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1.0 Introduction

1.1 Description
Florida Medicaid prescribed drug services provide outpatient prescription drugs to recipients.

1.1.1 Florida Medicaid Policies
This policy is intended for use by prescribed drug providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s general policy and any applicable service-specific and claim reimbursement policies with which providers must comply.


1.1.2 Statewide Medicaid Managed Care Plans
This Florida Medicaid policy provides the minimum requirements for all providers of prescribed drug services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration’s (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.

1.2 Legal Authority
Prescribed drug services are authorized by the following:
- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Chapter IV
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.250, F.A.C.

1.3 Definitions
1.3.1 Claim Reimbursement Policy
A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy
A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 General Policy
A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Long-term Care Plan
A managed care plan that provides services in accordance with section 409.98, F.S., for the long-term care program of the Statewide Medicaid Managed Care program.

1.3.5 Managed Medical Assistance Plan
A managed care plan that provides services in accordance with section 409.973, F.S., for the medical assistance program of the Statewide Medicaid Managed Care program.

1.3.6 Medically Necessary/Medical Necessity
In accordance with Rule 59G-1.010, F.A.C., “The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.”

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.”

1.3.7 National Drug Code
Eleven-digit number which serves as a universal product identifier for drugs (also referred to as NDC).

1.3.8 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.9 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient’s eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary prescribed drug services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

3.0 Eligible Provider

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Directly enrolled with Florida Medicaid if providing services through a fee-for-service delivery system
- Registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Pharmacies permitted by the Department of Health in accordance with Chapter 465, F.S.
- Practitioners, licensed in accordance with section 465.0276 F.S., and registered with their professional licensing board as a dispensing practitioner
4.0 Coverage Information

4.1 General Criteria
Florida Medicaid reimburses services that:

- Are determined medically necessary.
- Do not duplicate another service.
- Meet the criteria as specified in this policy.

4.2 Specific Criteria
Florida Medicaid reimburses for AHCA-approved drugs on the Prescription Drug List (PDL) developed and maintained in accordance with section 409.912, F.S. The Agency for Health Care Administration determines whether it is feasible to add a recommended drug to the PDL based on an assessment of the drug’s cost-effectiveness, clinical efficacy, and safety.

Florida Medicaid may reimburse for drugs that are not on the PDL, in accordance with section 409.912, F.S.

4.2.1 Immunizations and Vaccines
Florida Medicaid reimburses for the following for recipients residing in a nursing facility:

- One influenza vaccine per year, per recipient
- One pneumococcal vaccine every five years, per recipient
- One shingles vaccine per recipient aged 50-64

4.2.2 Over-the-Counter Drugs
Florida Medicaid reimburses for over-the-counter drugs listed on the PDL with a prescription from a licensed practitioner.

4.2.3 Mail Order Pharmacies
Florida Medicaid reimburses for mail order services provided by pharmacies located in Florida when they meet the following:

- Services present no additional cost to the recipient or Florida Medicaid
- Advertising or promotional materials meet the following:
  - Clearly state recipient participation is voluntary and does not preclude their receiving services through other providers
  - Do not claim the provider is recommended, or endorsed, by any state or county agency
  - Do not state, or imply, recipients will lose benefits if they do not enroll with the provider
- The provider replaces lost shipments at no additional cost to the recipient or Florida Medicaid

4.2.4 Physician-Administered Drugs
Florida Medicaid reimburses for physician-administered drugs when prescribed in a physician’s office.

5.0 Exclusion

5.1 General Non-Covered Criteria
Services related to this policy are not reimbursed when:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider’s service.
5.2 Specific Non-Covered Criteria
Florida Medicaid does not reimburse for the following:

- Automatic fills (original or refill) not requested by a recipient
- Drugs classified ineffective by the Centers for Medicare and Medicaid Services (CMS): Drugs Efficacy Study Implementation and Identical, Related and Similar drugs
- Drugs from a manufacturer not licensed in accordance with Chapter 499, F.S.
- Drugs from a manufacturer that does not have a rebate agreement with CMS
- Drugs used to treat infertility or enhance fertility
- Erectile dysfunction drugs
- Drugs for cosmetic use
- Drugs administered to recipients who are hospitalized or receiving services in an emergency department
- Drugs given by a hospital or ambulatory surgery center in conjunction with laboratory, x-ray, and other medical procedures
- Drugs dispensed to recipients in a skilled nursing facility that are covered by Medicare Part A
- Over-the-counter drugs, supplies, food supplements, and vitamins that are considered floor stock in a long-term care facility
- Drugs used for treatment, relief of pain, or symptom control related to a recipient’s terminal illness and related condition(s) when covered under the hospice benefit
- Hair growth restorers
- Medicare Part D copayment, deductibles, or coinsurance and prescriptions not covered due to the Medicare Part D coverage gap
- Oxygen, blood, and blood plasma
- Replacement services due to lost shipments or provider error
- Weight control medications
- Interdialytic parenteral nutrition administered during a dialysis session

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid’s recordkeeping and documentation policy.

6.2 Specific Criteria
Providers must use a counterfeit-proof prescription pad produced by an AHCA-approved vendor when writing hard copy prescription(s), in accordance with section 409.912, F.S.

Specifications and a list of approved vendors can be found on the fiscal agent’s Web site at http://portal.flmmis.com/FLPublic.

7.0 Authorization

7.1 General Criteria
As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

For recipients enrolled in a managed care plan, providers should request authorization through the recipient’s managed care plan. For recipients receiving services through the fee-
for-service delivery system, providers should request authorization through the Florida Medicaid Pharmacy Benefit Manager.

7.2 Specific Criteria
The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For information on authorization submission requirements, please refer to Florida Medicaid’s authorization policy.

Providers must obtain authorization from the Florida Medicaid Pharmacy Benefit Manager in the following circumstances:

- Change in therapy or increased dose for an early refill
- Drug is not on the PDL
- Indication not approved in labeling
- When indicated on the PDL

7.2.1 72-Hour Emergency Supply
During hours that the prior authorization line is not available, dispensing pharmacies will be reimbursed for the ingredient cost plus a dispensing fee for a 72-hour emergency supply. Reimbursement for emergency supply is limited to twice per recipient for the same generic sequence number within 30 consecutive days. The dispensing pharmacy cannot override claim system edits for drugs requiring a clinical prior authorization review, early refill rejections, high dose rejections, or for drugs restricted because of the patient’s age or eligibility issues.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

8.2.1 Partial Returns
Florida Medicaid reimburses providers a dispensing fee, a $5.00 restocking fee, and a unit dose repackaging fee for the product quantity submitted on the re-bill transaction.

8.2.2 Partial Filling
Florida Medicaid reimburses for partial filling of a prescription due to inventory constraints or other reasons. The dispensing fee will be applied to the initial fill. Providers must not split a dispensed prescription into multiple claims to generate multiple dispensing fees. No dispensing fee will be reimbursed when the prescription is completed.

Providers must use the partial fill coding designated in the National Council for Prescription Drug Program (NCPDP) standards.

Partial fills cannot be submitted using the Universal Claim Form (UCF).

Compounds cannot be submitted as partials.

8.2.3 Unit Dose Preparation Fee
Florida Medicaid reimburses providers an additional $0.015 per unit, for the first 120 units, for in-house unit dose packaging of tablets or capsules, per prescription when the drug is not otherwise available in unit-dose packaging.

8.2.4 Total Parenteral Nutrition
Florida Medicaid reimburses for total parenteral nutrition (TPN) for recipients in their homes when supplied by pharmacies that are equipped and licensed to prepare...
sterile intravenous products. Total parenteral nutrition is reimbursed as a compounded product; separate claims for the TPN components are not allowed.

8.3 Claim Type
Point-of-Sale/NCPDP UCF

8.4 Billing Code, Modifier, and Billing Unit
Providers must report the entire 11-digit NDC for the actual product dispensed.

Florida Medicaid requires reporting of NDCs on all claims for physician-administered drugs (J, Q, and S codes).

8.5 Rate
Florida Medicaid reimburses providers in accordance with Rule 59G-4.251, F.A.C.