



## Division of Public Health Purchase of Medical Care Services (POMCS)

# Pharmacy Billing Guide

10-20-2008

Volume 1, Number 2

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POMCS Website:  
<http://www.ncdhhs.gov/control/pomcs/pomcs.htm>

This guide has been prepared to assist pharmacy providers in billing the following Purchase of Medical Care Services (POMCS) fee for service payment programs.

**Adult Cystic Fibrosis Program**  
**Children's Special Health Services (CSHS)**  
**Kidney Program**  
**Migrant Health Program**  
**Sickle Cell Program**

### ADULT CYSTIC FIBROSIS PROGRAM

- The Adult Cystic Fibrosis Program reimburses for durable medical equipment (DME), oral formula and condition-related over-the-counter (OTC) drugs and supplies.

### CHILDREN SPECIAL HEALTH SERVICES (CSHS)

- The Children's Special Health Services Program is available to children who are not eligible for Medicaid. For children with post-adoption coverage, CSHS reimburses for prescription drugs, DME, oral formula, condition-related OTC drugs and supplies.

### KIDNEY PROGRAM

- The Kidney Program covers persons with End Stage Renal Disease who require dialysis or transplantation.
- Program payments are limited to \$300.00 per patient per fiscal year (July 1 - June 30).
- The program reimburses for condition-related drugs and supplies on the "Guidance for Payment of Kidney Program Pharmacy Claims" bulletin which can be found on the POMCS website.
- Providers should keep a record of the total amount received by individual patients to assist in monitoring the yearly

payment limit.

- Providers should not assume former patients will remain eligible and should always inquire about the patient's authorization if they do not have it.
- The program does not require prescriptions for OTC items.
- The "reference number" column on the claim form does not require a prescription number.

## **MIGRANT HEALTH PROGRAM**

- The Migrant Health Program reimburses for prescribed drugs and OTC drugs and supplies included on the Migrant Health Formulary. (However, due to funding constraints prescription drugs, OTC, DME, and supplies are **not currently covered**).
- The allowable patient co-payment is \$6.00 for each prescribed drug and supply and \$5.00 per claim, per date of service for all other services

## **SICKLE CELL PROGRAM**

- The Sickle Cell Program covers medications listed on the program formulary. This formulary is posted on the POMCS website.
- Erythropoietin (Epogen/Procrit) requires approval through a special application process.

## **POMCS Requirements**

### **Step 1: Financial Eligibility Determination**

- Clients must complete a financial eligibility application with a financial interviewer to assess their ability to pay for medical care using program guidelines and income scales.
- For the Migrant program, DHHS Form 3753 must be completed and forwarded to POMCS by an interviewer from one of the designated Migrant Health Entry Points. The Migrant Health Program does not use the Financial Eligibility Application (DHHS Form 3014).

### **Step 2: Authorization of Service**

- Requested services must be authorized before payment can be made, except in the Migrant Health Program.
- Authorization Request (DHHS Form 3056) must be submitted to Purchase of Medical Care Services with a physician's signature within 1 year after the date of service or it will be denied.
- Authorization Requests will be approved, denied, or placed in pending status for additional information within 45 days after receipt date. If additional information is requested it must be received within one year after the date of service or within 30 days after we request the additional information, which ever is later. If it is not received within that time the Authorization Request will be denied.
- Providers will receive a Reply to Authorization Request explaining if the service was approved or denied or requires

additional information. If additional information is needed to process the request, providers will receive a Request for Additional Information

- Migrant Health Program participants must have a current approved Eligibility Application (DHHS Form 3753) on file with Purchase of Medical Care Services before a claim can be paid.
- Pharmacy changes must be authorized before payment can be made to a new pharmacy.

### **Step 3: Claims**

Claims for authorized services must be received by POMCS within 1 year after the date of service or within 45 days after the service was approved, whichever is later or they will be denied.

### **Claim Forms**

- **Pharmacy Claim Form DHHS 3058** - A revised pharmacy claim form is available upon request or on the website and should be used for billing legend drugs and OTC drugs. Use of the revised form will be mandatory effective 01/01/07. Please note the following are required items:
  - Identify drug as brand or generic
  - Dispensing fee for brand or generic drug
- **HCFA/CMS 1500** – Use to bill DME, medical supplies, oral formula having HCPCS codes and OTC drugs. A list for HCPC codes is available upon request. When billing OTC drugs using this form, write “No Code” in the procedure code column. Please refer to the DME, Supplies and Oral Formula billing guide.

### **Claims Requirements**

- Claims must be received within one year after the dispensing date or they will be denied.
- Chain stores should include individual store numbers along with addresses.
- Enter last name, first name and middle initial, in that order on the claim form.
- Include the client's date of birth to the right of his/her name on the form.
- **Write the program name, Medicaid provider number and patient's case and authorization number on the claim in the spaces provided.**

### **Reimbursement**

- **Drugs** – Prescription drugs are paid at the Medicaid rate plus a dispensing fee (one fee per prescription drug per month). The dispensing fee must be billed to be paid. When the physician has written "Dispense as Written" in his handwriting on a prescription, the override "OA" should be entered on the claim form in the last two digits of the NDC number.
- **Formularies** - All POMCS program formularies are subject to change. Formularies are posted on the POMCS website
- **Medicaid co-payments** - DHHS programs do not pay the Medicaid co-payment or in any other way supplement

## Refunds of DHHS Payments

Refunds  
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Medicaid payments on Medicaid eligible patients.

- **DME, Medical Supplies, and Oral Formula** – These are also reimbursed at the Medicaid rate based on the item's HCPCS procedure code. Items for which there are no Medicaid rates are paid at the usual charge to the general public. A sales tax charge may not be added for prescription drugs or for equipment and supply items paid according to Medicaid code. The Medicaid rate is inclusive of tax and freight.
- **Response time to claims** - POMCS will make payment for an authorized service or provide a response within 45 days after receipt of a correctly completed claim.
- **Billing patient prohibited** - Providers may not bill the patient for any drug for which they have accepted partial or total payment from the program. Patients may only be billed for items for which the provider does not accept program payment. If a provider receives a third party payment after the program has paid, they must refund the lesser of the two amounts to the program.

### Medicaid Eligible Clients

- **DHHS programs will not cover services that should be covered by Medicaid.** Claims for services covered by Medicaid must be billed directly to Medicaid. If Medicaid pays the claim after DHHS has made payment, the full DHHS payment should be returned to DHHS. **Note:** Children's Special Health Services will accept claims for authorized durable medical equipment and certain supplies if the patient has Medicaid. Claims for diabetic supplies, tracheostomy supplies, enteral formula, equipment or supplies used to administer enteral formula and supplies on the Medicaid home health fee schedule must be billed directly to Medicaid.
- **Retroactive Medicaid coverage** - If the patient receives retroactive Medicaid coverage for dates of service paid by DHHS, the provider must bill Medicaid and return the DHHS payment.

### Refunds

- If another third party payor pays the claim after DHHS has made payment, the lesser of the two payments should be returned to DHHS.
- Refunds should identify the patient, program, case and authorization numbers.

State of North Carolina  
Michael F. Easley, Governor  
North Carolina Department of Health and Human Services  
Dempsey Benton, Secretary