DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	March 1, 2012	Initial version Uniform Managed Care Manual Chapter 2.2, "Uniform Managed Care Pharmacy Claims Manual." This chapter applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, and 529-12-0002.
Revision	2.1	March 20, 2013	Sections III and IV are modified to add clarifying language to the T.A.C. references. Section V is modified to add clarifying language. Section VI is modified to add clarifying language, to clarify Sub-Section D requirements for HRSA 340b claims and interest payments, and to add Sub-Section F "Medicaid Wrap-around Services for Outpatient Drugs and Biological Products". Section IX "Interest Payments" is added. Section X is modified to add clarifying language. Attachment A "Medicare Part B and D Claims Processing Flowchart" is added. Attachment B "Commercial COB Cost Avoidance Processing Flowchart" is added.
Revision	2.2	March 1, 2014	Section VI.A. is modified to remove language regarding Medicaid as the secondary payor for STAR Health. Section VI Sub-Section G "Flu Vaccines Provided in a Pharmacy" is added. This chapter applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-13-0042.
Revision	2.3	August 15, 2014	Section V. is modified to reference the MCO's relevant Contract. Section VI.D. is modified to clarify HRSA 340B claims submission codes. Section VIII. is modified to reference performance requirements and timeframes described in the Contract.
Revision	2.4	October 15, 2014	Revision 2.4 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.

			Section I. is modified to add the Medicare-Medicaid Dual Demonstration.
Revision	2.5	January 15, 2015	Section VI. E. is modified to add the URL for the HRSA Medicaid Exclusion file. Section VI.E. “Provider-Administered Drugs” is deleted and subsequent sections are re-lettered.
Revision	2.6	October 1, 2015	Revision 2.6 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Section I. is modified to add the STAR Kids Program. Section VI. E. is modified to change the section name from “Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products” to “Dual Eligible Members Medicaid Prescription Coverage for Outpatient Drugs and Biological Products” and update the requirements. Attachment A “Medicare Part B and D Claims Processing Flowchart” is deleted. Attachment B “Commercial COB Cost Avoidance Processing Flowchart” is renamed “COB Cost Avoidance Processing Flowchart” and re-lettered as Attachment A.
Revision	2.7	March 1, 2016	Section VI. G. “Covered Drugs Under Non-Risk Payment” is added. Attachment A “COB Cost Avoidance Processing Flowchart” is modified to add an exemption for family planning drugs.
Revision	2.8	November 1, 2016	Section VI. D. "Health Resources Services Administration (HRSA) 340B" is modified to update the policy language. Section VI. E. “Dual Eligible Members Medicaid Prescription Coverage for Outpatient Drugs and Biological Products” is modified to add references to Attachments B and C. Section VI. H. "Psychotropic Medication Utilization Review (PMUR)" is added. Section VI. I. "Managed Care Clinical Prior Authorization Criteria Implementation" is added. Attachment B. "Medicare Part B Pharmacy Claims Processing" is added. Attachment C. "Medicare Part D Pharmacy Claims Processing" is added.

Revision	2.9	March 13, 2020	Section VI. A. “Pharmacy Claim Processing and Payment Requirements” is modified to reference guides related to pharmacy Encounter data and acceptable reject codes. Section VI. D. “Health Resources Services Administration (HRSA) 340B” is modified to delete reference to the HRSA Medicaid Exclusion file. Section VI. F. “Flu Vaccines Provided in a Pharmacy” is modified to add information on the flu vaccine reporting season and approved flu vaccine, revise the claims processing requirements, and delete language as to what an MCO is not required to offer or pay and information on vaccine expenditure reporting. Section VI. G. “Covered Drugs Under Non-Risk Payment” is modified to provide the website location for non-risk drugs. Section VI. H. “Psychotropic Medication Utilization Review (PMUR)” was removed. Section VI. I. “Medically Necessary Non-Formulary Drug” was added. Section VII. #2 is modified to correct a typo in the reject message. Section VIII. is modified to add performance requirements and timeframes. Attachment A is modified to add that “No other OCC codes are acceptable” in the flowchart box for “Other Coverage Code (OCC) Values” and add a flowchart box for an acceptable reject codes reference.
Revision	2.9.1	June 15, 2020	Accessibility approved version.
Revision	2.10	June 14,2021	Section VI. “Pharmacy Claims Processing Requirements” G. "Covered Drugs Under Non-Risk Payment" updated source of non-risk drug list. Section VI. “Pharmacy Claims Processing Requirements”, F. “Flu Vaccines Provided in a Pharmacy” was renamed “Pharmacist-Administered Medications”.
Revision	2.10.1	June 21, 2021	Corrected revision date year from 2020 to 2021 in version 2.10 document history.
Revision	2.11	March 1, 2024	Section VI. F. “Pharmacist-Administered Medications” is modified to add COVID-19

			vaccines to MCO vaccine reimbursement requirements. Administrative Change – Section VI. “Pharmacy Claims Processing Requirements” D. “Health Resources Services Administration (HRSA) 340B” updated to include clarification of uses for the “Basis of Cost (BOC) Ø8” indicator when submitting a claim.
Revision	2.12	June 12, 2024	Section VI. J. “Drug Shortage Exceptions and Expedited Formulary or Preferred Drug List Request” was added. Attachment D - “Drug Shortage Notification and Expedited Formulary or Preferred Drug list Request Form and Instructions” was added.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

TABLE OF CONTENTS

I. APPLICABILITY OF CHAPTER 2.2

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), CHIP, STAR Kids, and STAR Health Programs. In this chapter, references to "CHIP" or the "CHIP Managed Care Program(s)" apply to the CHIP Program. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs. The term "MCO" may include health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all programs, except where noted.

II. PURPOSE

This chapter establishes pharmacy claims processing requirements and timelines, to the extent that they differ from the requirements and timelines in Chapter 2.0, "Uniform Managed Care Claims Manual." This chapter should be read in conjunction with Chapter 2.0, and unless otherwise noted in this chapter, all provisions of Chapter 2.0 apply to pharmacy claims.

III. STATUTORY AND REGULATORY AUTHORITY

Statutory and regulatory authority for this chapter includes the following, without limitation.

- All authorities cited in Chapter 2.0, "Uniform Managed Care Claims Manual;"

- Texas Insurance Code § 843.339, "Deadline for Action on Prescription Claims; Payment;"
- 1 Tex. Admin. Code Chapter 353, Subchapter J, "Outpatient Pharmacy Services" (Medicaid); and
- 1 Tex. Admin. Code Chapter 370, Subchapter H, "Outpatient Pharmacy Services" (CHIP).

IV. INFORMATIONAL RESOURCES

- Resources listed in Chapter 2.0, "Uniform Managed Care Claims Manual;" and
- 15 Tex. Admin. Code Chapter 354, Subchapter F, "Pharmacy Services," Division 6, "Pharmacy Claims" (related to the Vendor Drug Program/FFS).

V. PHARMACY CLAIMS DEFINITIONS

1. **Automated Prior Authorization Request:** A claim adjudication process applied by the MCO that automatically evaluates whether a submitted pharmacy claim meets Prior Authorization criteria (e.g., drug history shows previous filling of preferred drug, client has specific diagnosis), when the data exist, thereby allowing the claim to be adjudicated as payable without the prescriber's intervention.
2. **Clean Claim:** Refer to the Contract's definition of "Clean Claim." In addition, a Clean Pharmacy Claim must meet all requirements for accurate and complete data as defined in the applicable *NCPDP Post-Adjudication Companion Guide* and *HHSC's Encounter Submission Guidelines*.
3. **Cost Avoidance:** A coordination of benefits model for pharmacy claims that ensures compliance with 42 C.F.R. Subpart D, Chapter 433. The cost avoidance model checks for a client's other known insurance at the point of sale, preventing the MCO from paying a claim until the pharmacy attempts to obtain payment from the client's third-party insurance. The elements of Cost Avoidance include the following.
    - Determination that member has other prescription drug coverage through a third-party insurer.
    - Sending verified drug insurance eligibility and insurer information to the pharmacy point-of-sale system.
    - If member has other insurance, deny claim at point-of-sale and provide pharmacy with the third-party billing information so they can submit the claim to them.
    - Continue to reject the claim until billing to all other payors has been attempted.
    - If the pharmacy submits it to the third party insurer and it is denied, the MCO may pay the claim, depending on the reason for denial.
    - Continue covering co-pays and deductibles for members with third party insurance.

- Provide a toll-free number for members and providers to call to correct mistakes in third party insurance information so that the point-of-sale claims system will pay correctly (e.g., can use existing member or provider hotlines for this purpose).

4. **D.Ø Standard:** The most recent version of the National Council of Prescription Drug Program (NCPDP) Telecommunication Standard.
5. **Rejected Claim:** A claim filed with the MCO or its Subcontracted Claims Processor for pharmacy services rendered to a patient and the claim has been denied or not accepted for adjudication and payment. A rejected claim could be due to, but is not limited to the following situations: a patient was not a Member of the MCO at the time of service, a claim was filed with the MCO in error (wrong carrier), or the MCO is not responsible for Processing the claim but the claim is for a Member of the MCO as of the date of service.

Additional definitions are found in the MCO's relevant Contract and Chapter 2.0 of the Uniform Managed Care Manual (UMCM).

VI. PHARMACY CLAIMS PROCESSING REQUIREMENTS

A. Pharmacy Claim Processing and Payment Requirements

Clean Claims for outpatient pharmacy benefits must be adjudicated no later than: (1) 18 days after receipt if submitted electronically, or (2) 21 days after receipt if submitted non-electronically. Once a Clean Claim is received for a pharmacy claim, the MCOs are required, within the periods described above, to: (1) pay the total amount of the claim, or part of the claim, in accordance with the contract, (2) deny the entire claim, or part of the claim, and notify the provider why the claim will not be paid.

Payment is considered to have been paid on the date of: (1) the date of issue of a check for payment and its corresponding EOB to the provider by the MCO, or (2) electronic transmission, if payment is made electronically.

MCO must make every effort to avoid making more than one request to the provider for additional information in connection with a specific claim. MCO Claims procedures must include processes intended to prevent a provider claim from being repeatedly deficient-denied for reasons that were present on the original claim submission.

Whenever possible, the MCO should identify each applicable reason code and specific information requirements to inform the provider of the precise data fields and issues related to each claim. At minimum, MCO claim systems that employ a preset hierarchy of Deficient-Denial reasons, must provide sufficient information to the provider regarding the primary issue related to a claim.

The MCO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinatal Programs for Fraud, Abuse, or Waste. The MCO must not pay any claim submitted by a provider who is on payment hold

under the authority of HHSC or its authorized agent, or who has pending accounts receivable with HHSC.

MCOs must provide accurate and complete Encounter Data for pharmacy services. The Encounter Data must follow the format, rules, and data elements as described in the most current *NCPDP Post-Adjudication Companion Guide* and *HHSC's Encounter Submission Guidelines*. The MCO should attest to the information prior to the MCO's submission to HHSC. It is expected that MCO Pharmacy Claim Processing will comply with the requirements of the NCPDP B1/B2 HIPAA-compliant formats. This will produce consistent and verifiable data, whether self- reported by the MCO or produced by HHSC from the Encounter Data warehouse. The intent is to have uniform pharmacy claims data that can and will be verified both at the claims and Financial Statistical Report level, with the control file being the Encounter Data File.

If MCOs accept B3 claim transactions from pharmacies, the B3 transactions must be split into a B2 (reversal transaction) and B1 (new billing transaction) record on the encounter file provided to HHSC.

In addition to the fields required on the *NCPDP Post-Adjudication Companion Guide* and *HHSC's Encounter Submission Guidelines*, the pharmacy Encounter data provided to HHSC must include the following information:

1. The actual price paid by the MCO or its agent to the pharmacy for a drug, as well as the claim's component dollar amounts (e.g., ingredient costs, dispensing fees, and amounts paid by other payors);
2. Adjudicated paid claims, including compounds;
3. MCOs must provide detailed line items for each ingredient in multi-ingredient compounds;
4. Adjudicated denied/rejected claims (only applies to edits identified by HHSC)
    i. Acceptable reject codes are listed in the Pharmacy Post Adjudication Companion Guide.
5. All fields as required by HHSC in the NCPDP post-adjudication format, including paid amounts and third-party payments;
6. An indicator if claim was subjected to Prior Authorization processing. If yes, then what type of processing—PDL, clinical, or both; and
7. An indicator if a claim was subject to Prior Authorization and was exempted. If yes, then identify the reason for the exemption (as described in the NCPDP Post-Adjudication file layout).

The MCO must notify the pharmacy provider in writing that the provider has 120 days from the date of disposition to appeal. The MCO must process appeals and adjudicate the claim within 30 days from the date of receipt. A provider may appeal any disposition of a claim.

The MCO's subcontract with its Pharmacy Benefits Manager (PBM) must include a flow-down provision requiring the PBM to comply with the requirements of this section,

including a requirement to disclose the actual and component prices paid by the PBM to the pharmacy for each Encounter. PBMs must be held accountable for the required claims/encounter information.

B. Correction to a Paid Claim

NCPDP does not support a claim adjustment transaction in the D.Ø Standard, but corrections may be made to a clean claim. Once a claim has passed all edits, the payment amount reported to the pharmacy and the payment amount on that transaction may not be modified. Claim adjustments must be entered as a reversal transaction (B2) and a new billing transaction (B1).

C. Generic Substitution

A pharmacist may substitute a generically equivalent drug for the brand prescribed unless the prescriber writes in his/her own handwriting the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription (42 C.F.R. § 447.331 and 22 Tex. Admin. Code § 309.3). For electronic prescriptions, the MCO must follow the NCPDP standard designation for “Dispense as Written (i.e., DAW = 1).” The prescriber must indicate on the electronic prescription that DAW = 1 and in the “Notes to the Pharmacy,” the prescriber must type “Brand Medically Necessary.” If the electronic prescription is received by the pharmacy with DAW = 1 without the corresponding message, the pharmacist must contact the prescriber for a new prescription. DAW = 1 is not required when the brand is preferred and the generic equivalent is non-preferred.

D. Health Resources Services Administration (HRSA) 340B

The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program. The only outpatient pharmacy drug claims that HHSC will exclude from the drug rebate system invoicing process are those that are submitted with a “2Ø” in Submission Clarification Code (Field 42Ø-DK). The SCC = 2Ø indicates that the pharmacy has filled the prescription using stock purchased through the HRSA 340B program. MCOs must inform and educate pharmacy providers that it is the responsibility of the provider to correctly report claims filled with 340B stock for 340B-eligible patients to ensure rebates are not collected for these drugs. MCOs must allow for the SCC = 2Ø indicator to be submitted on pharmacy claims. The MCO must ensure that the SCC = 2Ø indicator is included on the encounter. The Basis of Cost (BOC) Ø8 must not be utilized as an indicator for 340B claims in lieu of the SCC 2Ø.

The MCO must develop a policy for accepting and appropriately reimbursing claims for drug products purchased through the 340B discount drug program and submit the policy to HHSC for review and approval. Any changes to the approved policy or reimbursement methodology must be prior approved by HHSC. MCOs must inform and educate pharmacy providers about its policy, notify pharmacy providers that adherence to the MCO’s and HHSC’s policies for 340B claims are subject to audit, and monitor 340B pharmacies to ensure claims are submitted appropriately. See the Vendor Drug Program Pharmacy Provider Procedures Manual for the HHSC policy.

E. Dual Eligible Members Medicaid Prescription Coverage for Outpatient Drugs and Biological Products

STAR+PLUS MCOs are responsible for providing outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals as identified on the HHSC drug exception file marked with "MD" or "MB" as Medicaid covered services for STAR+PLUS Members. Dual Eligible Members are individuals who are entitled to Medicare Part A and/or Part B and eligible for some form of Medicaid benefit. Medicaid pharmacy benefits for Dual Eligible Members can be defined in one of the following three categories:

1. Pharmacy Coverage for Medicare Part B with Medicaid

HHSC's drug exception file identifies the outpatient drugs, biological products, LHHS, and vitamins and minerals with "MB" that are payable by Medicare Part B for STAR+PLUS Members. STAR+PLUS MCOs are responsible to pay the cost sharing for outpatient drugs, biological products, and LHHS covered by Medicare Part B. See Attachment B.

If Medicare Part B provides a paid response, MCO should follow the guidelines below:

a. The claim is received with a $0.00 paid amount; Medicaid will cover the cost share/co-insurance deductible.
b. The claim is received with paid amount greater than $0.00, but less than the Medicaid allowed amount for identified drugs covered by Medicaid; Medicaid may cover the cost share portion up to the Medicaid allowed amount.

2. Medicare Part D with Medicaid – Wrap-Around Services

HHSC's drug exception file identifies the outpatient drugs, biological products, LHHS and vitamins and minerals with "MD" covered by Medicaid for STAR+PLUS Members enrolled in Medicare Part D. STAR+PLUS MCOs must pay claims for these drugs and products for these members. If the Member is eligible for Medicare Part B and the drug or product is a covered benefit of Medicare Part B, the MCO must validate Medicare Part B was billed in accordance with guidelines outlined in Section VI. E. 1. See Attachment C.

3. True Cross-over Claims

CMS states that individuals that are enrolled in Medicare Part A or Part B are also eligible for Medicare Part D. STAR+PLUS MCOs are responsible for validating the Medicare eligibility file and ensuring the pharmacy claims adjudicate as follows:

- If the client is eligible for Medicare Part D claims with a Medicare Part D covered drug and/or product must be billed to Medicare Part D and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid.
- Medicaid must continue to pay (and no change in processing will occur) for Medicare Part D wrap-around drugs after commercial insurance has been billed

or if there is no commercial insurance on file. These wrap-around drugs and products include non-prescription (over the counter medications), some products used in symptomatic relief of cough and colds, LHHS, some prescription vitamins and mineral products which are identified on the HHSC Drug Exception file.

- The cost-share (deductible, premium or co-pay) for Medicare Part B drugs and products after commercial insurance has been billed or if there is no commercial insurance on file.

If a client does not have Medicare Part D information on file or says that they are not enrolled in a Medicare Part D plan, the MCO should instruct the pharmacy to either:

- Bill the Medicare Limited Income (LI-NET) program, call LI-NET program at 800-783-1307 or visit the LI-NET Pharmacy portal at http://www.humana.com/pharmacists/resources/li_net.asp.
- Utilize the Facilitated Enrollment process to enroll the client in a plan by calling 800-633-4227, or;
- Call 1-800-MEDICARE (800-633-4227) for additional information.

For more information about Medicare Part B and Medicare Part D drug coverage, visit the CMS website at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf.

Attachment A is a flowchart that MCOs may use as a reference for cost avoidance or coordination of benefits (COB) when processing claims that are covered by commercial insurance. In accordance with UMCC Section 8.2.2.2, family planning drugs are exempt from the COB process.

Attachments B and C are flowcharts that MCOs must use for processing Medicaid claims with Medicare Part B and Medicare Part D.

F. Pharmacist-Administered Medications

Beginning September 1, 2020, MCOs must allow pharmacists to administer certain long-acting injectable antipsychotics, opioid antagonists, and flu vaccines. The Medicaid and CHIP Formularies will be updated to identify applicable products.

Flu vaccines eligible for administration in a pharmacy setting will be identified with drug programs “FL1” or “FL2” and include the coverage effective dates on the Formulary and MCO Drug Exception List (DEL) files. National drug codes (NDC) for flu vaccines will be provided later this summer.

Long-acting injectable antipsychotics and opioid antagonists used to treat substance-use disorder or opioid-use disorder eligible for administration in a pharmacy setting will be identified with drug program “INJ” and include the coverage effective dates on the Formulary and DEL files.

MCOs must reimburse pharmacies for pharmacist-administered medications as follows:

- For long-acting anti-psychotics, opiate dependence treatments, and emergency treatment for known or suspected opioid overdose: Reimburse the ingredient cost, dispensing fee, and applicable administration fees.
- For flu and COVID-19 vaccines: Reimburse ingredient costs and applicable administration fees.

MCOs are required to comply with the policy listed in UMCM Chapter 16.1, Medicaid and CHIP Operational Guidance.

G. Covered Drugs Under Non-Risk Payment

MCOs are responsible for providing certain drugs under non-risk, cost settlement basis, in accordance with UMCC Attachment A, Section 10.18, "Non-risk Payments for Drugs." The MCO must follow HHSC's clinical review criteria located at www.txvendordrug.com to approve the provision of these drugs. Reimbursement by HHSC may be up to the Medicaid fee-for-service rate that HHSC would have paid for the drug on the date of service for a valid claim. The fee-for-service ingredient cost is calculated using the National Average Drug Acquisition Cost (NADAC) price for formulary drugs covered under the pharmacy benefit. If the NADAC price is not available, the ingredient cost is calculated using wholesale acquisition cost minus two percent.

The non-risk payments will cover only the cost of the drugs. Reasonable administrative costs associated with coverage of these drugs as well as adjunctive therapies if any associated with the treatment of these drugs will be part of the existing Capitation Rate. The MCO may not include the cost of the drugs in the Financial Statistical Report (FSR).

HHSC publishes a daily non-risk drug file to TxMedCentral listing all drugs designated as eligible for non-risk-based payment. For each listed drug, the file contains the non-risk payment NDC, drug name, an indicator of whether the drug is on the formulary or a clinician-administered drug, and dates of eligibility for non-risk payment. HHSC uploads the daily file to the TxMedCentral website of each MCO's "MCOPHARM" folder and titled "CAD_Formulary_NRPjjjyy."

H. Managed Care Clinical Prior Authorization Criteria Implementation

MCOs must submit a report to HHSC that lists all Clinical Prior Authorization (Clinical PA) criteria approved by the HHSC Drug Utilization Review (DUR) Board and indicates whether the Clinical PA criteria is being applied by the plan for each Program. The MCO must submit a Clinical PA criteria report on a quarterly basis, by the last day of the month following the reporting period using the template contained in UMCM Chapter 5.13.6.

I. Medically Necessary Non-Formulary Drug

In the event a circumstance occurs in which a non-formulary drug has been identified as the only medically necessary and available recourse, the MCO may submit a request to Vendor Drug Pharmacy Operations at VDP-Operations@hhsc.state.tx.us for non-

emergency situations. The request must include the following information: Member's name, Medicaid ID, drug name, pharmacy, prescriber, a detailed description of the circumstance, and confirmation the case was reviewed by clinical staff. Requests received Monday - Friday by 4:00 p.m. will be processed by close of business on the day received. Requests received after 4:00 p.m., on weekends, or holidays will be processed the next business day.

Vendor Drug Pharmacy Operations must approve the request before the MCO may submit the claim. The required entries on the encounter to designate the drug as non-formulary/medically necessary are listed below:

- a "7" in the Submission Clarification Code field (Field 42Ø-DK) and
- the value "Q" (Drug not on Formulary) in the "Formulary Status" field (field 257)

This process is intended to help address access to care concerns in non-emergency situations. MCOs are responsible for providing medically necessary services in all situations, which may include coverage of prescriptions that come in after 4:00 p.m., on the weekend, or holiday.

J. Drug Shortage Exceptions and Expedited Formulary or Preferred Drug List Request

When a preferred drug on the Preferred Drug List (PDL) is placed on backorder, allocation, or in short supply, and the shortage is verifiable through the drug manufacturer and HHSC approved resources, MCOs may provide an exception for the allowance of a non-preferred drug. MCOs must complete and submit Form 1315 "Drug Shortage Notification and Expedited Formulary or Preferred Drug List Request Form" (Form 1315) to HHSC VDP within 2 business days after the MCO grants the drug shortage exception for coverage of the non-preferred drug. Only one Form 1315 submission to HHSC VDP is required for the same drug shortage exception. Multiple submissions for each shortage exception of the same drug are not necessary. The PDL prior authorization approval duration for the non-preferred drug must coincide with the backorder, allocation, or short supply duration of the preferred drug. If the drug shortage timeframe is unavailable or unknown, then a PDL prior authorization duration may be approved for six months.

The following are acceptable forms of documentation for drug shortage exceptions:

1. Drug shortage verification from the Food and Drug Administration (FDA) and/or American Society of Health-System Pharmacists ASHP) websites.
2. Direct documentation from the drug manufacturer confirming the backorder, allocation, or shortage through phone, email, portal messaging, and/or facsimile. Manufacturer agent contact information must be retained including name and email address.
3. Press or news releases from the drug manufacturer referencing the backorder, allocation, or shortage of the impacted drug.

MCOs must retain any documentation used to grant the PDL exception.

MCOs may also use Form 1315 to request additions to the formulary or PDL. HHSC will consider changing the formulary and PDL in response to these requests when the drug is in short supply, on backorder, or on allocation. Form 1315 as well as detailed instructions on how to complete the form can be found in Attachment D.

VII. MESSAGES TO PHARMACIES

1. General Rejection Message Instructions

The MCO must use the additional NCPDP message field (526-FQ) as needed when the standard reject code provides insufficient information for the pharmacy to determine next steps, or the standard reject code is used for multiple criteria (e.g., excessive quantity, prescription limits have been met).

2. 72-hour Emergency Prescription Rejection Message (Required Language)

The following message must be returned to pharmacies on all electronically-submitted claims that the MCO rejects because the prior authorization criteria have not been met.

“Prescriber should call [insert hotline or call center name and number] or RPH [or PHARMD] should submit 72 HR Emergency Rx if emergency and DR not available.”

VIII. PERFORMANCE REQUIREMENTS AND TIMEFRAMES

The MCO or its subcontracted claims processor must process and finalize claims according to the following performance requirements and timeframes:

1. Within 18 Days of receipt: Adjudicate 98 percent of all electronic Clean Claims by claim type and by Program.
2. Within 21 Days of receipt: Adjudicate 98 percent of all non-electronic Clean Claims by claim type and by Program.
3. Within 24 months from the date of service: finalize all claims, including appealed claims.

These requirements are subject to change due to changes in HHSC requirements, federal or state laws, rules, or regulations.

IX. INTEREST PAYMENTS

The MCO is subject to remedies, including liquidated damages, if the MCO does not pay providers interest at an 18% annual rate, calculated daily, for the full period in which the Clean Claim, or portion of the Clean Claim remains unadjudicated beyond the 18-day claims processing deadline if submitted electronically, or the 21-day claims processing deadline if submitted non-electronically.

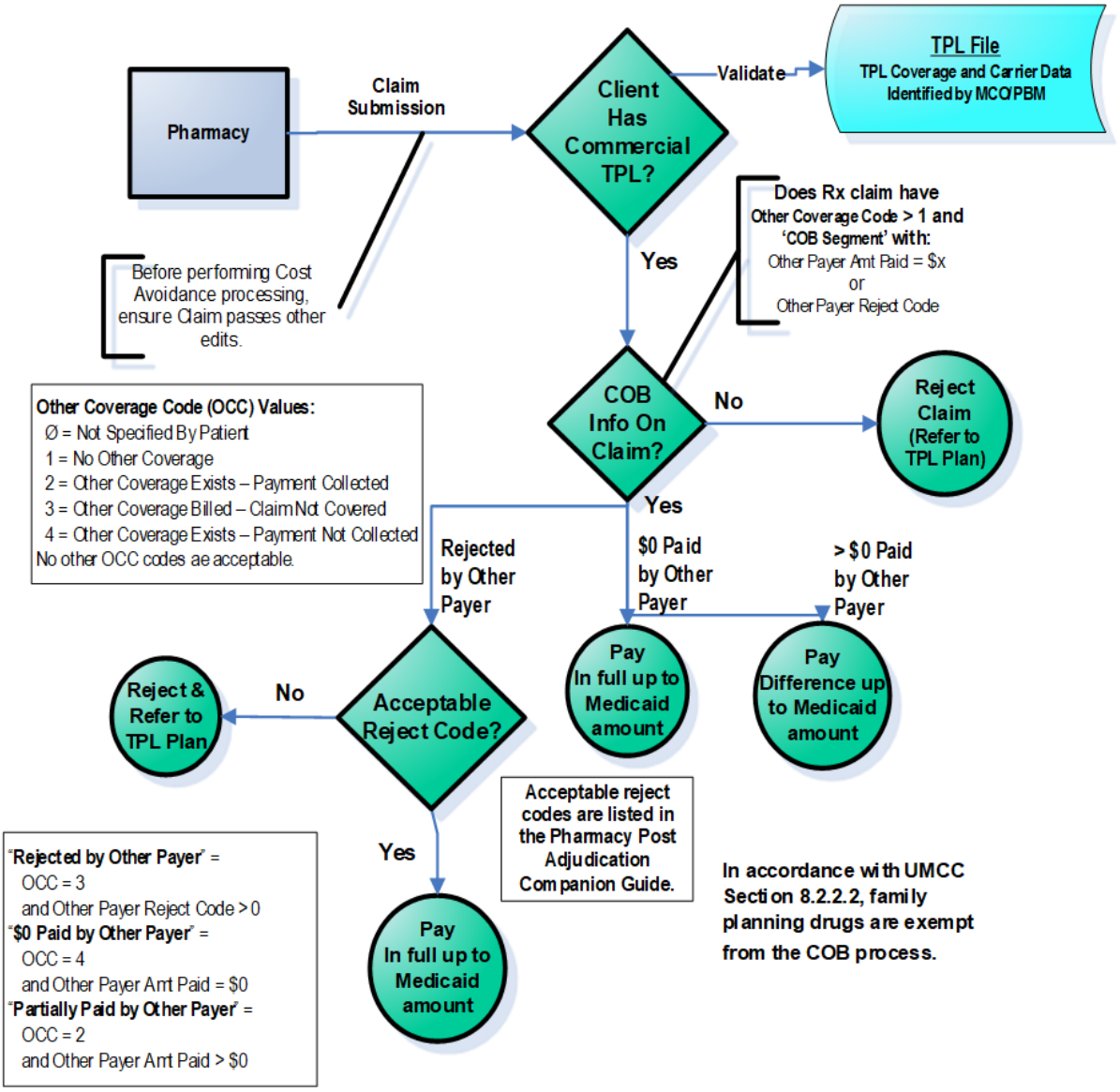
The principal amount on which the interest payment will be calculated is the amount due but unpaid at the contracted rate for the service.

The MCO and its subcontracted Claims Processors must keep an accurate and sufficient audit trail for each interest payment and its corresponding claims documentation and provide a detailed report to HHSC upon request.

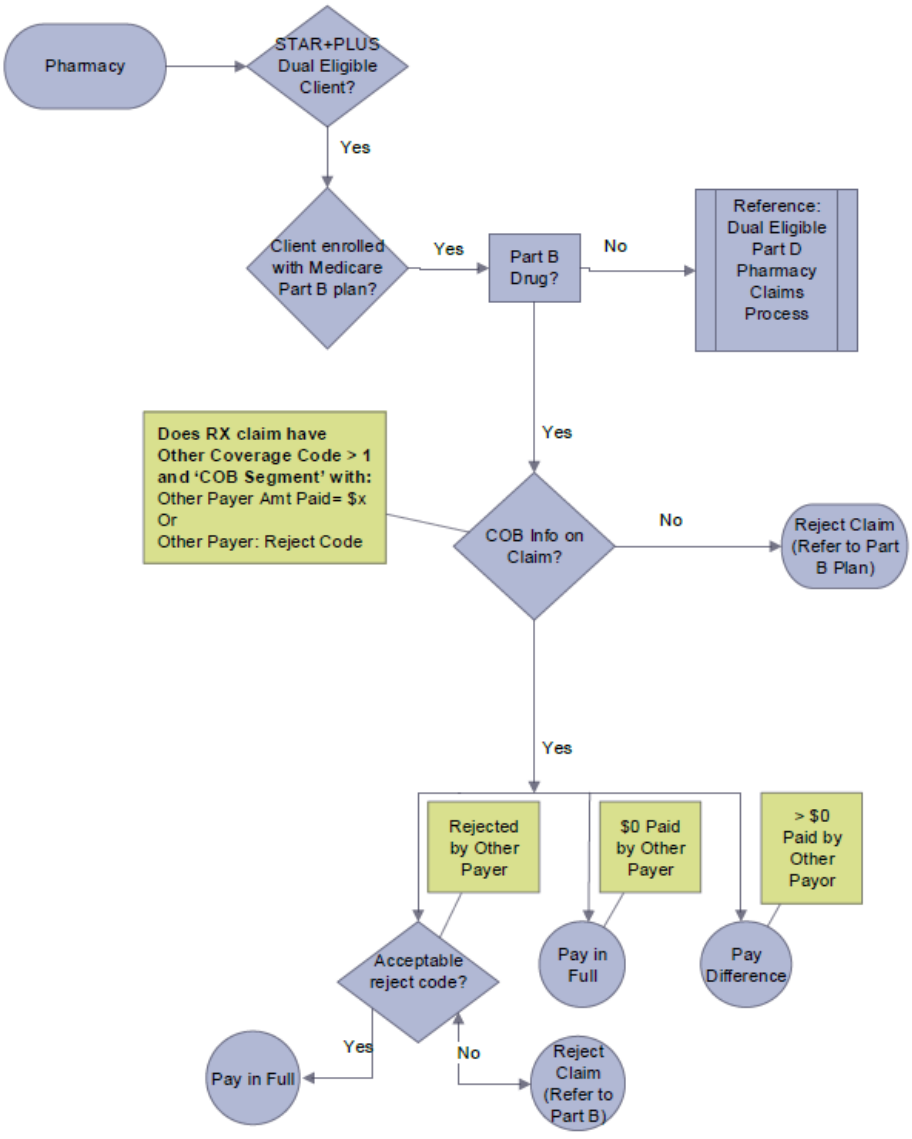
X. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

The MCO must comply with all HIPAA requirements as described in the contract. -The MCO must comply with HIPAA EDI requirements in claims and remittance transactions in the NCPDP B1/B2 HIPAA-compliant formats.

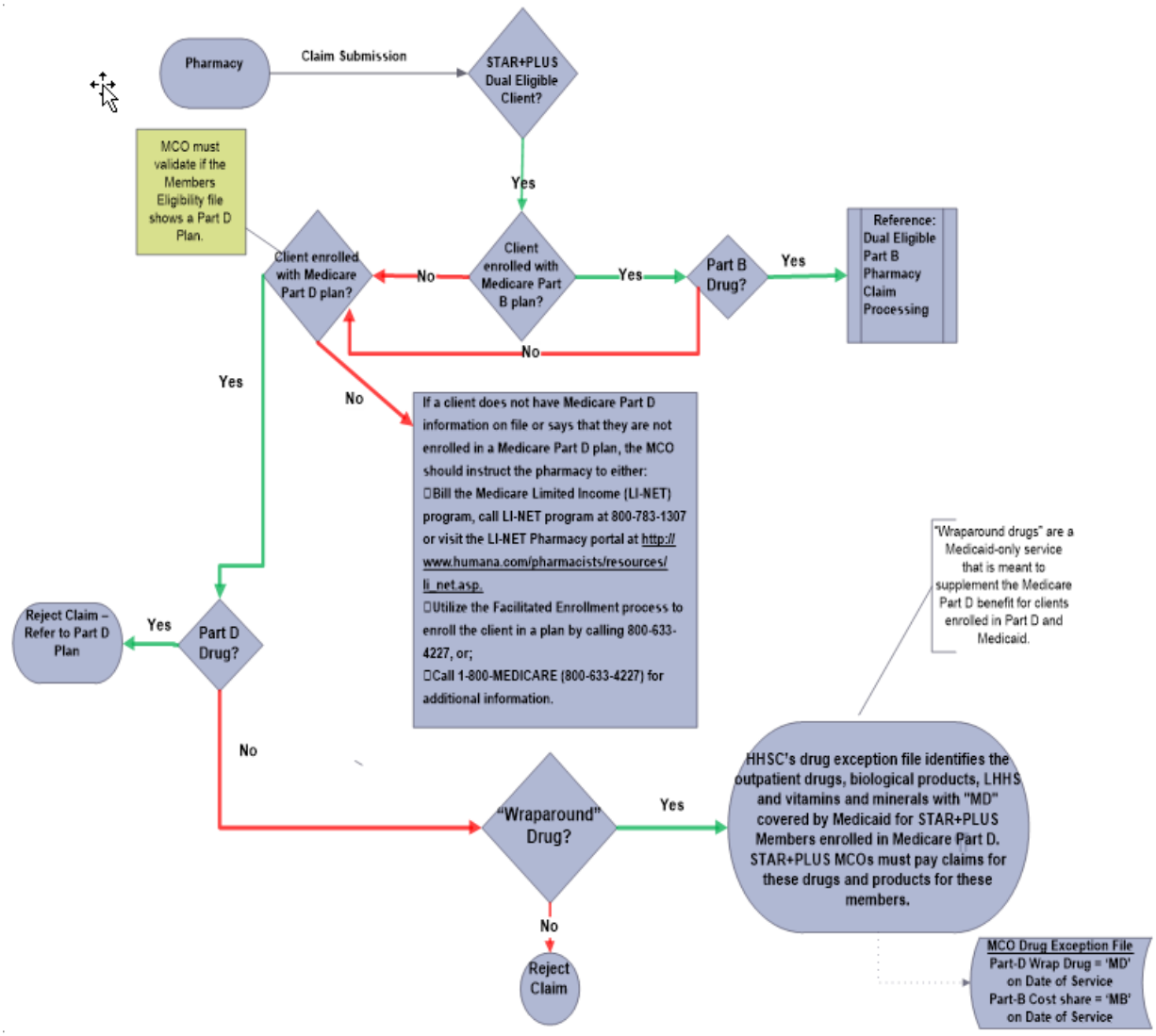
Attachment A – COB Cost Avoidance Processing Flowchart



Attachment B - Medicare Part B Pharmacy Claims Processing



Attachment C - Medicare Part D Pharmacy Claims Processing



Attachment D – Drug Shortage Notification and Expedited Formulary or Preferred Drug list Request Form and Instructions

Instructions (Please provide as much information as possible when filling out the form):

1. Reporter Information: Include your name, organization, and email address. Make sure to include whether you are at the pharmacy level, corporate level, provider level, MCO level, manufacturer level, or other professional organizations.
2. Drug Information: Be specific about strengths, dosage forms, and include all national drug codes (NDCs) impacted by the drug shortage or for the expedited formulary or PDL status change.
3. Drug Shortage and Expedited Formulary or Preferred Drug List (PDL) Change Request Information:
    - Drug Shortages:
        - Reason for Reporting a Drug Shortage: Is the shortage due to a backorder, allocation, short supply, recall, discontinuation by the manufacturer or another reason?
        - Extent of Shortage: Is the impact local, wholesaler, statewide, nationwide or another reason?
        - Estimated Length of Issue: What is the estimated time frame of the shortage? What are your sources of information? Are they website links, email with manufacturer or something else?
        - Drug Information: Has the shortage been verified with FDA, ASHP, drug manufacturer, or any other resources? Include website links, verification date, or manufacturer contact information if applicable.
    - Formulary Additions or PDL Status Changes
        - Formulary Addition or PDL Status Change: Is the request for a drug addition to the formulary? Is the request to recommend a change in the PDL status of a drug? Provide a rationale for the request of a PDL status change.
        - Product NDC change: Did the manufacturer change the drug's NDC or did the drug's NDC change for other reasons? Include the discontinued and new NDC.
        - Alternatives: Provide alternative drug (and NDC) suggestions and recommendations for formulary addition.

TEXAS Health and Human Services

Form 1315
February 2024

Texas Vendor Drug Program

Drug Shortage Notification and Expedited Formulary or Preferred Drug list Request

Submission Date: _____ Discovery or Issue Date: _____

Reporter Information

Reporter Name	Entity Representing (pharmacy, association, MCO)	
Reporter Title	Entity Address (Street, City, State and ZIP Code)	
Area Code and Phone No.	Area Code and Fax No.	Email
Pharmacy National Provider Information	Pharmacist in Charge	

Drug Information

11-digit National Drug Code	Drug Manufacturer	
Drug Name	Strength	Dosage Form
Additional Information		

Drug Shortage

Reason for Reporting Drug shortage, discontinuation, or for another reason?	
Extent of shortage Local, Nationwide, or another reason?	
Estimated Length of Issue Timeline If backorder, allocation or short supply, when will drug be available?	
Drug Information Additional sources of shortage information	☐ FDA website ☐ ASHP website ☐ Drug Manufacturer: Provide contact information _____ ☐ Other (Example: news or press releases):

TEXAS Health and Human Services

Form 1315
February 2024

Texas Vendor Drug Program

Drug Shortage Notification and Expedited Formulary or Preferred Drug list Request

Expedited Formulary or Preferred Drug List Request Information		
Formulary Inclusion Request	1.Is the drug covered on the Texas Medicaid Formulary?	☐ Yes ☐ No
	If "Yes" to #1 above, is the drug preferred	☐ Yes ☐ No
	Is a preferred drug list status change recommended	☐ Yes ☐ No
	If yes, please describe the change and provide a rationale	
Product National Drug Code Change Did the manufacturer introduce the same drug under a different NDC?	Discontinued NDC(s)	
	New NDC(s)	
Alternative Alternative drugs available		

HHSC VDP Use Only	
Request Outcome:	
Action plan:	
Requestor Communication Date:	Initial response date:
	Follow-up response date: