not detect the incorrect quantities, this can cause discrepancies with the number of units shown as dispensed on the claim.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data and determine if the provider billed incorrectly. This will entail looking at the claim; contacting the provider and requesting what the units represent (ML, GRAMS, and EACH). If it is an "each", determine what the "each" represents (CAP, TAB, kits or vials). If the claim was billed incorrectly, the provider must adjust the claim with the correct units.

Decimals

When the drug strength does not equal a whole number, or the units of measure or package size has a decimal in the units, a decimal point in the units could mean a provider error.

If the MCO does not detect the incorrect quantities, this can cause discrepancies because use of a decimal point may be illogical for many unit types for drug items.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the provider if the units

are unusual and the MCO DRAMS contact cannot tell whether the provider's units are correct or incorrect.

Units or Quantities Appear Inconsistent

If the units billed for a particular NDC are inconsistent with the number of prescriptions, the pharmacy reimbursement or lowest dispensable package size, the drug manufacturers will question the amount dispensed, if it appears to be an unexpected amount.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the provider if the units are unusual and the MCO DRAMS designate cannot tell whether the provider's units are correct or incorrect.

Terminated/Invalid NDCs

Terminated NDCs (dispute code N) are those products where the shelf life for the last lot produced has expired. Per CMS guidelines, the affected manufacturer or labeler is required to submit pricing data and pay rebates for four quarters past the termination date, but only for claims with a date of service prior to the termination date.

~~HSD~~HCA's PBM will contact the manufacturer to obtain the termination date and determine whether the date has been provided to CMS. If advised that a termination date has been sent to CMS and a sufficient amount of time has elapsed since that submission (two quarters), ~~HSD~~HCA's PBM will provide the MCO DRAMS contact staff with a list of the providers involved (i.e., those with the most claims for the drug and quarter in question). The MCO DRAMS contact must notify the providers. If the provider has the product on the shelf, they will need to provide the lot number and expiration date and provide the information to staff of ~~HSD~~HCA's PBM.

Affected claims must be checked to identify all DOS that fall after the termination date. For those claims, an adjustment must be made. The provider must adjust the claim if the incorrect NDC code was used.

State Units Exceed Expected Sales/No Record of Sales in the State

Manufacturers have a threshold on their NDC numbers and if they hit that threshold, they will dispute claims based on units exceed expected sales. They also will dispute if they show no record of sales of their product within the state.

In resolving this type of dispute, the MCO DRAMS contact should determine if the provider used the NDC code. Sometimes the provider can show they did order an item from out of state or have other documentation that their billing was correct. The MCO must obtain documentation from the provider of purchase, such as an invoice from their wholesaler with the NDC in question and the amount purchased. This must be forwarded to ~~HSD~~HCA's PBM so that it may provide the information to the drug manufacturer when requested. The provider must adjust the claim, if the incorrect NDC code was used originally.

Inaccurate NDC

A pharmacy or medical ~~provider must~~ ~~m~~ ~~m~~ ~~may~~provider may submit a claim in which the NDC billed is not the NDC dispensed. In resolving this type of dispute, the MCO ~~should~~must contact the provider and determine if they really used the NDC code reported.

The provider must adjust and resubmit the claim if the incorrect NDC code was used. All timely filing

Communicating with ~~HSD~~HCA's PBM on Disputes and Correcting Errors

The MCO is to notify ~~HSD~~HCA's PBM of claims on which the units were incorrect. ~~HSD~~HCA's PBM will enter a comment into DRAMS that the units were incorrect and that the MCO is working on adjustments. ~~HSD~~HCA's PBM will notify the manufacture regarding the status of the dispute. ~~HSD~~HCA's PBM cannot change the units on a claim, therefore, it is necessary for the MCO to have the provider adjust the claim. When the encounter data is adjusted, the DRAMS system will back out the incorrect quantity and issue new invoices with the new quantity as a prior quarter adjustment.

If the MCO verifies that some of the disputed quantities are correct, the MCO must notify ~~HSD~~HCA's PBM. ~~HSD~~HCA's PBM will enter a comment into DRAMS that the units were correct and state how the quantity was verified such as, a call to the provider. ~~HSD~~HCA's PBM will notify the manufacturer. The manufacturer may request further documentation such as an invoice from the provider. When further documentation is requested, ~~HSD~~HCA's PBM will notify the MCO who will be responsible for obtaining the documentation.

MCO Compliance with the PBM Regulation Act

- The MCO will ensure the PBMs are in compliance with the requirements outlined in the Pharmacy Benefits Manager Regulation Act, NMSA 1978 § 59A-61. A PBM or representative of a PBM may not do any of the following:
  - Engage in ~~S~~spread pricing.
  - Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.
  - Unless reviewed and approved by the Superintendent of Insurance Commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for any of the following:
    - The receipt and processing of a pharmacy claim.
    - The development or management of claims processing services in a pharmacy benefits manager network.
    - Participation in a pharmacy benefits manager network.
  - Unless reviewed and approved by the Commissioner in coordination with the Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy.
  - Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services no less than the ~~national average drug acquisition cost~~NADAC, or if the ~~national average drug acquisition cost~~NADAC is unavailable, no less than WAC ~~the wholesale acquisition cost plus 6%~~ (unless pricing ~~methodolgy~~methodology is established for Community Based Pharmacies).
  - Make or permit any reduction of payment for pharmacy goods or services by a pharmacy benefits manager or an insurer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.
  - After adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless 1 or more of the following applies:
    - The original claim was intentionally submitted fraudulently.

- The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services.
- The pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.

~~o~~

The MCOs shall ensure they are monitoring the PBMs' performance on an ongoing basis and the applicable requirements outlined in the Agreement 7.14: Major Subcontractors and Subcontractors are followed.

Uniform New Mexico HCV Checklist

HUMAN SERVICES DEPARTMENT

PATIENT NAME: _____ **DOB:** _____

1. DIAGNOSIS: ☐ Chronic Hepatitis C Infection, **Genotype** ____ **Subtype** (if applicable)___ **(attach results), HCV RNA Level within the past 6 months: Level:**_____ **Date:**____/_____/____**(attach results)**

2. ADDITIONAL REQUIRED LABS (within 3 months of request- please attach results)

   ☐ AST, ☐ ALT, ☐ Bilirubin, ☐ Albumin, ☐ INR, ☐ Platelet count, ☐ Hemoglobin, ☐ Creatinine.
   Also document ☐ HBsAg, ☐ anti-HBs, ☐ anti-HBc

3. LIVER ASSESSMENT: There are seven stages of liver changes in chronic HCV infection – no liver fibrosis (F0), increasing levels of fibrotic change (F1, F2 and F3), cirrhosis (F4), decompensated cirrhosis and hepatocellular carcinoma.

   a. **FIBROSIS/CIRRHOSIS ASSESSMENT:** (provide information using at least one of the following methods)

      Indirect markers:

      APRI _____ $APRI = \frac{\frac{\text{AST Level}}{\text{AST Upper Limit of Normal}}}{\text{Platelet Count (10}^9\text{/L)}} \times 100$

      FIB-4 _____ $FIB\text{-}4 = \frac{\text{Age (years)} \times \text{AST (U/L)}}{\text{Platelet Count (10}^9\text{/L)} \times \sqrt{\text{ALT (U/L)}}}$

      Imaging Study: Method Used: _____ **Attach results**

   b. Does the patient have history, physical exam, laboratory, or radiographic imaging consistent with **decompensated cirrhosis** (i.e. ascites, encephalopathy, bleeding varices, etc.)?
      No ☐ **Yes** ☐ (attach relevant results and notes)

      Child-Pugh Score (circle one): Class A (CTP 5-6) B (CTP 7-9) C (CTP 10-15) *See table on page 2 for calculation method*
      If patient has decompensated liver disease (Child-Pugh B or C), it is recommended that treatment be co-managed with a gastroenterologist, infectious disease specialist or hepatologist, and that referral for transplant be strongly considered.

4. LIVER TRANSPLANT No ☐ Yes ☐ (If yes, check one): ☐ Transplant date_____ ☐ Being considered for transplant

5. Is patient TREATMENT EXPERIENCED? No ☐ If no, go to 6. Yes ☐ If yes, complete a – c below. If treatment experienced with Direct Acting Antivirals (DAA), also complete question d.

   a. List regimen(s) patient has received in past including year and duration of therapy:
      _____

   b. Did patient complete treatment regimen(s)? Unknown ☐ **Yes** ☐ **No** ☐ If "No," reason for discontinuation:
      _____

   c. What was patient's response to therapy? ☐ Unknown ☐ Relapse (post treatment SVR, then elevated HCV RNA level some time later) ☐ Non-response (HCV RNA remained detectable after complete treatment course)

   d. Have you reviewed the case with Project ECHO? **Yes** ☐ **No** ☐ If no, health plan may require Project ECHO consultation.

6. RESISTANCE TESTING (please attach results, if applicable)
   Does patient have genotype 1a and Zepatier will be prescribed? **No** ☐ **Yes** ☐ If yes, order ☐ NS5A

7. REQUESTED MEDICATION(S)

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

☐ **I am agreeable to approval and use of alternative drug(s), dose(s) and/or duration(s) based on current AASLD/IDSA guidance. Please have health plan contact me with recommendations.**
Comments: _____

NOTE: If you are submitting a request for treatment that is not recommended in the AASLD/IDSA guidance, please submit supporting medical literature.

8. ADHERENCE POTENTIAL ☐ I attest my belief that this patient is capable of full adherence to the above treatment

SEE ADDITIONAL RECOMMENDATIONS ON PAGE 2

HUMAN SERVICES DEPARTMENT	**Section 20: Pharmacy**	**Revision dates:** October 1, 2020; July 1, 2024 **Effective dates:** July 1, 2024~~January 1, 2019~~