North Carolina Medicaid Direct Pharmacy Provider Manual

North Carolina Pharmacy Benefit Administrator (PBA) System Implementation

Prepared for the North Carolina Department of Health and Human Services

Prime Therapeutics State Government Solutions LLC

Revision History

Version	Date	Name	Comments
1.0	1/15/2026	Ashley Sipes Anita Martin	Document Creation
		Deneatra Harmon Bridgette Devine	Document Revision
2.0	2/12/2026	Ashley Sipes	Updates made to Section 5.3.2 based on feedback received.
3.0	2/13/2026	Deneatra Harmon	Received final approval from NCDHHS.

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1.0 Introduction

Effective May 2, 2026, Prime Therapeutics State Government Solutions LLC (Prime) will be the contracted vendor for the North Carolina Department of Health and Human Services (NCDHHS) Medicaid Direct Program.

Prime will administer the Point-of-Sale (POS) system to process pharmacy claim transactions. The POS system will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted.

Prime will respond to the pharmacy provider with information about client eligibility, the plan allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable rejection messages. ProDUR messages will be returned in the Drug Utilization Review (DUR) response fields. Other important related information will appear in the free-form message area.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

1.1 North Carolina Medicaid Pharmacy Program

This manual provides claims submission guidelines for the NCDHHS Medicaid Direct program administered by Prime.

- Important plan coverage and reimbursement policies are available in this *North Carolina Medicaid Direct Pharmacy Provider Manual*.
- A link to this manual is available on the Prime website, and all updates or revisions are posted on the NC Medicaid Pharmacy Portal.
- Additional North Carolina Medicaid State policy information, including Medicaid Direct program policies, can be found at *NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9*.
    - **Note:** This manual offers supplemental information for providers and members, but it does not replace the *NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9* document.

All enrolled providers must follow all NCDHHS policies and procedures included in the Provider Manual.

2.0 Pharmacy Provider Eligibility

To be eligible to bill for a product or service, providers must:

- Meet all Medicaid participation requirements; and
- Hold a current, signed NCDHHS Provider Administrative Participation Agreement; and
- Submit claims only for products and services that fall within the scope of their clinical practice, as defined by their licensing authority.

Note: Information related to pharmacy provider qualification and regulations, pharmacy changes (i.e., change of ownership, change of address, etc.), record retention, compliance and Medicaid Recoupments can be found in NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9.

3.0 Beneficiary Eligibility

3.1 General Eligibility

An eligible beneficiary must be enrolled in the NC Medicaid Program. Providers are required to verify each beneficiary's Medicaid eligibility each time a service is rendered. Some beneficiaries may have restrictions based on their eligibility category that could make them ineligible for certain services. All required claim fields must be completed. Refer to the *North Carolina Payer Specifications Sheet* document for details on the required fields.

3.2 Special Provisions Eligibility

3.2.1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Special Provision

Under 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act], Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that ensures coverage for medically necessary services, products, or procedures for beneficiaries under 21 years of age. These services must correct or improve a defect, physical or mental illness, or condition identified through a screening or evaluation by a licensed practitioner.

What EPSDT Covers

EPSDT includes most medical or remedial care needed to:

- Improve or maintain the child's health in the best possible condition.
- Compensate for a health problem.
- Prevent the condition from worsening.
- Prevent the development of additional health problems.

What EPSDT Does Not Cover

EPSDT does not require coverage for services that are:

- Unsafe, ineffective, experimental or investigational
- Not medical in nature or not generally accepted as standard medical practice

Service Limitations

Limits on scope, amount, duration, frequency or location of service may be exceeded if provider documentation shows the service is medically necessary to correct or improve the condition, maintain health, or prevent worsening or additional problems.

Prior Approval

If a service or drug requires prior approval, EPSDT does not eliminate that requirement – even if the beneficiary is under 21.

To request a PA, have the prescriber contact the Clinical Support Center at 1-844-620-6116.

4.0 Prime Services Support Centers

Prime has a Pharmacy Support Center (PSC), Clinical Support Center (CSC), Beneficiary Help Desk and Web Support Center to assist pharmacies, prescribers and beneficiaries.

Provider Services	Phone Number/Email	Availability/ Comments
Prime Pharmacy Call Center (will connect callers to both the PSC and CSC)	1-844-620-6116	24/7/365
Prime Member Help Desk	1-844-620-6116	24/7/365
Prime Pharmacy Call Center Fax Line	1-866-422-8981	24/7/365
Prime Web Support Call Center	1-844-620-6116	8:00 a.m. – 8:00 p.m. Monday through Friday
Prime Provider Portal	https://pba.medicaid.ncdhhs.gov/	24/7/365

Table 4.0-1: Prime Provider Services

4.1 Pharmacy and Clinical Support Centers

Prime provides a toll-free support line for pharmacies available 24 hours a day, 7 days a week, 365 days a year, to assist with questions related to coverage, claims processing and plan eligibility.

Examples of concerns/issues addressed by the PSC staff include:

- **Claims Processing Messages** – Contact the PSC at the time of dispensing if assistance is needed with alert or denial messages. Prime staff can provide details on all error messages, including ProDUR messaging.
- **Clinical Issues** – The CSC will assist with initiating clinical Prior Authorizations (PAs). If a pharmacist's question requires a clinical response, a second level of assistance is available.

Note: The PSC is not a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist.

4.2 Prime Beneficiary Help Desk

The Beneficiary Help Desk is available 24 hours a day, 7 days a week, 365 days a year to assist members with:

- Understanding which medications are preferred and covered by the plan
- Guidance on the steps required to complete a Prior Authorization (PA) request with their prescriber
- Assistance with claims inquiries

4.3 Prime Website Pharmacy Portal

Announcements, provider forms, drug information, *North Carolina Medicaid Direct Pharmacy Provider Manual*, *Payer Specifications* sheet, policies and bulletins will be available on the Prime North Carolina Medicaid Web Portal.

5.0 Program Setup

5.1 Member Identification Card

A beneficiary identification (ID) card displays coverage information for the eligible member only. The ID card includes:

- Member ID – consists of nine (9) digits followed by one (1) alpha character in the tenth position
- Member Name
- Other essential information and instructions needed for accurate claim submission, such as Pharmacy Call Center phone numbers

Additional details about member eligibility are available online through NC Medicaid Eligibility.

5.2 Claim Formats

NC Medicaid requires all providers to use online, real-time POS for claim processing.

Pharmacies should work with their software vendor regarding online capabilities.

Web Claim Submission may be permitted in certain circumstances.

Claims must be submitted in the current NCPDP Standard Version D.0.

5.3 Point-of-Sale – NCPDP Version D.0

Prime uses an online, real-time POS system to provide submitters with immediate information on:

- Member eligibility
- Claim status
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR alerts

The POS system works in conjunction with a pharmacy's in-house operating system. While pharmacy systems vary, this manual addresses only the response messages from Prime's POS system, and not the technical operation of individual pharmacy systems.

Pharmacies should confirm with their software vendors that their system can process claims according to the *North Carolina Medicaid Payer Specifications Sheet*.

5.3.1 Supported POS Transaction Types

A pharmacy's ability to use the transaction types below depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1) and reversals (B2). Other transactions listed in the table below are also supported.

- **Original Claims Adjudication (B1)** – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
- **Claims Reversal (B2)** – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- **Claims Rebill (B3)** – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 103) is equal to B3.
- **Eligibility Inquiry (E1)** – This transaction is used by the pharmacy to provide the status of a beneficiary's Medicare health plan covering the individual, along with details regarding primary and supplemental coverage if applicable.

NCPDP D.0 Transaction Code	Transaction Name
B1	**Billing**
B2	**Reversal**
B3	**Re-Bill**
E1	**Eligibility Inquiry**

Table 5.3.1-1: NCPDP D.0 Transaction Codes and Definitions

5.3.2 Required Data Elements

A software vendor utilizes Prime's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The Prime claims processing system has program-specific field requirements, e.g., Mandatory, Situational, and Not Required. The table below lists abbreviations that are used throughout the payer specifications to depict field requirements. For additional information, refer to the *North Carolina Payer Specifications Sheet* on the North Carolina Medicaid Pharmacy Portal.

Code	Description
M	**MANDATORY** Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. The fields must be sent if the segment is required for the transaction.
R	**REQUIRED** Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	**QUALIFIED REQUIREMENT** "Required when" the situations designated have qualifications for use ("Required if x," "Not required if y").

Table 5.3.2-1: Payer Specifications and Descriptions

Claims are not processed without all the required (or mandatory) data elements.

Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Claims are edited for valid format and valid values on fields that are not required.

If data are sent in fields not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks results in claim denials.

- **Required Segments** – The transaction types implemented by Prime have NCPDP-defined request formats or segments.
- **Payer Specifications** – A list of transaction types and their field requirements are available online on the North Carolina Medicaid Pharmacy Portal. These specifications list B1, B2 and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional) and values supported by Prime.
- **Program Setup** – Table 5.3.2-2 lists required values unique to plan programs.

NCPDP Field	NCPDP Field Name	Description/Value
101-A1	BIN Number	610242
104-A4	Processor Control #	781640064
301-C1	Group	Leave blank; **Do Not Send** Claims submitted with a value in the Group field will reject *NCPDP EC 06 – M/I Group ID* and return the additional message *"Do not submit a Group ID. Leave Group ID blank and resubmit."*
444-E9	Provider ID #	National Provider Identifier (NPI) 10 bytes (numeric)
302-C2	Cardholder ID #	Cardholder ID up to 20 bytes (numeric)
411-DB	Prescriber ID #	Prescriber's individual NPI 10 bytes (numeric)
407-D7	Product Code	National Drug Code (NDC) 11 digits

Table 5.3.2-2: Required Programs Unique to Plan Programs

5.4 Point-of-Sale Downtime

In the event of POS system downtime (whether scheduled or unscheduled), providers will receive reject codes and supplemental messaging.

Scheduled downtime generally occurs late Saturday night through early Sunday morning.

NCPDP Reject Code	NCPDP Reject Code Description	Explanation
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within timeout period.
99	Host Processing Error	Do not retransmit claims.

Table 5.4-1: NCPDP Reject Codes and Explanations

Note: The CSC and PSC will continue to be available 24/7/365 to assist with questions.

5.5 Paper Claims

Paper claims are not accepted. All claims must be submitted electronically through the POS system.

6.0 Program Specifications

6.1 Plan Co-Pays and Exemptions

6.1.1 Plan Co-Pays

Standard Co-Pay	
Generic	$4.00
Brand	

Table 6.1.1-1: Standard Co-Pays

Pharmacy providers may not refuse services to any Medicaid beneficiary because the individual cannot pay a copayment. Providers are also prohibited from intentionally waiving or reducing copayments for Medicaid beneficiaries.

6.1.2 Plan Co-Pay Exemptions

The following table outlines the situations/beneficiaries who are exempt from co-pay.

North Carolina Medicaid Co-Pay Exemptions
Beneficiaries < 21 years old
Beneficiaries residing in a nursing home facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or a mental health hospital
CAP, family planning, and sickle cell beneficiaries
Pregnant women
Beneficiary is a member of a federally recognized tribe
Family planning medications, diabetic supplies, condoms, spermicide films and gels, vaccines, opioid antagonists, nicotine replacement therapy, HIV antiretrovirals, and medications used to treat opioid disorder
Claims billed to Medicare

Table 6.1.2-1: NC Medicaid Co-Pay Exemptions

6.2 Timely Filing Limits

Claims that exceed the maximum filing limit, as indicated below, will deny with *NCPDP EC 81 – Claim too old* with the additional message, *"Timely filing exceeded."*

Description	Time Frame
B1 = Original Claim	365 Calendar Days
B2 = Reversal	365 Calendar Days
B3 = Re-Bill	18 months
Note: Medicare and Medicaid Crossover and other third-party claims must be received within 180 calendar days from the date of payment or denial from the third-party payor, or 365 calendar days from the (Date of Service) DOS, whichever is later.	

Table 6.2-1: Timely Filing Timeframes

6.2.1 Timely Filing Overrides

- Federal regulations require Medicaid claims to be submitted within the specified time limits in the above section.
- NC Medicaid only allows timely filing overrides in very limited circumstances, such as:
  - Eligibility was not approved within the filing year
  - Beneficiary granted retroactive eligibility

Failure by the provider to file or follow up timely is not a valid reason for override and will result in claim denial.

For timely filing override requests, providers:

- Must show original claim was submitted within the initial 365-day period
- Should submit requests electronically for faster processing
- Include required attachments and use appropriate delay reason codes

For assistance, providers should contact the PSC at 1-844-620-6116.

6.3 Dispensing Limits/Claim Restrictions

6.3.1 Dispensing Quantity Limitations

The maximum allowable quantity for most drugs is a 34-day supply, unless one of the exceptions below applies:

Product Description	Additional Comments
Birth Control and Hormone Replacement Therapies	• Up to 12 months of oral birth control medications are allowed • Up to 3 months of prepackaged hormone replacement therapies are allowed
Non-Controlled Maintenance Medications	• Up to a 90-day supply of non-controlled, maintenance medications
Hepatitis C Medications	• Up to a 90-day supply of Hepatitis C medications
Quantity and Episodic Drugs	• Certain drugs are intended for episodic use and may be dispensed in quantities supporting less than daily use.
Providers should consult the PDL or PA criteria on the NC Medicaid Pharmacy Portal for details on drug/product-specific quantity per day, days' supply limitations and PA requirements.	

Table 6.3.1-1: Exceptions to Dispensing Quantity Limitations

6.3.2 Cost Ceiling

A cost ceiling of $9,999.00 applies to all drugs, including compounds, except for the products listed below.

Claims that exceed this amount will be denied *NCPDP EC 78 – Cost Exceeds Maximum*.

Providers should review the specific reject message and contact the CSC at 1-844-620-6116 for assistance or to request a possible override.

The following products will be exempt from the cost ceiling:

Cost Ceiling	
Description	
Bleeding Disorder (Antihemophilic Factors, ITP, etc.)	Immune Globulins
Antineoplastic Agents	Colony Stimulating Factors
Anticonvulsant Agents	Antipsychotics and Antidepressants
Hetlioz	Immunosuppressive Agents
Antiviral Agents (including Hepatitis and HIV Agents)	Cystic Fibrosis Agents (Kalydeco, Orkambi, etc.)
Systemic Antipsoriatic Agents	Bile Agents
Respiratory Agents	Systemic Hormonal Agents
Pulmonary Hypertension Agents	Hemostatics
Growth Hormones	Xyrem
Ventavis	Veletri
Zavesca	

Table 6.3.2-1: Drug Cost Ceiling Descriptions

6.3.2.1 Claims > $1 Million

Due to NCPDP D.0 standard limitations, claims submitted greater than $999,999.99 will deny *NCPDP EC M8 – Host Provider File Error* and return the message, *"Not covered at point of service. If eligible for exception to pay at POS contact the Call Center at 844-620-6116."*

6.3.3 Controlled Product Limitations

6.3.3.1 Morphine Milligram Equivalent

Prime will follow current Centers for Medicare & Medicaid Services (CMS)/Centers for Disease Control and Prevention (CDC) guidelines to set a maximum Morphine Milligram Equivalent (MME) threshold. When this threshold is reached, the POS system will send a message to the pharmacy alerting the provider about the risk of an excessive dose.

The total MME for all active opioid prescriptions for a beneficiary will be limited to 90 MME per day. Claims exceeding this limit will be denied with *NCPDP EC 76 – Plan Limitations Exceeded* and will include the message: *"PA required when daily dose exceeds 90 MME/day."*

Note: Buprenorphine products used for medication-assisted treatment (i.e., Sublocade, Suboxone, etc.) are exempt from this MME limit. MME limitations will apply to Buprenorphine products used for chronic pain (i.e., Butrans).

6.3.3.2 Opioid Limitations

All claims for Schedule II Controlled Substances (CII) products must be submitted with the quantity prescribed (NCPDP Field ID: 460-ET), otherwise the claim will deny *NCPDP EC ET – M/I Quantity Prescribed* and return the additional message, *"Quantity prescribed must be greater than 0 for all schedule II drugs."*

The quantity prescribed field for CII products is not required for compound claims.

Providers should consult the PA criteria on the NC Medicaid Pharmacy Portal for details on PA requirements.

6.3.3.2.1 Short-Acting Opioids

Beneficiaries without Cancer or Sickle Cell Diagnosis

- Preferred Short-Acting Opioids:
  - Limited to 90 MME/day and 7-day supply
  - Claims exceeding the limits will deny with *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message(s):
    - *"Exceeds 7-day supply. Pharmacy PA required."* and/or
    - *"PA required when daily dose exceeds 90 MME/day."*
  - Claims within limit will continue through adjudication.
- Non-Preferred Short-Acting Opioids:
  - Limited to 90 MME/day and 7-day supply
  - Claims without an active PA will deny with *NCPDP EC 75 – Prior Authorization Required* and return the additional message, *"Pharmacy PA required."*
  - If limits are exceeded, the denial will deny with both *NCPDP EC 75 – Prior Authorization Required* and *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message(s):
    - *"Exceeds 7-day supply. Drug Non-Preferred. Pharmacy PA required."*
    - *"PA required when daily dose exceeds 90 MME/day. Drug Non-Preferred. Pharmacy PA required."*

Beneficiaries with Cancer Diagnosis

- PA, days' supply limits, and MME thresholds do not apply.
- Claims will continue through adjudication if cancer diagnosis is in history (past 365 days) or on the incoming claim.
- See *Appendix F – Cancer Diagnoses* for details on applicable diagnosis codes.

Beneficiaries with Sickle Cell Diagnosis

- Preferred Short-Acting Opioids:
  - Seven-day supply limit is waived.
  - Claims exceeding 90 MME/day will deny with *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"PA required when daily dose exceeds 90 MME/day."*
  - See *Appendix G – Sickle Cell Diagnoses* for details on applicable diagnosis codes.
- Non-Preferred Short-Acting Opioids:
  - Same rules as beneficiaries without sickle cell diagnosis

Note: A qualifying cancer or sickle cell diagnosis must be documented in the beneficiary's medical history or entered on the incoming claim.

6.3.3.2.2 Long-Acting Opioids

Beneficiaries without Cancer Diagnosis

- Preferred Long-Acting Opioids:
  - Limited to 90 MME/day and 7-day supply
  - Beneficiary must:
    - Have a history of a short-acting opioid within the past 45 days
    - Have a diagnosis within the past 365 days, or entered on the incoming claim of moderate to severe pain
    - See *Appendix E – Moderate to Severe Pain Diagnoses* for details on applicable diagnosis codes.
  - Claims without an active authorization will deny *NCPDP EC 75 – Prior Authorization Required* and return the additional message, *"Pharmacy PA required."*
  - Claims without an active authorization and that exceed the 7-day supply limitations will deny with both *NCPDP EC 75 – Prior Authorization Required* and *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Exceeds 7-day supply. Pharmacy PA required."*
  - Claims without an active authorization and that exceed the 90 MME per day limitation will deny with both *NCPDP EC 75 – Prior Authorization Required* and *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"PA required when daily dose exceeds 90 MME/day. Pharmacy PA required."*

- Claims meeting all criteria will continue through adjudication.

- Non-Preferred Long-Acting Opioids:
  - Limited to 90 MME/day and 7-day supply
  - Beneficiary must:
    - Have a diagnosis within the past 365 days, or entered on the incoming claim of moderate to severe pain
    - History of 2 preferred opioids within the past 365 days
  - Claims for non-preferred long-acting opioids will be denied with *NCPDP EC 75 – Prior Authorization Required* and will return the additional message, *"Drug Non-Preferred. Pharmacy PA required."* This applies regardless of whether the claim meets the criteria outlined above, due to the drug's non-preferred status.
  - Claims submitted with no active authorization, and that exceed the days' supply limit will deny for both *NCPDP EC 75 – Prior Authorization Required* and *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Exceeds 7-day supply. Drug Non-Preferred. Pharmacy PA required."* This applies regardless of whether the claim meets the criteria outlined above, due to the drug's non-preferred status.
  - Claims submitted with no active authorization, and that exceed 90 MME per day will deny for both *NCPDP EC 75 – Prior Authorization Required* and *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"PA required when daily dose exceeds 90 MME/Day. Drug Non-Preferred. Pharmacy PA required."* This applies regardless of whether the claim meets the criteria outlined above, due to the drug's non-preferred status.

Beneficiaries with Cancer Diagnosis

- PA, days' supply limits, and MME thresholds do not apply.
- Claims will continue through adjudication if cancer diagnosis is in history (past 365 days) or on the incoming claim.
- See *Appendix F – Cancer Diagnoses* for details on applicable diagnosis codes.

Note: A qualifying cancer or sickle cell diagnosis must be documented in the beneficiary's medical history or entered on the incoming claim.

6.3.3.3 Sedative/Hypnotic Limitation Policy

Sedative hypnotics are limited to a quantity of 15 per 30 days. Claims submitted that exceed this limitation will deny *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Sedative Hypnotics limited to 15 per calendar month."*

6.3.4 Concurrent Use of Opioids, Benzodiazepines, and/or Antipsychotics

The SUPPORT for Patients and Communities Act requires states to have an automated claims review process (as designed and implemented by the state) that monitors when a beneficiary is concurrently prescribed opioids and benzodiazepines, or opioids and antipsychotics.

Claims for an opioid or benzodiazepine with overlapping use of a different opioid or benzodiazepine within the previous one hundred (100) days will deny *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Concurrent drug use: Opioids and Benzodiazepines. Enter SCC-10 if it is medically necessary after consulting with prescriber."*

Similarly, claims for an opioid, or antipsychotic, with overlapping use of a different opioid or antipsychotic within the previous one hundred (100) days will deny with *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Concurrent drug use: Opioids and Antipsychotics. Enter SCC-10 if it is medically necessary after consulting with the prescriber."*

A Submission Clarification Code (SCC) '10' may be entered to bypass the above edits when the pharmacist has consulted with the prescriber and clinical rationale was provided.

Claims submitted for an opioid where there is overlapping use of a different opioid will follow the ProDUR therapeutic duplication logic found in *Section 10.0 – Prospective Drug Utilization Review* for additional information.

6.4 Partial Fills

Partial fills are not allowed. Claims submitted as a partial fill will be denied *NCPDP EC RK – Partial Fill Transaction Not Supported*.

6.5 Incremental Fills

Incremental fills are permitted and will only be denied if the Quantity Prescribed (NCPDP Field ID: 460-ET) is less than the quantity submitted. In such cases, the claim will deny *NCPDP EC ET – M/I Quantity Prescribed* and return the additional message, *"Quantity prescribed must be greater than or equal to quantity billed."*

Co-pay (if applicable) and dispensing fees will apply to each fill.

Note: The above will not apply to compound claims.

6.6 Generic Substitution

6.6.1 Dispense As Written (DAW) Requirements

Pharmacists must dispense a generic equivalent when available, even if the prescription lists a brand-name drug, unless the prescriber has indicated "Medically Necessary" in their own

handwriting on the prescription. When this documentation is present, the pharmacist must dispense the brand-name drug.

Important Notes:

- If the prescription lists a brand name but does not include “Medically Necessary,” the pharmacist must dispense the generic equivalent.
- If “Medically Necessary” is indicated, the brand drug will be dispensed; however, prior authorization may still be required.
- Prescribers cannot indicate “Medically Necessary” by phone or e-prescription for Maximum Allowable Cost (MAC) drugs (see *Section 13.3 – State Maximum Allowable Cost (SMAC) List* for additional information.)
- For non-MAC drugs, pharmacists may accept oral authorization from the prescriber, write “Medically Necessary” on the prescription, and initial it.
- For MAC drugs:
    - A prescriber’s signature over a printed statement indicating “Dispense As Written” or “Medically Necessary” with a check or ‘X’ in a box on the prescription indicating “Dispense As Written” is unacceptable.
    - A handwritten statement transferred to a rubber stamp and then stamped on the prescription is unacceptable.
    - The abbreviation “DAW” indicated on the prescription by the prescriber is unacceptable.
- For telephone or e-prescriptions requiring brand only, the prescriber must send a new handwritten prescription with “Medically Necessary” written on it within 72 hours.

The following DAW codes are accepted for appropriate reimbursement of brand-name products. Use of a DAW code does not override claim edits.

- Claims submitted with DAW 2, 3, 4, 6 or 9 will not be denied; they will continue through adjudication but will not bypass NADAC or MAC rates and reimburse at the lesser of logic (see *Section 13.0 – Provider Reimbursement* for additional information.)
- Claims submitted for brand products with DAW 1, 7 or 8 will continue through adjudication and bypass NADAC Generic and MAC rates.
    - Claims submitted for prenatal vitamins with a DAW 1 or 8 will not bypass NADAC Generic and MAC rates.

DAW Code	DAW Description	Comments
DAW 0	No Product Selection Indicated	• Allowed for all drugs

DAW 1	Substitution Not Allowed by Prescriber	• Claims submitted for a multi-source brand product, where there is a SMAC or WAC price available and DAW1 is entered on the incoming claim will deny *NCPDP EC 75 – Prior Authorization Required*.
		  ○ There are instances where the PA requirement may be bypassed.
		• Claims submitted for family planning beneficiaries with a DAW 1 are not allowed and will deny *NCPDP EC 8K – DAW Code Not Supported* and return the additional message, *"DAW 1 not allowed."*
		• Claims submitted for Sickle Cell (SC) beneficiaries with a DAW 1 are not allowed and will deny *NCPDP EC 8K – DAW Code Not Supported*, unless the claim is for a brand Narrow Therapeutic Index (NTI) drug.
		  ○ Claims submitted for SC beneficiary, with a DAW1, for an NTI drug will continue through adjudication and bypass NADAC Generic and MAC rates.
		• Providers should not use DAW 1 for brand name, single-source drugs.

DAW 5	Substitution Allowed – Brand Drug Dispensed as a Generic	• Claims submitted for generic drugs will deny *NCPDP EC 8K – DAW Code Not Supported*.
DAW 7	Substitution Not Allowed – Brand Drug Mandated by Law	• Used for brand NTI drugs (see *Section 7.7 – Narrow Therapeutic Index (NTI) Drugs* for the list of NTI products) • Claims submitted with a DAW 7 for a non-NTI product will default to DAW 0, 2, 3, 4, 6 and 9 reimbursement methodology.
DAW 8	Substitution Allowed – Generic Drug Not Available in Marketplace	• Claims submitted for generic drugs will deny *NCPDP EC 8K – DAW Code Not Supported.*

Table 6.6.1-1: DAW Codes and Descriptions

6.7 Lock-In Program

The North Carolina Administrative Code (10A NCAC 22F.0704 and 10A NCAC 22F.0104), Session Law 2015-241, Section 12.F.16.(1), 42 CFR 431.54, and the State Plan Amendment authorize NC Medicaid to implement procedures to prevent beneficiary overutilization of Medicaid benefits. One such procedure is the Beneficiary Management Lock-In Program.

Program Overview

- Beneficiaries enrolled in Lock-In are restricted to:
  - One prescriber and one pharmacy for opioid analgesics and benzodiazepines.
- Exceptions:
  - A second prescriber may be allowed if one prescribes benzodiazepines and the other prescribes opioids, or if both practice in the same clinic.
  - A second pharmacy may be permitted if one dispenses benzodiazepines and the other opioids, or temporarily if the primary pharmacy does not have the medication in stock.
  - Non-opioid and non-benzodiazepine products will not be subject to lock-in.

Prescription Requirements

- All prescriptions for these medications must come from the assigned prescriber and pharmacy for claims to adjudicate.
- Claims submitted using a non-assigned pharmacy will deny with:
  - *NCPDP EC 50 – Non-Matched Pharmacy Number* and return the additional message, *"The pharmacy submitted is not the assigned Lock-In Pharmacy for the beneficiary."*
- Claims submitted using a non-assigned prescriber will deny with:
  - *NCPDP EC 56 – Non-Matched Prescriber ID* and return the additional message, *"The prescriber submitted is not the assigned Lock-In Prescriber for the beneficiary."*

For additional information related to a beneficiary's inclusion or exclusion from the Beneficiary Management Lock-In Program, please refer to the NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9.

6.7.1 Emergency Supplies for the Beneficiary Management Lock-In Program

In rare cases, an emergency override may be necessary for a Lock-In beneficiary. To indicate an emergency claim, pharmacy providers must enter:

- Level of Service (NCPDP Field ID: 418-DI): 3 – Emergency

Lock-In Emergency Claim Rules and Limitations

- Limited to a 4-day supply
- Only one emergency claim per beneficiary per year during the two-year lock-in period (calculated on a rolling 365-day basis)
- Claims exceeding the limit(s) will deny *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Lock-in emergency claims limited to 4-day supply, once per year."*
- Reimbursement will be for the drug cost only.
    - ❖ Coordination of Benefits (COB) and copays will still apply.

6.8 Hospice

Beneficiaries enrolled in hospice are covered under a per diem rate that includes all services related to the terminal illness.

Pharmacy claims for hospice beneficiaries are limited to medications and products unrelated to the beneficiary's terminal illness.

For a drug used for an indication not directly related to the terminal illness, submit the claim with:

- PA Type Code (NCPDP Field ID: 461-EU) = 1, and
- The diagnosis code (ICD-10) for the terminal illness
    - Do not submit the ICD-10 code for the drug's indication – only the terminal illness ICD-10 code.
    - Claims submitted without a diagnosis code will deny *NCPDP EC 39 – M/I Diagnosis Code*.

For the following categories, PA Type Code '1' is not permitted. Claims for hospice beneficiaries will deny with *NCPDP EC 70 – Product/Service Not Covered* and return the message, *"Recipient claim covered under Hospice."*

- Narcotic analgesics, or
- Narcotic analgesic combinations, or
- Hematinics, or

- Antiemetics, or
- Chemotherapeutics, or
- Antineoplastic aromatase inhibitors

6.9 Long-Term Care (LTC)

Long-Term Care (LTC) beneficiaries are identified by a specific living arrangement code (identified by the beneficiary's eligibility), or by one of the following Patient Residence Codes (NCPDP Field ID: 384-4X) being entered on the incoming claim:

- Patient Residence 2 – Skilled Nursing Facility, or
- Patient Residence 3 – Nursing Facility, or
- Patient Residence 9 – Intermediate Care Facility

Claims for LTC beneficiaries will be exempt from co-pay.

OTC products (except for insulins) are not covered for long-term care beneficiaries and claims will deny *NCPDP EC 63 – Institutionalized Patient Product/Service ID Not Covered* and return the additional message, *"OTC product denied – database indicates patient is a long-term care resident."*

NC Medicaid accepts an SCC (NCPDP Field ID: 420-DK) '18 – LTC Patient Admit/Readmit' for early refill alerts related to long-term care patient admissions and readmissions. By entering this code, the pharmacy is indicating that the transaction is for new dispensing of the medication due to the beneficiary's admission or readmission status. Claims submitted for a beneficiary entering or re-entering a long-term care facility, which reject *NCPDP EC 88 – DUR Reject Error* for early refill, must be submitted with the applicable DUR codes, an SCC '18,' and must also have either an applicable living arrangement code, or Patient Residence Code '2' entered on the claim in order to bypass the early refill reject and continue through adjudication. See *Section 10.0 – Prospective Drug Utilization Review* for additional information.

6.10 Sickle Cell

Beneficiaries enrolled in the Sickle cell program are limited to medications listed on the Sickle Cell formulary.

Co-pay and dispensing fees do not apply for beneficiaries enrolled in this program.

Note: A sickle cell diagnosis submitted on a claim does not determine Sickle Cell beneficiary status. Enrollment in the Sickle Cell program is based on group identification, not diagnosis codes.

7.0 Drug Information and Edits

The Medicaid Outpatient Pharmacy Programs shall cover prescribed drugs when they meet all of the following guidelines and required criteria:

- The prescribed drug must have Food and Drug Administration (FDA) approved indication or is used for a medically accepted indication for which it is prescribed unless the Division of Health Benefits (DHB) provides approval.
- The prescribed drug must bear the federal legend statement.
- A legend drug is defined by the Federal Food, Drug and Cosmetic Act, as amended, and under definition its label is required to bear the statement “Caution: Federal law prohibits dispensing without prescription.”
    - Legend drugs must be produced by a manufacturer that has signed a National Medicaid Drug Rebate Agreement with CMS.
    - NC Medicaid will notify pharmacy providers of any changes – additions or deletions – to the list of covered Medicaid Rebate Manufacturers through newsletters posted on the NC Medicaid Pharmacy Portal.
    - The NC Medicaid Outpatient Pharmacy program also participates in a supplemental drug rebate program. Drugs for which supplemental rebates are paid are added to the Preferred Drug List (PDL).
- Certain OTC products – including insulin – are covered when they meet the criteria described in *NC Medicaid Outpatient Pharmacy Clinical Coverage Policy 9A Over the Counter Products*. Refer to *Section 7.2 – Over-the-Counter (OTC) Products* for additional information.
- The prescription must be written for whom the claim is billed.
- The vaccine is a covered service when the pharmacy is compliant with all North Carolina Medicaid Billing Procedures, Federal and State laws.
- Prenatal vitamins and fluoride
- Legend Calcitrol (Vitamin D) when used for a predialysis beneficiary, a dialysis beneficiary and a hypoparathyroidism beneficiary.

7.1 Covered and Non-Covered Drugs

7.1.1 Covered Drugs

All medically necessary, FDA-approved drugs are covered unless the product is non-rebateable or specifically excluded as a non-benefit. If a drug requires a PA for payment, it is still considered "covered."

NCDHHS utilizes a PDL authorized by the North Carolina General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)]. The PDL identifies the preferred and non-preferred status of covered drugs within a PDL category and is available on the North Carolina Medicaid Pharmacy Portal.

Claims submitted for generic products, where the brand is preferred, will deny *NCPDP EC 606 – Brand Drug/Specific Labeler Code Required* with the additional message, *"Brand product preferred."*

Covered medications are subject to any applicable POS edits, which may include PA, quantity limitations, age limitations, etc.

Covered medications must be manufactured by a company engaged in the Federal Medicaid Rebate Drug Program.

All written (non-electronic) outpatient prescriptions must be written on a tamper-resistant prescription pad.

Note: Information in this section and the section below are not all-inclusive of covered or non-covered products. Providers should refer to the PDL on the North Carolina Medicaid Pharmacy Portal for drug/product coverage.

7.1.2 Non-Covered Drugs

NC Medicaid shall not cover the following drugs/products and claims submitted will deny *NCPDP EC 70 – Product/Service Not Covered*:

- Fertility drugs
- Drugs obtained from any beneficiary-assistance program
- Cough and cold products containing expectorants or cough suppressants
- Drug Efficacy Study Implementation, related, and similar/less than effective
- Cosmetic drugs
- Drug samples
- Legend vitamins and minerals

The table below provides information on drugs that are not routinely covered, but may be covered with exceptions as noted:

DRUG EDITS	
Description	**Comments**
Over-the-Counter (OTC) Products	▪ Most OTC products are not covered. Certain OTC items may be covered; see *Section 7.2 – Over-the-Counter (OTC)* for details.
Non-Rebateable Drugs	▪ Products without a federal rebate are not covered. There are exceptions for products known to be non-rebateable (e.g., vaccines, medical supplies, certain OTC items).
Durable Medical Equipment (DME)	▪ Select diabetic supplies may be covered. See *Section 7.2 – Over-the-Counter (OTC) Products* for additional information.
Intravenous (IV) Fluids and Irrigation Fluids ≥ 500ml	▪ Claims submitted for IV fluids/irrigation fluids ≥ 500ml will deny *NCPDP EC 76 – Plan Limitations Exceeded*, unless the claim is for a beneficiary with specific living arrangements.
Erectile Dysfunction Drugs	▪ Cialis 2.5 mg and 5 mg may be covered under certain circumstances. Please refer to the PDL and Prior Authorization requirements for additional information.

Table 7.1.2-1: Drugs Not Routinely Covered

7.1.2.1 Select Drug List

Claims submitted for any of the products below will deny *NCPDP EC 70 – Product/Service Not Covered* and return the additional message, *"Drug Not Covered at Place of Service."*

- Beqvez™ (Fidancogene Elparvovec-Dzkt)
- Casgevy® (Exagamglogene Autotemcel)
- Elevidys (Delandistrogene Moxreparvovec-Roki)
- Hemgenix® (Etranacogene Dezaparvovec-Drib)
- Itvisma® (Onasemnogene Abeparvovec-Brve)
- Kebilidi™ (Eladocagene Exuparvovec-Tneq)
- Luxturna® (Voretigene Neparvovec-Rzyl)
- Lyfgenia™ (Lovotibeglogene Autotemcel)
- Roctavian® (Valoctocogene Roxaparvovec-Rvox)
- Skysona™ (Elivadolgene Autotemcel)
- Zolgensma® (Onasemnogene Abeparvovec-Xioi)
- Zynteglo™ (Betibeglogene Autotemcel)

7.2 Over-the-Counter (OTC) Products

The following table provides a list of the OTC products covered by NCDHHS. Covered OTC medications follow the same restrictions as any legend drug.

Claims submitted for OTC products not included in the table below will deny *NCPDP EC 70 – Product/Service Not Covered* and return the additional message, *"The OTC product is not covered on outpatient pharmacy claims."*

OTC Drug Class Description	Drug Code Level	Drug Code
Aspirin	HIC3	M9P
Smoking Deterrent Agents (Nicotine)	HIC3	J3A
Proton Pump Inhibitors (PPI)	HIC3	D4J
2nd Generation Antihistamines – Decongestant Combination Products	HIC3	Z2Q
Insulins	HIC3	C4G
Syringes	HIC3	X2B
Test Strips	HIC3	M4A
Control Solution	HIC3	Y9A
Lancets	HIC3	Y3A
Lancing Devices	HIC3	Y9A
Pen Needles	HIC3	X2A
Contraceptives, Oral (Levonorgestrel)	HIC3	G8A
Cathartics and Laxatives **Note:** Limited to Polyethylene Glycol 3350	HIC3	D6S

OTC Drug Class Description	Drug Code Level	Drug Code
Naloxone OTC	HIC3	H3T
Spermicide Films	GSN	015903
Spermicide Gels	GSN	011979
Condoms	GSN	022218, 022219, 022221
Condoms, Female	GSN	022231
Additional Notes		
• Claims submitted for test strips, lancets, control solutions, and lancing devices that are not manufactured by ROCHE will be denied *NCPDP EC 75 – Prior Authorization Required Covered* and return the additional message, *"ROCHE products preferred."* – The above-mentioned reject will be bypassed if a claim is submitted with a primary payer, and the other payer pays at least $0.01. • Claims for diabetic test strips must be billed in multiples of 50 or 51. Claims for syringes and lancets must be billed in multiples of 100. • Beneficiaries are allowed 1 covered meter every 2 years (730 days) • All blood glucose meters are billed using the NC Medicaid Free BIN Meter program. BIN: 610524, PCN: 1016, Group: 40026479, ID: 066499643 • POS claims for diabetic supplies follow the same limitations as the DME program. • Diabetic supplies, including other brands, can also be submitted under the DME program. • Additional information on the DME program can be found in the NC Division of Medical Assistance Durable Medical Equipment and Supplies Clinical Coverage Policy No: 5A		

Table 7.2-1: OTC Products Covered by NCDHHS

7.3 Family Planning (FP) Services

NCDHHS Family Planning (FP) Services provides services to eligible beneficiaries regardless of age or gender. Beneficiaries enrolled for family planning will be provided with limited coverage for family planning and family-planning services only.

FP Medicaid will cover the following products for applicable beneficiaries when a prescription is provided to the pharmacy:

- Oral contraceptives (up to a 12-month supply)
- Contraceptive patches
- Contraceptive vaginal rings
- Emergency contraception
- Treatment for most Sexually Transmitted Infections (STIs)
- Medications for sterilization procedures

Claims submitted for an FP beneficiary for a product not included on the FP formulary will deny *NCPDP EC 70 – Product/Service Not Covered* and return the additional message, *"Drug is not covered by the beneficiary's benefit plan which is family planning coverage only."*

PAs are not required for FP products.

Claims submitted for an FP beneficiary must include one of the below primary diagnosis codes for contraception on the incoming claim, otherwise the claim will reject *NCPDP EC 39 – M/I Diagnosis Code* and return the additional message, *"Family Planning requires applicable diagnosis code."*

ICD-10-CM Codes for Family Planning		
• Z30.011	• Z30.012	• Z30.013
• Z30.014	• Z30.015	• Z30.016
• Z30.017	• Z30.018	• Z30.019
• Z30.02	• Z30.09	• Z30.2
• Z30.40	• Z30.41	• Z30.42
• Z30.430	• Z30.431	• Z30.432
• Z30.433	• Z30.44	• Z30.45
• Z30.46	• Z30.49	• Z30.8
• Z30.9	• Z31.61	• Z31.69

Table 7.3-1: Primary Diagnosis Codes for Family Planning

Claims submitted for an FP beneficiary for an applicable product for the treatment of an STI must have both an applicable primary diagnosis code (from the above list), and an applicable diagnosis code related to the STI (see *Section 16.5 – Appendix E – Family Planning STI Medication and Diagnosis List*). If a claim is submitted with only one diagnosis, or without any diagnosis present on the incoming claim will deny *NCPDP EC 39 – M/I Diagnosis Code* and return the additional message, *"Applicable diagnosis code(s) required."*

FP beneficiaries will be limited to six (6) STI treatments per rolling 365 days. The STI treatments may be for the same or different treatments. Claims submitted that exceed this limitation will deny *NCPDP EC 76 – Plan Limitations Exceeded*.

The above limitation may not apply if one of the following is true:

- Beneficiary is < 19 years old, or
- Beneficiary is female, and is > 55 years old, or
- Beneficiary is male, and is > 60 years old, or
- Claim submitted is for a covered vaccine

Claims submitted for an FP beneficiary for an applicable product for post-operative sterilization, must have both an applicable primary diagnosis code (as listed in the above table), and an applicable diagnosis code related to sterilization (see *Section 15.7 – Appendix G – Postoperative Sterilization Medication and Diagnosis List*). If a claim is submitted with only one diagnosis, or without any diagnosis present on the incoming claim will deny *NCPDP EC 39 – M/I Diagnosis Code* and return the additional message, *"Applicable diagnosis code(s) required."*

Beneficiaries in the FP program are exempt from co-pays.

Claims submitted for a brand-name product with a DAW 1 – Brand Medically Necessary are not allowed and will deny *NCPDP EC 8K – DAW Code Not Supported* and return the additional message, *"DAW 1 not allowed."*

Claims submitted for a contraceptive drug for FP beneficiaries, where the prescriber is an immunizing pharmacist (see *Section 7.11 – Immunizing Pharmacists* for additional information) will be denied *NCPDP EC 70 – Product/Service Not Covered* and return the additional message, *"Prescriber not eligible to prescribe the NDC for the Family Planning beneficiary."*

For additional information on Family Planning Services, see *Clinical Coverage Policy No: 1E-7*.

7.4 Age Restrictions

Age restrictions may apply to specific products.

When the product has either a minimum or maximum age requirement and the member age does not meet that requirement, the claim will reject with *NCPDP EC 60 – Product/Service Not Covered for Patient Age*.

7.5 Long-Acting Injectables (LAIs)

Long-Acting Injectables (LAIs) are drugs formulated for extended release, providing sustained therapeutic effects over a period ranging from several days to months.

North Carolina Medicaid reimburses an administration fee for LAI products billed through the outpatient POS pharmacy benefit when the following conditions are met:

- **Level of Service (LOS) Indicator Required:**
  - Pharmacies must input an LOS (Field 418-DI) indicator equal to 05 on the POS pharmacy claim of the drug being administered for payment of the administration fee when applicable.
    - If LOS is not entered on the claim, the administration fee will not be paid.
- **Administration Fee:**
  - The administration fee will be paid at a rate of $17.36.
- **Limitations:**
  - Only one administration fee per claim is allowed.
- The administration fee will not be paid on Indian Health Service (IHS)/Tribal pharmacy claims paid at the OMB encounter rate.
- The fee may be paid on compound drug claims if at least one injectable medication is included and LOS '05' is entered on the claim.
- Only one LOS code is allowed on a claim; therefore, an administration fee will not be reimbursed on emergency claims, or claims submitted for a mailing or delivery fee reimbursement.

Eligible Drug Routes of Administration for Administration Fee

Claims for covered drugs with any of the following route codes qualify for an administration fee if all of the above parameters have been met:

- A – Intravenous
- C – Intramuscular
- G – Subcutaneous
- 2 – Injection
- 9 – Intradermal

7.6 Narrow Therapeutic Index (NTI) Drugs

Under NC General Status 90-85.27, Narrow Therapeutic Index (NTI) drugs are defined as pharmaceuticals with a very narrow margin between therapeutic benefit and risk. These drugs typically meet one or more of the following criteria:

- Less than a twofold difference between the minimum toxic concentration and the minimum effective concentration in the blood.
- Formulations that exhibit limited or erratic absorption, formulation-dependent bioavailability, or wide intrapatient pharmacokinetic variability blood-level monitoring.

Designation of NTI Drugs

Drugs classified as NTI are designated by the Secretary of NCDHHS based on recommendations from the State Health Director, the NC Board of Pharmacy, and the NC Medical Board. These drugs are subject to the provisions of NCGS 90-85.28(b1).

The following products are identified as NTI drugs:

- Carbamazepine; all oral dosage forms
- Cyclosporine; all oral dosage forms
- Digoxin; all oral dosage forms
- Ethosuximide
- Levothyroxine Sodium tablets
- Lithium (including all salts); all oral dosage forms
- Phenytoin (including all salts); all oral dosage forms
- Procainamide
- Tacrolimus; all oral dosage forms
- Theophylline (including all salts); all oral dosage forms
- Warfarin Sodium tablets

The NTI drug list is reviewed annually and published in the NC Register by the NC Board of Pharmacy.

Dispensing Requirements for NTI Drugs

- A prescription for an NTI drug must be refilled using the same manufacturer's product as previously dispensed, unless:
    - The prescriber is notified before dispensing a different manufacturer's product, and
    - Both the prescriber and the beneficiary provide documented consent.
- When dispensing a brand NTI drug as medically necessary:
    - Use DAW 7 to indicate "brand required" and override any NADAC generic rate or MAC pricing.
    - Refer to *Section 6.6.1 – Dispense As Written (DAW) Requirements* for additional details.

7.7 Compounds

All compound claims must be submitted using the NCPDP Version D.0 multi-ingredient compound functionality. Each claim must include:

- Identification of all ingredients in the compound
- The quantity (units) for each ingredient
- The ingredient cost for each component

Medicaid will cover compound products when:

- The mixture of two or more ingredients is physically inseparable.
- At least one component is a legend drug.
- The quantity of the legend drug is sufficient to provide a therapeutic effect.
- The legend drug is manufactured by a company that has signed a national Medicaid Drug Rebate Agreement with CMS.

Additional Requirements:

- At least one item in the compound must be a covered drug.
- If any component requires a PA, approval must be obtained before payment will be made.
- Compound claims equivalent to an OTC product are not covered.

For more details on NCPDP required fields, refer to the *North Carolina Payer Specifications Sheet* document.

Important Notes for Compound Claim Submission:

To ensure compound claims adjudicate and reimburse correctly, providers must enter the following information in the Claim Segment header:

- Compound Code (NCPDP Field ID: 406-D6): Enter '2 – Compound' to identify the claim as a multi-ingredient compound.
- Product/Service ID Qualifier (NCPDP Field ID: 436-E1): Enter '00 – Not Specified'.
- Product/Service ID (NCPDP Field 407-D7): Enter '0'.

Additional Requirements:

- Enter the specific NDCs for each ingredient in the Compound Product ID (NCPDP Field ID: 489-TE) field.
- Submission Clarification Code (NCPDP Field ID: 420-DK): Value '8' allows processing if at least one ingredient is covered. Non-rebateable ingredients will process but only rebateable ingredients are reimbursed.
- Claims where all ingredients are OTC will deny *NCPDP EC 70 – Product/Service Not Covered*.
- Compound Type (NCPDP Field ID: 996-G1): Must be submitted on all compound claims, otherwise the claim will be rejected.
- Compound claims must include at least two ingredients, including one active/payable ingredient. Single-ingredient claims will deny *NCPDP EC 7Z – Compound Requires Two or More Ingredients*.
- Up to 25 ingredients are allowed per compound claim. Claims with more than 25 ingredients will deny *NCPDP EC 9K – Cmpd Ing Component Cnt Exceeds Num Ing Supported*.
- Pharmacies must transmit the same NDCs used to dispense the medication.
- The total cost must equal the sum of all ingredient costs; otherwise, the claim will deny.
- Duplicate NDCs within a compound are not allowed. These claims will deny with NCPDP EC 21 – M/I Product Service ID.
- For ProDUR processing, compounds are matched by the number and identity of ingredients.
- Duplicate edits apply regardless of compound status.

7.7.1 Fields Required for Submitting Multi-Ingredient Compounds

On the **Claim Segment:**

- Enter **Compound Code** (NCPDP Field ID: 406-D6) of “2.”
- Enter **Product/Service ID** (NCPDP Field ID: 407-D7) as “0” on the claim segment to identify the claim as a multi-ingredient compound.
- Enter **Product/Service ID Qualifier** (NCPDP Field ID: 436-E1) as “00” to identify the product as a multi-ingredient compound.
- Enter **Quantity Dispensed** (NCPDP Field ID: 442-E7) of entire product.
- Enter **Gross Amount Due** (NCPDP Field ID: 430-DU) for entire product.
- **Submission Clarification Code** (NCPDP Field ID: 420-DK) = Value “8” will only be permitted for compounds.

On the **Compound Segment**:

- **Compound Dosage Form Description Code** (NCPDP Field ID: 450-EF)
- **Compound Dispensing Unit Form Indicator** (NCPDP Field ID: 451-EG)
- **Compound Route of Administration** (NCPDP Field ID: 452-EH)
- **Compound Ingredient Component Count** (NCPDP Field ID: 447-EC)
  - Maximum of 25

For **each line item:**

- **Compound Product ID Qualifier** (NCPDP Field ID: 488-RE) of “00”
- **Compound Product ID** (NCPDP Field ID: 489-TE)
- **Compound Ingredient Quantity** (NCPDP Field ID: 448-ED)
- **Compound Ingredient Cost** (NCPDP Field ID: 449-EE)

7.8 – Antipsychotic Safety Adult Program (ASAP) and Antipsychotic Safety Kids Programs (A+Kids)

7.8.1 ASAP Program

The ASAP program is used for safety monitoring of NC Medicaid beneficiaries 18 years of age and older who are prescribed antipsychotic agents for use outside of the indications and dosage levels approved by the federal FDA.

All claims for atypical antipsychotics and second-generation antipsychotics will be treated as an off-label request and will require a PA.

Beneficiaries 18 years of age and older with any of the following diagnoses are exempt from PA:

- Schizophrenia
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Brief psychotic disorder
- Shared psychotic disorder
- Psychotic disorder Not Otherwise Specified
- Bipolar disorder
- Major depressive disorder with psychotic features
- Treatment-resistant depression (TRD) (antipsychotic use for TRD is adjunctive only)
- Tourette's syndrome
- Other psychoses

Claims submitted for a beneficiary without one of the above diagnoses will deny *NCPDP EC 75 – Prior Authorization Required* and return the additional message, *"Safety doc required, Prescriber call CSC at 1-844-620-6116. Consider override code 11."*

The PA requirement may be overridden when an SCC 11 is entered on the incoming claim.

Use of SCC 11 will be limited to 2 per rolling 365 days. Claims submitted which exceed this limit will deny *NCPDP EC 76 – Plan Limitations Exceeded* and return the additional message, *"Override limit exceeded. Prescriber call CSC at 1-844-620-6116."*

For additional information, see *NC Medicaid Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older Clinical Coverage Policy No: 9E*.

7.8.2 A+ Kids

The A+ Kids program is used for safety monitoring of NC Medicaid beneficiaries up to and including 17 years of age who are prescribed antipsychotic agents for use outside of the indications and dosage levels approved by the FDA.

All claims for first and second generation, typical and atypical antipsychotics for beneficiaries up to and including 17 years of age will be treated as an off-label request and will require a PA. Claims submitted without a PA will deny *NCPDP EC 75 – Prior Authorization Required*.

For additional information, see *NC Medicaid Off Label Antipsychotic Safety Monitoring In Beneficiaries Through Age 17 Clinical Coverage Policy No.: 9D*.

7.9 Vaccines

Pharmacy providers who administer immunizations may bill NC Medicaid for vaccines on pharmacy claims.

An immunizing pharmacist shall administer only those vaccines or immunizations permitted by G.S. 90 85.15B and shall do so subject to all requirements of that statute and the NC Board of Pharmacy rules.

The Department of Public Health prohibits pharmacies from participating in the Vaccine for Children program, therefore, Medicaid will only permit vaccinations by immunizing pharmacists for beneficiaries 19 years of age and older (exception is made for COVID-19 vaccines as set forth by the 9th Amendment to PREP act for the duration of its effect, also found in the *Guidance for PREP Act Coverage for Qualified Pharmacy Technicians and State-Authorized Pharmacy Interns for Childhood Vaccines, COVID-19 Vaccines, and COVID-19 Testing*.

Note: As of January 1, 2025, COVID-19 vaccines are no longer covered as a pharmacy benefit for beneficiaries ages 3 to 18 years old.

The Vaccine POS Catalog provides a list of covered vaccine NDCs, maximum dose and age limitations.

Claims submitted for beneficiaries less than 19 years of age will deny *NCPDP EC 60 – Product/Service Not Covered for Patient Age*.

Claims submitted that exceed the maximum dose will deny *NCPDP EC 76 – Plan Limitations Exceeded*.

See *Section 13.5 - Vaccine Reimbursement* for details regarding reimbursement.

7.9.1 Vaccine Administration Rates

The following administration rates for pharmacy immunizations will be added to the reimbursement amount of the vaccine:

- Administration rate for beneficiaries 19-20 years of age is $20.45.
- Administration rate for beneficiaries 21 years of age and older is $13.30.
- Administration rate for COVID-19 vaccines for beneficiaries 3 years of age and older was $65.00 through September 30, 2024. As of October 1, 2024, the COVID-19 administration rate aligns with the standard administration rate of $30.00.
    - **Note:** As of January 1, 2025, COVID-19 vaccines are no longer covered as a pharmacy benefit for beneficiaries ages 3 to 18 years old and will deny *NCPDP EC 70 – Product/Service Not Covered*.

7.10 Immunizing Pharmacists

Beginning January 8, 2024, NCDHHS began authorizing immunizing pharmacists to dispense, deliver, or administer the medications listed below. Immunizing pharmacists are identified by the Service Provider NPI being submitted in the Prescriber ID field (NCPDP Field ID: 411-DB).

Currently, only the below products may be prescribed and dispensed by an immunizing pharmacist. Claims submitted for these products will follow standard reimbursement (see *Section 13.0 – Provider Reimbursement*).

Products not allowed to be prescribed by immunizing pharmacists will deny *NCPDP EC 6Z – Provider Not Elig to Perform Serv/Dispense Product* and return the additional message, *"Prescriber not eligible to prescribe this medication."*

Self-Administered Hormonal Contraceptives:

- Combined oral contraceptives
- Transdermal contraceptive patches
- Progestin only pills

Nicotine Replacement Therapies

- Nicotine patches
- Nicotine gum
- Nicotine lozenges
- Nicotine oral inhaler
- Nicotine nasal inhaler

Prenatal Vitamins

- Any prescription prenatal vitamin formulation containing ≥ 400 mcg folic acid

Post-Exposure Prophylaxis (PEP) for HIV

- Tenofovir Disoproxil Fumarate 300 mg/Emtricitabine 200 mg
- Raltegravir 400 mg
- Dolutegravir 500 mg
- Darunavir 800 mg
- Ritonavir 100 mg

Glucagon

- Glucagon 1 mg/mL Emergency Injection Kit
- Glucagen 1 mg/mL Hypokit Injection
- Gvoke® 0.5 mg/0.1 mL Prefilled Syringe or Auto-Injector
- Gvoke® 1 mg/0.2 mL Prefilled Syringe or Auto-Injector
- Baqsimi®

For additional information, see Immunizing Pharmacists Enrollment Opening in January 2024.

7.11 Hemophilia Specialty Pharmacy Program

The North Carolina General Assembly ([Session Law 2012-142, Section 10.48(a2)]) requires NC Medicaid Pharmacy Programs to maintain a specialty pharmacy program for hemophilia drugs.

For detailed requirements and guidelines, refer to *Clinical Coverage Policy No. 9B – Hemophilia Specialty Pharmacy Program* on the NC Medicaid website: https://medicaid.ncdhhs.gov/9b-hemophilia-specialty-pharmacy-program.

8.0 Prior Authorization (PA)

Under Section 1927(d)(1)(B)(i) of the Social Security Act, Medicaid may limit coverage of an outpatient drug if it is prescribed for a use that is not a medically accepted indication.

A medically accepted indication is any use of a covered outpatient drug that is:

- Approved under the Federal Food, Drug, and Cosmetic Act, or
- Supported by citations included or approved for inclusion in one or more of the following compendia:
    - *American Hospital Formulary Service Drug Information*
    - *United States Pharmacopeia-Drug Information* (or successor publications)
    - *DRUGDEX Information System*
    - Peer-reviewed medical literature (as per 1927(d)(1)(B)(ii))

8.0.1 PA Requests

The Prime Clinical Call Center manages PA requests for:

- Drugs requiring PA
- Drugs subject to clinical edits
- Drugs prescribed outside FDA-approved guidelines, evidence-based standards, or NC Medicaid Drug Criteria when medically necessary

Who Can Submit Requests?

- The prescribing physician or their documented agent
- Pharmacists may not submit a PA request, except when the pharmacist is servicing nursing facilities, adult care homes, or ICF/IID.
    - **Note:** Pharmacists may not request PA for Brand-Name Schedule II narcotics or sedative hypnotics.

Submission Methods

- Telephone: 1-844-620-6116
- Fax: 1-866-422-8981
- Mail:

  Prime Therapeutics
  ATTN: GV-4201
  PO Box 64811
  St. Paul, MN 55164-0811

- WebPA: Through the CoverMyMeds® platform (link available on the NC Medicaid Provider Portal)

Provider Responsibilities

Refer to [PA Requirements/Criteria Link] for:

- A list of drugs requiring PA
- Medical necessity criteria for drugs/products that require PA

Providers should submit the following with the PA request:

- Health record documentation supporting medical necessity
- Explanation of other drugs tried or why alternatives cannot be used
- Prescriber's rationale for why FDA guidelines or NC Medicaid criteria are insufficient
- Supporting compendia or peer-reviewed literature (per 42 U.S.C. 1396r-8(g)(1)(B))

New-to-Market Products

Claims for new or existing products may require PA. Clinical reviews will be conducted for new-to-market products to develop coverage criteria. Reviews include:

- New variations of existing products
- New indications for existing products
- Changes in indications
- Changes in dosing

8.0.2 Retroactive Prior Authorization

A retroactive PA may be considered when a beneficiary did not have Medicaid coverage on the DOS but is later approved for Medicaid with a retroactive eligibility date. This applies to medication requests within the pharmacy PA program for DOS up to one year after dispensing.

How to Request a Retroactive PA:

- Contact the Clinical Call Center (CSC) at 1-844-620-6116.
- Requests are reviewed on a case-by-case basis.

If no PA exists and the beneficiary meets full approval criteria, a retroactive PA may be issued to cover both the backdated period and the standard forward approval period.

Who Can Submit Requests:

- Prescribers

- Pharmacists servicing nursing facilities, adult care homes, or ICF/IID, or LTC facilities.
    - **Note:** Pharmacists may not request PA for Brand Name Schedule II narcotics or sedative hypnotics.

8.0.3 Reconsiderations and Appeals

Appeals for North Carolina Medicaid are handled by NCDHHS and the Office of Administrative Hearing.

North Carolina Medicaid beneficiaries have the right to appeal a denied prior authorization decision. They may request a State Fair Hearing within thirty (30) days (excluding holidays) from the date they receive the denial letter.

As part of the appeal request, beneficiaries may:

- Submit new or additional information for reconsideration, and/or
- Choose to continue through the appeal process.

Instructions outlining the appeal submission procedure and appeal process will be included in the denial letter.

9.0 Emergency Protocols

9.1 Emergency Preparedness Protocol

When a State of Emergency is declared by the North Carolina Governor, Federal Emergency Management Agency (FEMA), or the President of the United States, the NC Secretary of Health and Human Services may activate special protocols (see below) to ensure uninterrupted access to life-saving medications for NC Medicaid beneficiaries.

- Waive prior authorization requirements.
- Allow maximum extended days' supply, if requested and available at the time of refill.
- Lift "refill-too-soon" edits.

Providers will be notified of activation and any restrictions through the NC Medicaid Pharmacy Portal.

When a state of emergency has been declared and activated, enrolled pharmacy providers shall enter an SCC (NCPDP Field ID: 420-DK): 13 on the claim and all applicable values for early refill override(s) in the Reason for Service Code (NCPDP Field ID: 439-E4), Professional Service Code (NCPDP Field ID: 440-E5) and Result of Service Code (NCPDP Field ID: 441-E6) fields (see *Section 10.2 – ProDUR Alerts and Overrides* for additional information). Early Refill overrides will be allowed for all medications. Co-pay requirements will remain applicable to these pharmacy claims.

9.2 72-Hour Emergency Supply

Pharmacy providers may dispense up to a 72-hour supply of a covered medication in emergency situations.

Emergency claims will be allowed for both non-controlled and controlled products and will only override the PA requirement for rebate-eligible covered drugs; all other edits (i.e., quantity limitations, days' supply, etc.) will apply.

Emergency claims will be limited to one (1) emergency fill, per product and strength, per 30 days. Claims submitted that exceed this limitation will be denied *NCPDP EC 76 – Plan Limitations Exceeded*.

Emergency claims may be submitted at POS and will be identified by a 'Level of Service (NCPDP Field ID: 418-DI): 3 – Emergency' being entered on the incoming claim.

Note: Pharmacy providers should contact the Call Center at 1-844-620-6116 for possible override of unbreakable packages.

10.0 Prospective Drug Utilization Review

Federal rules require that each state Medicaid program includes a comprehensive DUR program to improve the quality and cost effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

The program enhances the quality and appropriateness of beneficiary care by educating physicians and pharmacists on common drug therapy problems to improve prescribing and dispensing practices.

ProDUR is the component of DUR that reviews medication therapy before a prescription is dispensed. It includes the detection, evaluation and counseling steps that help identify potential drug-related issues. The ProDUR system supports pharmacists by flagging situations where a drug therapy concern may exist.

By reviewing claims submitted from all participating pharmacies, the ProDUR system can identify issues such as drug-drug interactions or therapy duplications based on a patient's medication history. Pharmacists then apply their clinical training and professional judgment to resolve these issues and ensure beneficiaries receive appropriate and safe medication therapy.

Refer to the *NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9* (see *Attachment E: Drug Use Review Program, A. NC Medicaid)* for information related to the Drug Use Review Board.

10.1 Drug Utilization Review Edits

A prospective review of drug therapy is performed at the time a prescription is filled. This review includes a thorough screening of the prescription to identify potential drug-related issues. Multiple alerts on a prescription are prioritized according to the hierarchy below. These alerts are evaluated using established clinical standards:

- Early Refill/Overuse Precaution (ER)
- Drug-Drug Interactions (DD)
- Therapeutic Duplication (TD)
- Ingredient Duplication (ID)
- Minimum/Maximum Daily Dosing (LD/HD)
- Drug to Pregnancy Precautions (PG)
- Drug-Disease Contraindications (MC)
- Late Refill (LR)
- Drug to Pediatric Precautions (PA)
- Drug to Geriatric Precautions (PA)

This review helps ensure that each prescription is safe, appropriate and effective for the beneficiary before medication is dispensed.

10.2 ProDUR Alerts and Overrides

The NCPDP ProDUR alerts the dispensing pharmacist when a potential conflict or drug-therapy concern is identified during claim processing.

Before a claim can continue through adjudication, ProDUR alerts require the pharmacist to submit the appropriate NCPDP Professional Service and Result of Service codes. These codes document the pharmacist's professional judgment and confirm how the identified issue was addressed.

If the pharmacist determines dispensing the prescription is clinically appropriate, the pharmacy must respond to the alert by submitting the applicable NCPDP Reason for Service, Professional Service and Result of Service codes. Proper documentation of the DUR intervention is required for the claim to continue through adjudication.

Note: If multiple DUR alerts are generated for a single claim, the pharmacist must provide a response for each individual alert.

The following table lists the NCPDP interactive DUR Reason for Service, Professional Service, and Result of Service codes, which may be used to override ProDUR denials at the POS.

Claims submitted with service codes that do not correspond to the Reason for Service codes listed in the table will continue to reject with *NCPDP EC 88 – DUR Reject Error*.

If a claim rejects with a DUR Reason for Service Code and the pharmacy does not submit an override, it will be assumed that the prescription was not filled. In these situations, pharmacies are not required to submit a "Not Filled" Result of Service Code.

It is imperative that pharmacists submit an accurate days' supply, as ProDUR utilizes the quantity dispensed and days' supply to calculate the beneficiary's daily dose. Incorrect days' supply values may trigger DUR rejects such as High Dose (HD), Early Refill (ER), etc.

The correct pharmacy and prescriber NPI must also be submitted, as it is essential for accurately identifying the prescriber and pharmacist involved in the beneficiary's medication therapy.

NC Medicaid applies maximum days' supply limitations, including the 34-day maximum (or 90 days when permitted). Maximum days' supply limits cannot be overridden. See *Section 6.3 – Dispensing Limits/Claim Restrictions* for additional information.

Reason For Service Code(s)	Provider Override Allowed?	Applicable Professional Service Code(s)/Description	Applicable Result of Service Code(s)/Description
• ER – Overuse Precaution • DD – Drug-Drug Interaction • TD – Therapeutic Duplication • HD – High Dose • PG – Drug to Pregnancy	Y	• M0: Prescriber Consulted • P0: Patient Consulted • R0: Pharmacist Consulted Other Source • 00: No Intervention • Blank: Not Specified	• 1A: Filled, False Positive • 1B: Filled Prescription As Is • 1C: Filled with Different Dose • 1D: Filled with Different Directions • 1E: Filled with Different Drug • 1F: Filled with Different Quantity • 1G: Filled with Prescriber Approval • 2A: Prescription Not Filled • 2B: Prescription Not Filled – Directions Clarified

Table 10.2-1: Reason for Service Codes and Descriptions

Non-Controlled Products

To override a Reason for Service Code: ER – Overuse Precaution for a non-controlled medication, the pharmacy must submit:

- A valid SCC of:
  - 03 – Vacation Supply, or
  - 04 – Lost Prescription, or
  - 05 – Therapy Change, or
  - 18 – LTC Patient Admit/Readmit, and
- The appropriate Professional Service Code and Result of Service Code documenting the pharmacist's clinical intervention.

When the required codes are submitted, the claim may continue through adjudication. For more information about vacation supplies or lost/stolen/damaged medication, see *Section 10.3 – Vacation Fills* and *Section 10.4 – Lost/Stolen/Damaged Medication*.

Claims for products that are not an opioid or benzodiazepine will have a 75 percent early refill tolerance.

Note: Claims for early refills of non-controlled products without a valid SCC code and the requirement Professional Service and Result of Service codes will continue to reject with *NCPDP EC 88 – DUR Reject Error*.

Opioids and Benzodiazepines

LTC Beneficiaries

To override a Reason for Service Code: ER – Overuse Precaution for an opioid or benzodiazepine dispensed to an LTC beneficiary (identified by an applicable living arrangement indicator or Patient Residence Code (NCPDP Field ID: 384-4X): 2, the pharmacy must submit:

- A valid SCC code:
    - 03 – Vacation Supply, or
    - 04 – Lost Prescription, or
    - 05 – Therapy Change, or
    - 18 – TC Patient Admit/Readmit, and
- The appropriate Professional Service and Result of Service codes.

Claims for products that are an opioid or a benzodiazepine will have an 85 percent refill tolerance.

For more information about vacation supplies or lost/stolen/damaged medication, see *Section 10.3 – Vacation Fills* and *Section 10.4 – Lost/Stolen/Damaged Medication*.

- Non-LTC Beneficiaries

For non-LTC beneficiaries, an override for ER – Overuse Precaution for an opioid or benzodiazepine will be allowed only for a therapy change. The pharmacy must submit:

- A valid SCC code:
    - 05 – Therapy Change, and
    - The appropriate Professional Service Code and Result of Service Code.

Note: Claims for early refills of controlled products without a valid SCC code and the requirement Professional Service and Result of Service codes will continue to reject with *NCPDP EC 88 – DUR Reject Error*.

All ProDUR alert messages appear at the end of the claim's adjudication transmission.

Alerts appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, DD, HD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. • 1 = Your Pharmacy • 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. • 1 = First Databank • 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. • 0 = No Value • 1 = Same Prescriber • 2 = Other Prescriber

Table 10.2-2: ProDUR Alert Messages and Definitions

10.3 Vacation Fills

A vacation fill may be approved when a beneficiary is traveling and requires an early refill to ensure continuity of therapy.

- Vacation fills are limited to one occurrence of up to 5 consecutive days within a 365-day period.
- To override a Reason for Service Code: ER – Overuse Precaution for a vacation fill, the pharmacy must submit:
    - A valid SCC code:
    - 03 – Vacation Supply, and
    - The appropriate Professional Service Code and Result of Service Code documenting the pharmacist's intervention.

These codes must be included for the claim to continue through adjudication.

10.4 Lost/Stolen/Damaged Medication Fills

A lost, stolen or damaged medication fill may be approved when a beneficiary reports that their medication is no longer available due to loss, theft or damage.

- Lost/Stolen/Damaged fills are limited to one occurrence on a single DOS within a 365-day period.
- To override a Reason for Service Code: ER – Overuse Precaution for a lost/stolen/damaged fill, the pharmacy must submit:
    - A valid SCC code:
        - 04 – Lost Prescription, and
        - The appropriate Professional Service Code and Result of Service Code documenting the pharmacist's intervention.

These codes must be included for the claim to continue through adjudication.

10.5 Counseling

Pharmacists must offer counseling to every Medicaid beneficiary receiving a prescription whenever, in the pharmacist's professional judgment, counseling is warranted. Counseling should provide information that helps the beneficiary use their medication safely and effectively. Counseling may include:

- The name and purpose of the medication
- Dosage form, strength, route of administration, and expected duration of therapy
- Any special instructions or precautions related to the preparation, administration or use
- Common or significant side effects, adverse reactions, drug interaction, allergy considerations or therapeutic contraindications
- Techniques for self-monitoring (e.g., symptoms, blood glucose, blood pressure)
- Proper storage requirements
- Information about refills
- What to do if a dose is missed

While beneficiaries have the right to decline counseling, pharmacists are still required to offer it for each prescription.

10.6 Retrospective DUR (RetroDUR)

Information regarding RetroDUR can be found in *NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No.: 9*.

11.0 Coordination of Benefits (COB)

NC Medicaid is the payer of last resort. Providers must bill all other payers first before submitting a claim to Medicaid. COB edits apply when Third-Party Liability (TPL) exists for the member on the claim DOS.

TPL refers to any other source responsible for health care costs, including:

- An insurance plan or carrier
- A program
- A commercial carrier

These may include:

- Individual or group plans
- Employer-sponsored coverage
- Employer-related
- Self-insured or self-funded plans

The terms *Third-Party Liability* and *other insurance* are used interchangeably to mean any entity other than Medicaid that has financial obligation for health care coverage.

Prior authorization is not required for claims submitted if a Third-Party Payer has made payment equal to or greater than 60 percent of the Medicaid Allowed Amount (billed Gross Amount Due (GAD)). All other edits will apply.

11.1 COB General Instructions

11.1.1 COB Process

COB processing requires that the Other Payer Amount Paid (NCPDP Field ID: 431-DV), Other Payer ID (NCPDP Field ID: 340-7C), Other Payer Date (NCPDP Field ID: 443-E8), and Other Payer Patient Responsibility (NCPDP Field ID: 352-NQ) be submitted on the claim. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.

If a beneficiary has other coverage on the claim DOS and it is not reported on the pharmacy's claim submission, NC Medicaid will deny the claim in the POS system with *NCPDP EC 41 – Submit Bill to Other Processor or Primary Payer* and return the Other Payer details (see below) of the active TPL on file in the "COB Response Segment" if available:

- Other Payer Coverage Type
- Other Payer ID Qualifier
- Other Payer ID

- Other Payer Processor Control Number
- Other Payer Cardholder ID
- Other Payer Group ID
- Other Payer Person Code
- Other Payer Help Desk Phone Number
- Other Payer Patient Relationship Code
- Other Payer Benefit Effective Date
- Other Payer Benefit Termination Date

Note: Items returned are subject to information received on the beneficiary's TPL record(s).

Reimbursement will be calculated to pay the lesser of NC Medicaid's maximum allowed amount, less than the third-party payment, or the Other Payer Patient Responsibility as reported by the primary carrier.

For beneficiaries subject to copays, NC Medicaid copayments will be deducted. In some cases, the resulting Medicaid payment may be $0.00.

The following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes. Where applicable, it has been noted which Other Coverage Code (OCC) should be used based on the error codes received from the primary carrier.

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
0 – Not Specified	Use when beneficiary has no TPL.	• If the member has active TPL, the claim will reject *NCPDP EC 41 – Submit Bill to Other Process or Primary Payer*. • Do not submit additional COB fields when submitting a claim with OCC 0.
1 – No Other Coverage	Use when beneficiary cannot verify other insurance, or states that they do not have other insurance.	• Claims submitted with an OCC 1 will bypass COB and will continue through adjudication.
2 – Other Coverage Exists, Payment Collected	Use when any positive amount of money is collected from another payer.	• Claims will adjudicate when all applicable fields are completed. • Claims submitted without applicable COB fields will reject.
3 – Other Coverage Exists, Claim Not Covered	Use when drug is not covered by primary payer.	
4 – Other Coverage Exists, Payment Not Collected	Use when coverage exists but no payment was collected.	

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
8 – Claim Billing for a Co-Pay	OCC 8 is not allowed.	• Claims submitted with an OCC 8 will deny *NCPDP EC 13 – M/I Other Coverage Code.*

Table 11.1.1-1: NCPDP TPL Codes

For additional information related to NCPDP field submission requirements, refer to the *North Carolina Medicaid Direct NCPDP D.0 Payer Specifications* document on the North Carolina Medicaid Pharmacy Portal.

11.1.2 OCC 3 Reject Codes

Claims submitted with an OCC 3 must be submitted with an applicable NCPDP reject code in the Other Payer Reject Code (NCPDP Field ID: 472-6E) field. Claims submitted with a missing or invalid NCPDP reject code will deny *NCPDP EC 6E – M/I Other Payer Reject Code.*

11.2 Medicare Claims Processing

Some beneficiaries receive both Medicare and Medicaid. When this happens, pharmacies must bill Medicare first for any drugs that Medicare covers.

After Medicare processes the claim:

- If Medicare does not pay the full Medicare-Allowed amount due to deductible or coinsurance, and the drug is not priced higher than Medicaid's allowed amount, the pharmacy may bill Medicaid for the remaining balance.
- Claims paid by Medicare will be exempt from co-pays.

In some instances, certain drugs are only covered by Medicare for specific diagnoses (i.e., Imuran and Methotrexate may only be covered for cancer diagnoses.)

If the beneficiary does not meet Medicare's diagnosis requirements, Medicaid may cover the drug. To override, pharmacy providers may enter a "1" in the Prior Authorization Type Code (NCPDP Field ID: 461-EU) field.

Claims submitted where the beneficiary has Medicare Part B and the product is covered by Part B will deny *NCPDP EC A6 – Prod/Service May Be Covered Under Medicare Part B* and return the additional message, *"Medicare Part B eligible."*

Claims submitted where the beneficiary has Medicare Part D and the product is covered by Part D will deny *NCPDP EC 620 – This Product/Service May Be Covered Under Part D* and return the additional message, *"Bill Medicare Part D."*

If Medicare accepted the claim, but did not collect a payment, the pharmacy must submit:

- OCC (NCPDP Field ID: 308-C8) = 4
- Other Payment Amount Paid (OPAP) (NCPDP Field ID: 431-DV) = $0.00
- Other Payer-Patient Responsibility Amount (OPPRA) (NCPDP Field ID: 352-NQ) = Medicare Co-Pay Amount

If Medicare accepted the claim, and a payment was collected by Medicare, the pharmacy must submit:

- OCC = 2
- OPAP = Amount Paid by Medicare
- OPPRA = Co-Pay Amount

Prime will reimburse the claim at the lesser of the beneficiary's co-pay amount from Medicare, or the NC Medicaid allowed amount minus the Other Payer Amount Paid (if applicable).

Claims submitted with an OCC 2 or 4 where an OPPRA amount has not been submitted or where the value $0 will deny *NCPDP EC NQ – M/I Other Payer Patient Responsibility Amount.*

11.2.1 Qualified Medicare Beneficiary (QMB) Only

Beneficiaries who are of Qualified Medicare Beneficiary (QMB) status will only have coverage for claims paid by Part B for the remaining cost associated with the product after Medicare Part B has paid. No other claims will be paid.

The pharmacy must submit applicable values in these three fields:

- Other Payer-Patient Responsibility Amount Count (NCPDP Field ID: 353-NR)
- Other Payer-Patient Responsibility Amount Qualifier (NCPDP Field ID: 351-NP)
- OPPRA (NCPDP Field ID: 352-NQ)

Claims submitted for beneficiaries eligible for Medicare Part B only (QMB only), for a product not covered by Medicare Part B will deny *NCPDP EC AE – QMB (Qualified Medicare Beneficiary) – Bill Medicare* and return the message, *"Member only has pharmacy coverage for covered Medicare Part B products."*

12.0 340B Drug Discount Program

Federal law prohibits duplicate discounts, which means that manufacturers are not required to provide both a discounted 340B price and a Medicaid drug rebate for the same drug.

To submit 340B claims, receive applicable reimbursement and prevent duplicate discounts, 340B covered entities must submit:

- An SCC (NCPDP Field ID: 420-DK) of '20 – 340B' and
- Basis of Cost (BOC) Determination (NCPDP Field ID: 423-DN) of '08 – 340B/Disproportionate Share Pricing/Public Health Service' on all claims utilizing 340B drugs at the time of submission
- Submit the actual purchased drug price in the Usual and Customary (U&C) field (NCPDP Field ID: 426-DQ).

Claims submitted with SCC '20' and BOC '08' by a non-340B provider will deny *NCPDP EC 6Z – Provider Not Eligible to Perform Service/Dispense Product"* and return the additional message, *"340B claims not allowed for non 340B pharmacies."* This denial may be bypassed by entering an SCC = '99.'

Claims submitted for a 340B provider without an SCC 20 will reject *NCPDP EC 34 – M/I Submission Clarification Code* and return the additional message, *"Claim 340B codes are mismatched."*

Claims submitted for a 340B without a BOC 08 will reject *NCPDP EC DN – M/I Basis of Cost Determination* with the additional message of *"340B pharmacy must submit BOC 08 for 340B claims."*

Claims submitted for a 340B provider with an SCC '20' and BOC '8'entered on the claim, will continue through adjudication and if payable, reimburse at the 340B rate (see *Section 13.4 – 340B Claims Reimbursement* for additional information.)

13.0 Provider Reimbursement

Reimbursement is determined by using the cost per unit times the quantity dispensed plus the dispensing fee (when applicable).

Reimbursement is limited to the applicable drug price in effect on the claim DOS, not on the date of payment.

Claims submitted for products where no valid price type exists will deny *NCPDP EC 85 – Claim Not Processed* and return the additional message, *"No valid adjudication pricing record exists for the NDC."*

Claims submitted where the GAD (NCPDP Field ID: 430-DU) submitted is blank, or $0.00, will deny *NCPDP EC DU – M/I Gross Amount Due*.

Claims submitted where the U&C (NCPDP Field ID: 426-DQ) submitted is blank, or $0.00, will deny *NCPDP EC DQ – M/I Usual and Customary Charge*.

For non-340B claims and non-vaccine claims, the maximum payment is the lower of the following:

- National Average Drug Acquisition Cost (Brand or Generic) + Professional Dispensing Fee, or
- SMAC + Professional Dispensing Fee, or
- GAD, or
- U&C
- For drugs that do not have a published NADAC, or SMAC, the maximum payment will be the lesser of the Wholesale Acquisition Cost (WAC) + Professional Dispensing Fee, or GAD, or U&C
- See *Section 13.4 – 340B Claims Reimbursement* and *Section 13.5 – Vaccine Reimbursement* for additional details on reimbursement for these claim types.

13.1 Professional Dispensing Fees

The dispensing fee for generic drugs or brand-name drugs is based on the Cost of Dispensing study conducted on behalf of the NCDHHS DHB.

Any changes in the dispensing fee amount will be reported in the NC Medicaid Pharmacy Newsletters.

A dispensing fee is paid per covered outpatient prescription.

Dispense fees will not apply to claims submitted for vaccines, condoms, spermicide films or gels, diabetic supplies or IHS pharmacy claims paid at the OMB Encounter Rate.

The following dispensing fees will apply to pharmacy claims:

Non-Hemophilia Claims:

- $10.24 per claim

Hemophilia Claims:

- If a claim is submitted for a hemophilia product by a Hemophilia Treatment Center (HTC), the dispense fee will be $0.04 per unit of drug.
- If a claim is submitted for a hemophilia product by a non-HTC, the dispense fee will be $0.025 per unit of drug.

13.2 Prescription Delivery Fees

Prescriptions for NC Medicaid beneficiaries are eligible for the addition of a mailing or delivery fee via the guidelines in the table below:

Prescription Delivery Fees
Fee for prescriptions delivered by mail (US Postal Service, UPS, FedEx or similar service): $1.50 **Note:** Pharmacies must input an LOS: 02 on the claim in order for the fee to be reimbursed.
Fee for prescriptions to be hand-delivered by the pharmacy provider (Courier, or other person-to-person delivery to the beneficiary or their designee): $3.00 **Note:** Pharmacies must input an LOS: 06 on the claim in order for the fee to be reimbursed.
Additional Notes
• Prescription delivery fees are limited to one mail or delivery fee, per beneficiary, per Pharmacy NPI, per day. Claims exceeding the 1 delivery fee per day will deny *NCPDP EC 78 – Cost Exceeds Maximum* and return the additional message, *"Delivery fee previously paid."* • No more than one delivery fee will be paid on a single claim. • Pharmacies cannot request an emergency supply and a delivery fee on the same claim. • Denied pharmacy claims will not reimburse a mail or delivery fee. • The delivery fee(s) will be reimbursed regardless of the fee amount being entered in the Other Amount Claim – Submitted Qualifier (NCPDP Field ID: 480-H9), so long as the applicable LOS code(s) is entered on the claim. • Delivery fees will not be paid for vaccine claims. • Mailing and delivery fees will be returned on the POS pharmacy transaction in the Other Amount Paid (NCPDP Field ID: 565-J4) field.

Table 13.2-1: Prescription Delivery Fees for NC Medicaid Beneficiaries

13.3 State Maximum Allowable Cost (SMAC) List

The Outpatient Pharmacy program uses a SMAC list for generic and multi-source brand drugs that do not have a NADAC price. NC Medicaid is responsible for determining which products are included on the SMAC list.

- The SMAC list generally includes products with A-rated equivalents and at least two manufacturers.
- SMAC reimbursement is calculated by applying a percentage factor to the lowest-priced generic.
- If this calculation results in a price lower than the second-lowest generic, an additional margin (at least 10 percent) is added to the second-lowest price to set at the SMAC rate.
- The margin varies by product, and the SMAC pricing factor may change as determined by NC Medicaid.

- The SMAC list is posted on the NC Medicaid website: https://medicaid.ncdhhs.gov.

13.3.1 Provider State MAC Inquiries

The NC Medicaid Program contracts with Myers & Stauffer, LLC to manage the SMAC program for generic drugs and hemophilia drugs.

Provider Inquiries

Providers may contact Myers & Stauffer, LLC for:

- Questions about the SMAC rate or how it was calculated.
- Concerns about changes in drug acquisition cost or product availability.
- Requests for a copy of the SMAC list.

SMAC Pricing Inquiry Process

- Providers with questions about the SMAC rate must complete the *State MAC Pricing Inquiry Worksheet* available at State Maximum Allowable Cost (SMAC) and Pricing Inquiry Worksheet.
    - Submit the completed worksheet along with copies of drug purchase records showing the current price paid for the drug(s) in question.

Review and Decision

- Myers & Stauffer, LLC may:
    - Collect additional purchase records from other pharmacies, and/or
    - Contact manufacturers to confirm product availability.
- After reviewing all data, Myers & Stauffer, LLC prepares an analysis for NC Medicaid.
- NC Medicaid will communicate the final decision to the pharmacy.
- If a rate adjustment is approved, the SMAC rate and effective date will be updated in the pharmacy claims processing system.

13.4 340B Claims Reimbursement

13.4.1 340B Regular Ingredient Purchased Drugs

Claims submitted for 340B regular ingredient purchased drugs will be reimbursed at the lower of the following price types:

- 340B Ceiling Rate, if available + Professional Dispensing Fee, or
- NADAC, if available + Professional Dispensing Fee, or
- WAC + Professional Dispensing Fee, or
- SMAC + Professional Dispensing Fee, or
- U&C + Professional Dispensing Fee, or
- GAD

Note: Providers must submit the actual purchased drug price in the U&C field. If the 340B acquisition cost is higher than the 340B Ceiling price, the claim will pay the 340B Ceiling Rate and return the additional message, *"Submitted 340B acquisition cost was higher than expected. Reimbursement will be calculated based on the 340B Ceiling Rate."*

13.4.2 340B Hemophilia/BFC Purchased Drugs

Claims submitted for a 340B Hemophilia/BFC purchased drug will be reimbursed at the lower of the following price types:

- 340B Hemophilia SMAC Rate + Professional Dispensing Fee (see *Section 13.1 – Professional Dispensing Fees* for additional information related to Hemophilia Professional Dispensing Fee rates), or
- U&C, or
- GAD

Note: Providers must submit the actual purchased drug price in the U&C field.

13.5 Vaccine Reimbursement

Claims submitted for a vaccine will be reimbursed at the lower of the following price types:

- Vaccine POS Reimbursement Rate, or
- U&C, or
- GAD

Note: No professional dispensing fee will be reimbursed for vaccines. Refer to the Vaccine Point-of-Sale (POS) Catalogs and Rate Listings site for additional information.

13.6 Indian Health Services/Encounter Rates

Indian Health Service (IHS) | Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U)		
Claims submitted for IHS pharmacies will reimburse at the following OMB encounter rate (determined by the DOS of the claim)		
Effective Start Date	**Effective End Date**	**Value Amount**
01/01/2021	12/31/2021	$519.00
01/01/2022	12/31/2022	$640.00
01/01/2023	12/31/2023	$654.00
01/01/2024	12/31/2024	$719.00

Additional Notes:

- IHS pharmacy claims will not reimburse a dispensing fee when paid at the OMB encounter rate.
- IHS pharmacy claims will not reimburse an administration fee for long-acting injectable claims submitted with an LOS: 5 when paid at the OMB encounter rate.
- IHS pharmacy claims will not reimburse a delivery or shipping fee when paid at the OMB encounter rate.
- The OMB encounter rate(s) will not apply to claims submitted where COB is present and the calculated cost of the claim is >$1,000.00.
- The OMB encounter rate(s) will apply to claims submitted where COB is present and the calculated cost of the claim is < $1,000.00. TPL will be deducted accordingly.
- Claims submitted for a beneficiary using an IHS pharmacy NPI will be exempt from co-pay.
- IHS and I/T/U facilities will receive one (1) OMB encounter rate for each Covered Outpatient Drug (COD) filled or refilled, for a maximum of two (2) OMB encounter payments per beneficiary, per day, per facility. Third and subsequent pharmacy claims for the same day will be reimbursed at $0.00 and return the additional message, *"Max 2 flat rate claims paid*."
- The following products and scenarios are not covered under the OMB encounter rate and will follow the lesser of logic in the tables above:
  - Claims submitted with a total calculated allowable amount > $1,000.00.
    - Total Allowable Amount = Ingredient Cost (Drug Rate x Units) + Dispensing Fee
  - Diabetic testing supplies
  - Drugs dispensed to beneficiaries assigned to family planning
  - Drugs free of charge and vaccines
  - Emergency supplies
  - 340B purchased drugs
  - Claims submitted for a beneficiary with Medicare coverage for Medicare Part B and Part D covered drugs

Note: Compound claims will be treated as one COD.

Table 13.6-1 Indian Health Services Encounter Rates

13.7 Retroactive Medicaid Eligibility and Provider Reimbursement

If a provider bills a private beneficiary for services later determined to be covered under Medicaid, and the beneficiary is found to be retroactively eligible, the provider may submit a claim for Medicaid reimbursement.

Upon receiving payment from Medicaid, the provider must refund the beneficiary for all amounts paid for covered services, except for any third-party payments or cost-sharing amounts.

14.0 Definitions, Abbreviations and Acronyms

Term	Definition
A+Kids	Antipsychotic Safety Kids Programs
ASAP	Antipsychotic Safety Adult Program
BIN	Banking Identification Number
BOC	Basis of Cost
CDC	Centers for Disease Control and Prevention
CII	Schedule II Controlled Substances
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COD	Covered Outpatient Drug
CSC	Clinical Support Center
DAW	Dispense as Written
DD	Drug-to-Drug
DHB	Division of Health Benefits
DME	Durable Medical Equipment
DOS	Date of Service
DUR	Drug Utilization Review
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Early Refill
FDA	Food and Drug Administration
FP	Family Planning
GAD	Gross Amount Due
HD	High Dose
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ID	Identification
IHS	Indian Health Service
I/T/U	Indian Tribe, Tribal Organization, Urban Indian Organization
LAIs	Long-Acting Injectables
LOS	Level of Service
LTC	Long-Term Care
LTE	Less than Effective
MAC	Maximum Allowable Cost
MME	Morphine Milligram Equivalent

Term	Definition
NADAC	National Average Drug Acquisition Cost
NCDHHS	North Carolina Department of Health and Human Services
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NTI	Narrow Therapeutic Index
OCC	Other Coverage Code
OPAP	Other Payer Amount Paid
OPPRA	Oher Payer-Patient Responsibility Amount
OTC	Over-the-Counter
PAs	Prior Authorizations
PDL	Preferred Drug List
PEP	postexposure prophylaxis
POS	Point-of-Sale
Prime	Prime Therapeutics State Government Solutions LLC
ProDUR	Prospective Drug Utilization Review
PSC	Pharmacy Support Center
RetroDUR	Retrospective Drug Utilization Review
SCC	Submission Clarification Code
SMAC	North Carolina State Maximum Allowable Cost
STI	Sexually Transmitted Infections
TPL	Third-Party Liability
TRD	Treatment-Resistant Depression
U&C	Usual and Customary
WAC	Wholesale Acquisition Cost

15.0 Appendices

15.1 Appendix A – Directory

Provider Services	Phone Number/Email/Web Address
Prime Pharmacy Call Center (will connect callers to both the PSC and CSC) Available 24/7/365	Phone: 1-844-620-6116 Fax: 1-866-422-8981
Prime Web Support Call Center Available 8:00 a.m. to 8:00 p.m., Monday-Friday	Phone: 1-844-620-6116
Prime NC Medicaid Pharmacy Portal	https://pba.medicaid.ncdhhs.gov/
PA Appeals	Phone: 984-236-1860 Fax: 984-236-1871 Mail: Attn: Clerk of Court 1711 New Hope Church Road Raleigh, NC 27609
New or Replacement ID Card	888-245-0179
Medicaid Beneficiaries Requesting NEW Medicaid Coverage, Reapplying, Verifying Eligibility	888-245-0179
Department of Public Health (DPH) Beneficiaries Requesting NEW Coverage, Reapplying, Verifying Eligibility	919-707-5000
Department of Mental Health Beneficiaries Requesting NEW Coverage, Reapplying, Verifying Eligibility	919-715-3197
NCDHHS Provider Enrollment	Phone: 800-688-6696 Fax Number: 855-710-1965 E-mail: NCTracksprovider@nctracks.com
North Carolina Medicaid Fraud, Waste, and Program Abuse Tip Line	1-877-362-8471
North Carolina Office of Compliance and Program Integrity	Phone: 1-919-527-7700 Fax Number: 1-919-831-1808
North Carolina Medicaid Fraud and Abuse Confidential Complaint Form	Service Catalog Public - Complaints + Investigations

15.2 Appendix B – ICD-10 CM Codes to Indicate Pregnancy

ICD-10-CM					
• O09.00	• O09.293	• O09.521	• O09.72	• O09.90	• Z34.02
• O09.01	• O09.299	• O09.522	• O09.73	• O09.91	• Z34.03
• O09.02	• O09.30	• O09.523	• O09.811	• O09.92	• Z34.80
• O09.03	• O09.31	• O09.529	• O09.812	• O09.93	• Z34.81
• O09.10	• O09.32	• O09.611	• O09.813	• O36.80X0	• Z34.82
• O09.11	• O09.33	• O09.612	• O09.819	• O36.80x1	• Z34.83
• O09.12	• O09.40	• O09.613	• O09.821	• O36.80X2	• Z34.90
• O09.13	• O09.41	• O09.619	• O09.822	• O36.80X3	• Z34.91
• O09.211	• O09.42	• O09.621	• O09.823	• O36.80X4	• Z34.92
• O09.212	• O09.43	• O09.622	• O09.829	• O36.80X5	• Z34.93
• O09.213	• O09.511	• O09.623	• O09.891	• O36.80X9	
• O09.219	• O09.512	• O09.629	• O09.892	• Z33.1	
• O09.291	• O09.513	• O09.70	• O09.893	• Z34.00	
• O09.292	• O09.519	• O09.71	• O09.899	• Z34.01	

15.3 Appendix C – ICD-10 CM Codes for Cancer Diagnoses

ICD-10 Disease Blocks	Disease Block Descriptions
C00-C14	Malignant Neoplasms of Lip, Oral Cavity and Pharynx
C15-C26	Malignant Neoplasms of Digestive Organs
C30-C39	Malignant Neoplasms of Respiratory and Intrathoracic Organs
C40-C41	Malignant Neoplasms of Bone and Articular Cartilage
C43-C44	Melanoma and Other Malignant Neoplasms of Skin
C45-C49	Malignant Neoplasms of Mesothelial and Soft Tissue
C4A	Merkel Cell Carcinoma
C50	Malignant Neoplasm of Breast
C51-C58	Malignant Neoplasms of Female Genital Organs
C60-C63	Malignant Neoplasms of Male Genital Organs
C64-C68	Malignant Neoplasms of Urinary Tract
C69-C72	Malignant Neoplasms of Eye, Brain and Other Parts of Central Nervous System
C76-C80	Malignant Neoplasms of Ill-Defined, Other Secondary and Unspecified Sites
C7A	Malignant Neuroendocrine Tumors
C7B	Secondary Neuroendocrine Tumors
C81-C96	Malignant Neoplasms of Lymphoid, Hematopoietic and Related Tissue

15.4 Appendix D – ICD-10 CM Codes for Sickle Cell Diagnoses

ICD-10 Codes	ICD-10 Descriptions
D57	Sickle Cell Disorders
D57.0	HB-SS Disease with Crisis
D57.00	HB-SS Disease with Crisis, Unspecified
D57.01	HB-SS Disease with Acute Chest Syndrome
D57.02	HB-SS Disease with Splenic Sequestration
D57.1	Sickle-Cell Disease without Crisis
D57.2	Sickle Cell/HB-C Disease
D57.20	Sickle Cell/HB-C Disease without Crisis
D57.21	Sickle Cell/HB-C Disease with Crisis
D57.211	Sickle Cell/HB-C Disease with Acute Chest Syndrome
D57.212	Sickle Cell/HB-C Disease with Splenic Sequestration
D57.219	Sickle Cell/HB-C Disease with Crisis, Unspecified
D57.4	Sickle Cell Thalassemia
D57.40	Sickle Cell Thalassemia without crisis
D57.41	Sickle Cell Thalassemia with crisis
D57.411	Sickle Cell Thalassemia with Acute Chest Syndrome
D57.412	Sickle Cell Thalassemia with Splenic Sequestration
D57.419	Sickle Cell Thalassemia with Crisis, Unspecified
D57.8	Other Sickle Cell Disorders
D57.80	Other Sickle Cell Disorders without crisis
D57.81	Other Sickle Cell Disorders with crisis
D57.811	Other Sickle Cell Disorders with Acute Chest Syndrome
D57.812	Other Sickle Cell Disorders with Splenic Sequestration
D57.819	Other Sickle Cell Disorders with Crisis, Unspecified

15.5 Appendix E – ICD-10 CM Codes for Moderate to Severe Pain Diagnoses

ICD-10 Codes	ICD-10 Descriptions
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
G89.0	Central pain syndrome
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute postprocedural pain
G89.21	Chronic pain due to trauma
G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic postprocedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
H57.10	Ocular pain, unspecified eye
H57.11	Ocular pain, right eye
H57.12	Ocular pain, left eye
H57.13	Ocular pain, bilateral
H92.01	Otalgia, right ear
H92.02	Otalgia, left ear
H92.03	Otalgia, bilateral
H92.09	Otalgia, unspecified ear
K08.89	Other specified disorders of teeth and supporting structures
K08.9	Disorder of teeth and supporting structures, unspecified
K14.6	Glossodynia
M25.50	Pain in unspecified joint
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.519	Pain in unspecified shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.529	Pain in unspecified elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M25.539	Pain in unspecified wrist
M25.541	Pain in joints of right hand

ICD-10 Codes	ICD-10 Descriptions
M25.542	Pain in joints of left hand
M25.549	Pain in joints of unspecified hand
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559	Pain in unspecified hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569	Pain in unspecified knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.579	Pain in unspecified ankle and joints of unspecified foot
M25.59	Pain in other specified joint
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M54.81	Occipital neuralgia
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M79.0	Rheumatism, unspecified
M79.10	Myalgia, unspecified site
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site
M79.2	Neuralgia and neuritis, unspecified
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.603	Pain in arm, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.606	Pain in leg, unspecified

ICD-10 Codes	ICD-10 Descriptions
M79.609	Pain in unspecified limb
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.629	Pain in unspecified upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.639	Pain in unspecified forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.643	Pain in unspecified hand
M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.646	Pain in unspecified finger(s)
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676	Pain in unspecified toe(s)
M79.7	Fibromyalgia
N23	Unspecified renal colic
N64.4	Mastodynia
R07.0	Pain in throat
R07.1	Chest pain on breathing
R07.2	Precordial pain
R07.81	Pleurodynia
R07.82	Intercostal pain
R07.89	Other chest pain
R07.9	Chest pain, unspecified
R10.0	Acute abdomen
R10.10	Upper abdominal pain, unspecified

ICD-10 Codes	ICD-10 Descriptions
R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.13	Epigastric pain
R10.2	Pelvic and perineal pain
R10.30	Lower abdominal pain, unspecified
R10.31	Right lower quadrant pain
R10.32	Left lower quadrant pain
R10.33	Periumbilical pain
R10.811	Right upper quadrant abdominal tenderness
R10.812	Left upper quadrant abdominal tenderness
R10.813	Right lower quadrant abdominal tenderness
R10.814	Left lower quadrant abdominal tenderness
R10.815	Periumbilic abdominal tenderness
R10.816	Epigastric abdominal tenderness
R10.817	Generalized abdominal tenderness
R10.819	Abdominal tenderness, unspecified site
R10.821	Right upper quadrant rebound abdominal tenderness
R10.822	Left upper quadrant rebound abdominal tenderness
R10.823	Right lower quadrant rebound abdominal tenderness
R10.824	Left lower quadrant rebound abdominal tenderness
R10.825	Periumbilic rebound abdominal tenderness
R10.826	Epigastric rebound abdominal tenderness
R10.827	Generalized rebound abdominal tenderness
R10.829	Rebound abdominal tenderness, unspecified site
R10.84	Generalized abdominal pain
R10.9	Unspecified abdominal pain
R51.9	Headache, unspecified
R52	Pain, unspecified

15.6 Appendix F – Family Planning STI Medication and Diagnosis List

All prescriptions for FP beneficiaries for family planning STI medications must include a primary diagnosis and one of the following diagnoses:	
STI Diagnosis	**Approved Medications**
Herpes	• Acyclovir 200mg, 400mg, 800mg • Famciclovir 125mg, 250mg, 500mg • Valacyclovir 500mg. 1.0gm
Chlamydia	• Azithromycin 250mg, 500mg, 1gm • Doxycycline 100mg • Erythromycin 250mg, 400mg, 500mg, 800mg • Ofloxacin 200mg, 300mg, 400mg • Levofloxacin 500mg • Tetracycline 250mg, 500mg
Syphilis	• Azithromycin 1gm • Benzathine Penicillin G 2.5 million units • Ceftriaxone 250mg • Ciprofloxacin 500mg • Doxycycline 100mg • Erythromycin 500mg • Tetracycline 500mg
Gonorrhea	• Azithromycin 250mg, 500mg, 1gm • Cefixime 400mg • Ceftriaxone 125mg, 250mg, 500mg • Cefotaxime 500mg • Cefoxitin 2gm with Probenecid 1gm • Ciprofloxacin 250mg, 500mg • Cefpodoxime 200mg • Doxycycline 100mg • Gatifloxacin 400mg • Levofloxacin 250mg • Ofloxacin 400mg • Sulfamethoxazole/TMP • Gentamicin 240mg IM
Other Sexually Transmitted Infections	• Azithromycin 250mg, 500mg, 1gm • Doxycycline 100mg • Erythromycin 500mg, 800mg • Gatifloxacin 400mg • Levofloxacin 250mg, 500mg • Ofloxacin 200mg, 300mg 400mg • Moxifloxacin 400mg

All prescriptions for FP beneficiaries for family planning STI medications must include a primary diagnosis and one of the following diagnoses:	
STI Diagnosis	**Approved Medications**
Candidiasis	• Butoconazole 2% cream • Fluconazole 50mg, 100mg. 150mg, 200mg • Miconazole 200mg suppository • Terconazole 80mg suppository • Terconazole cream 0.4%, 0.8%
Trichomoniasis	• Metronidazole 250mg, 500mg. 750mg. 2gm • Tinidazole 2000mg
Bacterial Vaginosis	• Metronidazole 250mg, 500mg • Metronidazole Gel 0.75% • Clindamycin cream 2% • Clindamycin oral 150mg, 300mg • Clindamycin ovules 100mg • Tinidazole 250mg, 500mg, 1gm, 2gm
Pubic Louse	• Permethrin 5% cream • Lindane 1% shampoo

15.7 Appendix G – Postoperative Sterilization Medication and Diagnosis List

All prescriptions for postoperative sterilization for family planning beneficiaries must include a primary diagnosis and a sterilization diagnosis.	
Drug Type	**Approved Medications**
Antibiotics	• Amox TR-K CLV 500-125mg; 1000-62.5mg • Amoxicillin 250mg, 500mg • Cephalexin 250mg; 500mg • Doxycycline 100mg • Erythromycin ES 400mg • Levofloxacin 500mg • Metronidazole 500mg • Penicillin VK 500mg • Sulfamethoxazole/TMP DS • Azithromax 250mg
Analgesics	• Acetaminophen/Cod #2, #3 • Hydrocodone/Acetaminophen 5/325mg, 5/500mg, 7.5/325mg, 7.5/500mg, 7.5/650mg, 7.5/750mg, 10/325mg, 10/500mg, 10/650mg, 10/660mg, 10/750mg • Hydrocodone/Ibuprofen 2.5/200mg, 5/200mg, 7.5/200mg, 10/200mg • Ibuprofen 400mg, 600mg, 800mg • Ketorolac 10mg • Naproxen 500mg • Naproxen Sodium 550mg • Oxycodone 5mg • Oxycodone/Acetaminophen 2.5/325mg, 5/325mg, 7.5/325mg, 7.5/500mg, 10/325mg, 10/650mg
Antiemetics	• Promethazine 25mg