



Handbook for Providers of Pharmacy Services

Chapter P-200 Policy and Procedures For Pharmacy Services

Illinois Department of Healthcare and Family Services

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Chapter P-200

Pharmacy Services

Table of Contents

[Foreword](#)

[Acronyms and Definitions](#)

P-200 [Basic Provisions](#)

P-201 [Provider Enrollment](#)

- 201.1 Enrollment Requirements Specific to Pharmacy Providers
- 201.2 Enrollment Approval
- 201.3 Enrollment Denial
- 201.4 Provider File Maintenance
- 201.5 Changes in Ownership, Corporate Structure or Location
- 201.6 Changes to the Pharmacist-In-Charge

P-202 [Claim Preparation and Submittal](#)

- 202.1 Charges
- 202.2 Third Party Payment Sources
- 202.3 Charges for 340B Providers
- 202.4 Claims for Medicare Part B Covered Services
- 202.5 Prescriber Information
- 202.6 Electronic Claims Submittal
- 202.7 Direct Data Entry (DDE) Through MEDI
- 202.8 Paper Claims
- 202.9 Paper Claims for Multiple Dates of Service Wherein Participant is Eligible Under Different Programs

P-203 [Reimbursement](#)

- 203.1 Reimbursement Methodology
- 203.2 Copayments
- 203.3 Remittance Advice
- 203.4 Electronic Claims Status Inquiry

P-204 [Covered Services and Coverage Limitations](#)

- 204.1 Refill-Too-Soon
- 204.2 Preferred Drug List (PDL)
- 204.3 Three Brand Name Drug Limit
- 204.4 Quantity
- 204.5 Daily Dose Limits

- 204.6 Durable Medical Equipment (DME)
- 204.7 Emergency Contraceptives
- 204.8 Copay only Billing
- 204.9 Administration of Vaccines
- 204.10 Blood Clotting Factor
- 204.11 Ninety (90) Day Supply
- 204.12 Fourteen (14) Day Supply for Long Term Care Residents
- 204.13 Four (4) Prescription Policy

P-205 Prior Approval Information

- 205.1 Prior Approval – General Information
- 205.2 Prior Approval Requests
- 205.3 Documentation Required For Prior Approval Requests
- 205.4 Notification of Disposition of Prior Approval Request
- 205.5 Timeliness of Prior Approval Requests
- 205.6 Post Approvals

P-206 Non-Covered Services

- 206.1 Returned Pharmacy Items
- 206.2 Medicare Part D Covered Drugs
- 206.3 Certain Prescription Pharmacy Items
- 206.4 Certain Items Dispensed to Long Term Care Facility Residents
- 206.5 Certain Items Dispensed to Hospice Patients
- 206.6 OTC Items Dispensed to All Kids Premium Level 2 through 8 Participants
- 206.7 Limited Coverage Over-the-Counter Items
- 206.8 Durable Medical Equipment and Supply Items

P-208 Filling of Prescriptions

- 208.1 Prescription Forms
- 208.2 Verbal Prescriptions
- 208.3 Tamper Resistant Pads
 - 208.3.1 Tamper Resistant Characteristics
 - 208.3.2 Managed Care Participants
 - 208.3.3 Medicaid as a Secondary Payer
 - 208.3.4 72-Hour Grace Period
 - 208.3.5 Computer-Generated Prescriptions
- 208.4 Refills
- 208.5 Pharmacists Ineligible to Participate in the Medicaid Program

P-209 Documentation and Record Keeping Requirements

- 209.1 Invoices
- 209.2 Transfer of Stock
- 209.3 Prescription Record Requirements

P-210 Recipient Restriction Program

Appendices

- P-1 Technical Guidelines for Paper Claim Preparation Form HFS 215, Drug Invoice
- P-2 Technical Guidelines for Paper Claim Preparation [Form HFS 3797, Medicare Crossover Invoice \(pdf\)](#)
- P-3 Explanation of Information on [Provider Information Sheet](#)
- P-3a Facsimile of Provider Information Sheet
- P-4 Third Party Liability Billing Instructions
- P-5 Medications Subject to the 90 Day Supply Policy

Foreword

Purpose

This handbook, along with recent [provider notices](#), will act as an effective guide to your participation in the [Department's Medical Programs](#). It also provides supplemental information on the Department's requirements for provider participation and enrollment specific to pharmacy providers.

[The Pharmacy Handbook](#) can be viewed on the Department's website.

It is important that both the provider of service and the provider's billing personnel read all materials, prior to providing services, to ensure a thorough understanding of the Department's policies and procedures. Revisions and supplements to this Handbook will be released as operating experience and/or state or federal regulations necessitate. The updates will be posted to the Department's website on the [Provider Notices page](#).

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The [Recipient Eligibility Verification \(REV\) System](#), the Automated Voice Response System (AVRS) at 1-800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

Providers will be held responsible for compliance with all policies and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Pharmacy Services at 1-877-782-5565, Option 7 or 217-782-5565, Option 7.

Acronyms and Definitions

Carry-Over Days: Carry-Over Days is a component of the Department's Refill-Too-Soon editing. Carry-Over Days is the number of days left on the preceding prescription when a refill is filled early. For claims editing purposes, the total number of Carry-Over Days is added to the day's supply of the refill, and the sum total of those two numbers is then used in subsequent Refill-Too-Soon editing.

Compound Drug: A compound drug is defined as a pharmaceutical product that results from the combining, mixing, or altering of two or more ingredients, excluding flavorings, to create a customized medication for an individual patient in response to a licensed practitioner's prescription.

Department of Healthcare and Family Services (HFS) or (Department): The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs, including [All Kids](#), [FamilyCare](#), Veterans Care, and [Health Benefits for Workers with Disabilities \(HBWD\)](#).

Dual Eligible: A Dual Eligible is an individual who is eligible for both Medicare (Part A and/or Part B) and Medicaid at the same time.

Durable Medical Equipment (DME): Durable Medical Equipment refers to non-drug, healthcare related equipment items prescribed for a patient, such as blood glucose monitors and nebulizers.

Innovator: The manufacturer whose name is listed on the application to FDA for approval of a new drug. In the case where the original manufacturer does not market the new drug, but licenses another company to exclusively market the product, the marketer is known as the innovator.

Legend Drug: A legend drug is any drug that, under state and/or federal laws and regulations, can only be dispensed by prescription.

[Medical Electronic Data Interchange \(MEDI\)](#): The Medical Electronic Data Interchange is the Department's secure website that allows providers or their authorized representatives to check Medical Assistance eligibility, submit claims and prior authorization requests, check claim status or download remittance advices.

Multi-Source Drug: A drug marketed or sold by two or more manufacturers or labelers.

[National Provider Identifier \(NPI\)](#): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the [National Provider Identifier \(NPI\)](#).

National Drug Code (NDC): A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The [National Drug Code \(NDC\)](#) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type. All products billed through the Pharmacy Program are billed using an NDC.

Over-the-Counter (OTC) Drug/Product: An over-the-counter drug/product is any drug/product that, under state and federal laws and regulations, can be dispensed without a prescription or purchased without a prescription.

Pharmacy Practice Act: The Pharmacy Practice Act is the Illinois state law that governs the practice of pharmacy in the State of Illinois.

Provider Information Sheet: A Provider Information Sheet is a document generated by HFS' Provider Enrollment Section (PES) that contains provider-specific data elements from the Department's Provider Database. The Provider Information Sheet is shared with the enrolled provider and is used to ensure that the provider's information in the Department's records is accurate.

Provider Enrollment Section (PES): The section of the [Department of Healthcare and Family Services](#) that is responsible for maintaining provider enrollment records.

Refill-Too-Soon: Refill-Too-Soon is an edit in the Department's claims processing system that prevents prescriptions from being refilled too early.

[Section 1927 of the Social Security Act \(SSA\)](#): Section 1927 of the Social Security Act is the Section of the SSA that contains provisions under which state Medicaid pharmacy programs must operate in order to be eligible for federal matching funds.

Single-Source Drug: A single-source drug is a drug, available from only one manufacturer, and is still under patent protection; or a drug that is no longer available from the patent holder and only one generic equivalent is available.

State Maximum Allowable Cost (SMAC): The State Maximum Allowable Cost (SMAC) is a Department-established maximum reimbursement rate for drugs and non-drug items.

Usual and Customary (U & C) Charge: The usual and customary charge is the amount a provider would charge cash customers for a prescription, exclusive of sales tax.

Chapter P-200

Pharmacy Services

P-200 Basic Provisions

Pharmacy providers must enroll in the Department's Medical Assistance Programs to be eligible for payment by the Department via the Illinois Medicaid Program Advanced Cloud Technology [IMPACT](#) system. In order to be eligible for reimbursement, services must be provided in full compliance with the policies and procedures contained in this handbook and the general provisions contained in [Chapter 100, Handbook for Providers of Medical Services](#).

P-201 Provider Enrollment

P-201.1 Enrollment Requirements Specific to Pharmacy Providers

A pharmacy holding a valid license, issued by the state in which the pharmacy is located, is eligible to be considered for enrollment in the Department's Medical Assistance Programs. A pharmacy cannot enroll as an HFS provider until the pharmacy is issued a license. Application for license does not qualify the pharmacy for consideration for enrollment with the Department.

A pharmacy located in and/or administratively associated with a long term care facility or group medical practice must provide the same scope of pharmacy services as a pharmacy not so affiliated, and must be retail in nature, and open and accessible to the general public. A pharmacy may not limit their pharmacy services to those prescriptions written by a particular:

- Prescriber.
- Group of prescribers.
- Group practice.

In compliance with the Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#), Illinois has an electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)).

Illinois IMPACT is a multi-agency effort to replace the Department's Medicaid Management Information System (MMIS) with a web-based system that meets federal requirements, is more convenient for providers and increases efficiency by automating and expediting state agency processes.

Under the IMPACT system, category of service(s) (COS) is replaced with [Specialties and Subspecialties](#). When enrolling in [IMPACT](#), a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

Refer to [IMPACT Provider Types, Specialties and Subspecialties](#) for additional information.

P-201.2 Enrollment Approval

Upon approval of a provider enrollment application, the provider will receive a computer-generated notification, the [Provider Information Sheet](#), listing data on the Department's provider files. The provider should review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix P-3.

If all information is correct, the provider should retain the [Provider Information Sheet](#) for subsequent use in completing claims to ensure that all identifying information

required is an exact match to that in the Department files. If any of the information is incorrect, refer to [Topic P-201.4](#).

P-201.3 Enrollment Denial

If a provider's application for participation in the Department's Medical Assistance Programs is denied, upon denial, the provider will receive written notification of the reason for denial. If the provider disagrees with the Department's actions, the provider may, within 10 days of receipt of the written notification, submit a request for a hearing. The notification provides instructions regarding requesting for a hearing. The Department will notify the provider in writing of the date, time, and place of the review hearing. Refer to [89 Ill. Adm. Code, Part 104, Subpart C](#) for complete details of the hearing process.

Providers requesting reinstatement following termination should send the request in writing to the Office of Inspector General at:

Office of Inspector General
404 North 5th Street
Springfield, IL 62702

P-201.4 Provider File Maintenance

The provider information in the Department's files must be current, and must be maintained on an ongoing basis. The Department and the provider share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the [Provider Information Sheet](#) is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via [IMPACT](#).

Failure of a provider to properly update the [IMPACT](#) with corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change to information on file, the Department will generate an updated [Provider Information Sheet](#) reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

P-201.5 Changes in Ownership, Corporate Structure, or Location

Approval of a provider enrollment application applies only to the pharmacy's current, existing ownership, corporate structure and location at the time of application. Participation approval is not transferable. The [Illinois Department of Financial and Professional Regulation \(IDFPR\)](#) regularly notify the Department of licensure changes. Participation approval terminates when ownership, corporate structure or location changes.

If a pharmacy plans a change in ownership, corporate structure, or location, but wants to continue uninterrupted participation after the change, the pharmacy should notify the Department. This will allow time for enrollment of the "new" pharmacy without disruption of participation. If advance notice cannot be provided to the Department, the pharmacy should provide notification in writing, as soon as possible, subsequent to the changes. Changes in ownership or corporate structure must be in accordance with the rules and regulations of [IDFPR](#).

P-201.6 Change to Pharmacist-In-Charge

In the event that the pharmacist-in-charge changes, the Department must be notified, in writing, immediately; however, no [Provider Information Sheet](#) will be generated.

P-202 Claim Preparation and Submittal

P-202.1 Charges

Providers must charge the Department no more than their [Usual and Customary Charge](#) for any prescription or Over-the-Counter (OTC) drug or pharmacy item. The Usual and Customary Charge is the amount charged for the same prescription to cash customers exclusive of sales tax. The Department reimburses the lesser of the provider's charges or the Department's maximum allowable amount. The payment amount is returned to the pharmacy in the real-time response for claims billed electronically through NCPDP D.0, and is also included on the remittance advice.

Discounts provided to the general public must also be provided to Medical Assistance participants. If, however, discounts are allowed only to a certain defined group, then the discount should be extended to a Medical Assistance participant if they can be considered a member of the group. For example, if the pharmacy extends a discount to "senior citizens," then the pharmacy must extend the discount to all Medical Assistance "senior citizens." A pharmacy cannot exclude a Medical Assistance participant from a discount group based solely on their status as a Medical Assistance participant. However, Medical Assistance participants can constitute a special group and receive a discount.

The Department does not reimburse for additional expenses incurred by a pharmacy through use of a unit dose system of dispensing or the purchase of convenience packaged pharmacy items.

For compound prescriptions, providers are required to charge the Department no more than their [Usual and Customary Charge](#) for each ingredient in the compounded prescription. When the provider is submitting a claim for a compound prescription electronically, through NCPDP D.0 or DDE, and one of the ingredients in the compound is not payable, the entire claim will reject. The provider may, at its option, submit a Submission Clarification Code of 08 (field 42Ø-DK for claims submitted electronically through NCPDP D.0) to avoid having the entire claim reject. This will allow the Department to process the claim, bypassing those ingredients that are not payable, and reimbursing for those ingredients that are payable. Further instructions are included in [Chapter 300, Handbook for Electronic Processing](#), NCPDP.

P-202.2 Third Party Payment Sources

The Department is the payer of last resort and it is the responsibility of the provider to ascertain from the participant whether there is a third party resource that is available to pay for the services rendered. If a third party is billed, then the third party payment **must** be recorded on the subsequent claim submitted to the Department.

If a pharmacy submits a claim for a participant for whom Department records show TPL, and the claim does not contain a value greater than \$0 in field 431 DV Other Payer Amount Paid, the claim will reject for NCPDP error code 41 - Submit Bill to Other Processor or Primary Payer, regardless of the Other Coverage Code (OCC) submitted in Field 308 C8. The rejection message will identify the third party on the Department's records. Refer to Appendix P-4 for billing instructions for Error Code 41.

P-202.3 Charges for 340B Providers

HFS requires all 340B-eligible providers, as defined in [Section 340B](#) of the federal Public Health Services Act, to be enrolled as a 340B provider, and precludes those providers from “carving out” Medicaid from their purchases. 340B providers must bill the Department their actual acquisition cost (AAC), plus the 340B dispensing fee. Only one dispensing fee shall be paid for each 30-day supply. The requirement to include Medicaid in their purchases does not apply when the 340B entity uses a contract pharmacy to dispense their 340B purchased drugs. Contract pharmacies may not bill the Department for 340B purchased drugs.

Pharmacy providers submitting claims through the point-of-sale system for drugs purchased through the 340B program must identify the drug as a 340B purchased drug by populating the Submission Clarification Code (420-DK) field with a value of 20. Providers are also required to add the dispensing fee to the provider charge.

P-202.4 Claims for Medicare Part B Covered Services

The Department covers Medicare Part B deductible and coinsurance for individuals eligible for both Medicare and Medicaid, called Dual Eligibles. Typically, claims billed to Medicare automatically cross over to HFS' claims processing system for processing. Occasionally, however, claims do not cross over automatically. In those cases, the pharmacy must bill HFS using the [HFS 3797 Medicare Crossover Invoice \(pdf\)](#) either on paper or through Direct Data Entry (DDE). For further information about submitting claims via the DDE system, see P-202.7. Instructions for completing form [HFS 3797 \(pdf\)](#) are included in Appendix P-2.

For general information on submitting claims for Medicare Part B covered services provided to participants eligible for Medicare Part B, refer to [Provider Handbook Chapter 100](#).

P-202.5 Prescriber Information

Prescriber ID is a required field on a drug claim. The Department requires the [National Provider Identification \(NPI\)](#) in the Prescriber ID field (411-DB). Pharmacies are expected to use diligence in obtaining a prescriber's NPI for all prescriptions billed to HFS. Claims that do not contain the prescriber's NPI will be rejected.

A prescriber does not have to be enrolled to participate in the Department's Medical Assistance programs in order for the pharmacy to be reimbursed for a prescription.

However, HFS will reject claims submitted for prescriptions if the prescriber is barred, terminated, or suspended from participation in the Medicaid Program.

To verify if a provider has been sanctioned by the Federal or State Office of Inspector General, you may check the [OIG Provider Sanctions Web-page](#).

P-202.6 Electronic Claim Submittal

The Department recommends that pharmacy providers submit claims electronically via the NCPDP D.0 real time transactions or via the Department's DDE (Direct Data Entry) system. Claims for any services that do not require attachments or accompanying documentation should be submitted electronically. General information concerning electronic claims submittal can be found in Chapter 100. [Chapter 300, Handbook for Electronic Processing](#) contains information specific to conducting Electronic Data Interchange (EDI) with the Department, including information on submittal of X12 or NCPDP D.0 format transactions.

Specific programming instructions for submittal of NCPDP D.0 format transactions are contained in NCPDP Provider Payor Sheets for Input Transactions and NCPDP Provider Payor Sheets For Response Transactions.

If a problem occurs with a claim submitted in an electronic format, providers should contact the Department at 1-877-782-5565, Option 7 or 217-782-5565, Option 7. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

The Department recommends that pharmacy software be capable of the following NCPDP Version D.0 transactions:

- B1 – Billing
- B2 – Billing Reversal
- B3 – Billing Rebill
- D1 – Predetermination of Benefits
- E1 – Eligibility Verification
- P2 – Prior Approval Reversal
- P3 – Prior Approval Inquiry
- P4 – Prior Approval Request Only
- S1 – Service Billing
- S2 – Service Reversal
- S3 – Service Rebill

HFS' BIN is 008259.

P-202.7 Direct Data Entry (DDE) through MEDI

Pharmacies may submit claims electronically via the Internet through the Department's [Medical Electronic Data Interchange \(MEDI\)](#) system using Direct Data

Entry (DDE). [MEDI](#) is a secure, Internet-based system which allows medical providers and other designated entities to send data to and request data from the Department with safeguards for both provider and participant data. Through the MEDI system, users may submit claims, and check the status of claims via the HIPAA 276 – 277 transactions. [MEDI](#) is available **free of charge** to medical providers and their authorized agents. In order to access the DDE system, the individual submitting the claim must be enrolled for MEDI participation.

DDE is a “Capture Only” transaction, unlike the real time NCPDP D.0 transactions. A real time response is not returned to the provider. Editing and field completion requirements are the same for both means of submission.

Refer to the [MEDI Help Manual](#) for more information about DDE, or contact the MEDI Help Desk at 1-800-366-8768.

Note: The DDE system may be used to submit a claim or request a prior approval. It does not have the capability to reverse a claim.

P-202.8 Paper Claims

Form HFS 215, Drug Invoice, is to be used to submit charges for claims that cannot be submitted electronically, or by providers who do not have the capability to submit claims electronically. Detailed instructions for its completion are included in Appendix P-1. Form HFS 215 may be requested on the HFS [Forms Requisition](#) webpage.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Turnaround on a claim scanability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Refer to Appendix P-1 for technical guidelines to assist in preparing paper claims for processing.

The Department offers a claim scan-imaging evaluation. Send sample claims with a request for evaluation to the following address:

Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

All routine pharmacy paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form HFS 1415 (Drug Invoice Envelope). Use of this preaddressed envelope will ensure that claims are properly routed for processing.

For a non-routine claim submittal, use Form HFS 2248 (Special Handling Envelope). A non-routine claim is any claim with documentation attached, e.g., the Form HFS 1411 – Temporary MediPlan Card.

P-202.9 Paper Claims for Multiple Dates of Service when Participant is Eligible under Different Programs

If multiple dates of service are being billed for a participant who is eligible under different programs for those dates of service, those dates of service cannot be billed on the same Form HFS 215 Drug Invoice claim form.

P-203 Reimbursement

P-203.1 Reimbursement Methodology

Legend Drugs

The [Department](#) establishes upper limits on payments for all pharmacy items in accordance with federal regulations. The Department's payment limits are based on the Department's maximum allowable cost. Effective July 1, 2012, for legend (prescription) drugs, the Department shall pay the lower of:

- the pharmacy's usual and customary charge to the general public; or
- the Department's maximum price plus the established dispensing fee. The Department shall pay only one dispensing fee per 30-day supply for those drugs dispensed in accordance with Section 140.443(h)

Maximum Price

For generic drugs, the Department's maximum price is calculated at the lowest of:

- Wholesale Acquisition Cost (WAC);
- The Federal Upper Limit (FUL) as established under section 1927(e)(4) of the Social Security Act (42 USC 139r-8(4)); or
- The State Upper Limit.

For brand name drugs, the Department's maximum price is calculated at the lower of:

- WAC; or
- The State Upper Limit.

Over-the-Counter Products

For over-the-counter items that are covered, pharmacies will be reimbursed at the lowest of:

- The pharmacy's usual and customary charge to the general public;
- WAC + 25%; or
- The State Upper Limit.

State Maximum Allowable Cost (SMAC)

The Department may establish a State Maximum Allowable Cost (SMAC) for drug and non-drug items. A comprehensive listing of SMAC prices, rate updates, and rate review request forms are available on the [State MAC List Website](#).

Providers experiencing difficulty in obtaining products at or below the established SMAC should contact the Illinois SMAC Help Desk at 1-877-256-7330 available Monday through Friday, 8:00 AM to 5:00 PM, excepting holidays; or via fax at 1-877-781-7982.

P-203.2 Copayments

Participants are responsible for paying part of the costs involved in obtaining pharmacy services. The Department automatically deducts applicable copayment amounts from Medicaid payments. Pharmacies should not reduce the billed amount of a claim by the amount of copayments or record any dollar amount in the "Patient Paid" field for real-time claims submission.

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the participant. Federal regulations stipulate that a provider cannot deny services to an individual covered under a Title XIX or Title XXI program due to the person's inability to pay a co-payment. This requirement does not apply to the [All Kids](#) Premium Level 2. Providers may apply their office policies relating to the co-payments to participants covered under the [All Kids](#) Premium Level 2.

Providers should refer to [Provider Handbook Chapter 100 General Policy and Procedures](#), Appendix 12 for the copayment amount for each new or refilled prescription.

When billing the Department, providers should bill their usual and customary charge and **should not** report the participant's co-payment or coinsurance on the claim. The Department will automatically deduct the co-payment or coinsurance. The Remittance Advice will reflect the amount of the co-payment or coinsurance withheld by the Department.

P-203.3 Remittance Advice

The Department is required to report the disposition of every claim received. The Department uses Form HFS 194-M-2 (Remittance Advice). Form HFS 194-M-2 will continue to be sent to the same address as the warrant even after the availability of the HIPAA 835 Electronic Remittance Advice.

Form HFS 194-M-C (Billing Certification Form) must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice, which reports the disposition of any claims. Refer to [Chapter 100 General Policy and Procedures](#), for further details. This requirement applies regardless of whether you use the paper or electronic media for claims resolution.

P-203.4 Electronic Claims Status Inquiry

Pharmacies may check the status of claims using the HIPAA 276 (Claims Status Inquiry Transaction) on the Department's [MEDI system](#). Before submitting a Claims Status Inquiry transaction using the DDE system, review and understand the User Manual for the various screens.

P-204 Covered Services and Coverage Limitations

[Section 1927 of the Social Security Act](#), limits the Department's coverage of drug products to those drug products manufactured by companies that have signed rebate agreements with the federal government. A listing of drug manufacturers with signed rebate agreements is available on the Department's [Pharmaceutical Labelers with Signed Rebate Agreements Web-page](#).

P-204.1 Refill-Too-Soon

The Department uses Refill-Too-Soon (RTS) editing to ensure that a participant does not refill a prescription too early, before he or she has exhausted a sufficient amount of his or her previous prescription of the same drug. If a participant tries to refill a prescription before he or she has utilized a sufficient amount of the previous prescription for the same drug, based on the days' supply on the claim for the previous prescription, the claim will reject with an RTS message. RTS thresholds are drug-specific. Different drugs have different thresholds, based upon appropriateness.

RTS logic will compute the RTS threshold based on the days' supply carried over from the prior prescription plus the days' supply of the new prescription. For example, if a participant filled a prescription for a thirty (30) day supply, and then refilled it on the 23rd day for a thirty (30) day supply, the prescription would be filled seven (7) days early. The system will add the seven (7) days to the days' supply of the refilled prescription for a total of thirty-seven (37) days' supply. The RTS threshold will then be calculated using the thirty-seven (37) days.

The Department does not approve RTS overrides for participants who reside in a long term care (LTC) facility, are admitted to the hospital, and later return to the same facility. In these instances, the LTC facility must retain the unused portion of the participant's medication in the facility's secure medication location for use upon the participant's return to the facility. Additionally, the Department does not approve RTS overrides for participants who are transferred from one LTC facility to another LTC facility. In these instances, the LTC facility must transfer the unused portion of the patient's medication to the new facility.

The Department will not cover lost, stolen, or destroyed over the counter (OTC) medication for any participant. The Department will not cover lost, stolen, or destroyed prescription medications for adults with the exception of the list below.

For children through the age of 20, the Department will grant approval for lost, stolen, or destroyed medications no more than once a year (one single approval, not one approval per prescription), with the exception of the list below. More than one request may be approved, when clinically appropriate, for medications on the exception list.

Exception List: **(applies to adults and children)**

- Contraceptives
- Anticonvulsants (when prescribed for seizure disorder)
- Albuterol inhaler (when prescribed for asthma or COPD)
- Immunosuppressive agents (when prescribed for transplant patients)
- Insulin (vial only)
- Antipsychotics (when prescribed for schizophrenia)

RTS overrides for lost, stolen or destroyed medications can be requested by a pharmacy or a prescriber's office, with the exception of override requests for controlled substances. Overrides for controlled substances, with the exception of anticonvulsants when prescribed for seizure disorder, must be requested by the prescriber. Presentation of a new prescription from the prescriber at the pharmacy will meet the requirement of a request by the prescriber for controlled substances. If the request is for medication that was stolen, a police report number must be submitted with the request for RTS.

The Department does not cover vacation supplies of medications for adults. Vacation supplies for children through the age of 20 are reviewed on a case-by-case basis. A vacation supply is an extended supply intended for use while the participant is out of the state/country.

P-204.2 Preferred Drug List (PDL)

The Department maintains a [Preferred Drug List \(PDL\)](#) in many therapeutic classes. It is the Department's goal to ensure broad access to a variety of preferred drugs in each class. Most classes have multiple preferred products. Therefore, the Department generally expects patients to use multiple preferred products before being approved for a non-preferred product. However, if there is a clinical reason that a patient must use a non-preferred product before having tried and failed the preferred alternatives, the provider should submit a prior approval request supported with clinical justification.

Generally, preferred drugs do not require prior approval, and non-preferred drugs do require prior approval. In certain classes of drugs, both the preferred and non-preferred drugs require prior approval in order to ensure safety or appropriate utilization, e.g., growth hormones and TNF Alpha Blockers/Biological Modifiers. In these cases, if the participant meets the criteria to be approved for a drug in the class, then the Department expects the participant to use a preferred product, unless there is a clinical reason that the participant must use a non-preferred product without having tried the preferred products.

P-204.3 Three Brand Name Drug Limit

The Department limits the number of brand name drugs participants age 21 and over may receive each month. Prior approval will be required for a brand name drug when the Department has already been billed for three brand name drugs in the preceding 30-day period. The following drug categories are not subject to the three-

brand limit prior approval process regardless of whether the participant has received three brand name drugs in the preceding 30-day period:

- Drugs for which there are no alternative generic therapies for the condition being treated.
- Drugs for which the generic alternatives are deemed clinically inappropriate for the majority of participants.
- Brand name drugs that are less expensive to the Department than their generic alternatives.
- Drugs in the following classes:
 - Antiretrovirals
 - Antineoplastics
 - Anti-Rejection Agents

When a claim is submitted for the fourth brand name drug for a participant who has received three brand name drugs in the preceding 30-day period, the pharmacy will receive the following error message: "Brand Name Limit Exceeded."

The pharmacy should contact the prescriber to determine whether the patient can be switched to a generic alternative. If the prescriber and pharmacist determine that the patient cannot be switched to a generic alternative, the provider can request prior authorization with clinical justification for the brand name drug.

To request an exception to the Three Brand Name Drug Limit through the prior approval process, the provider should check the box labeled Three Brand Limit Override on the Form [HFS 3082 \(pdf\)](#), Request for Drug Prior Approval, or, if requesting prior approval via telephone or NCPDP D.0 Prior Approval transaction, the provider should note that he or she is requesting an exception to the Three Brand Name Drug Limit.

Refer to [Topic P-205.2](#) for information on requesting Prior Approval.

P-204.4 Quantity

The Department expects prescribers to prescribe and pharmacies to dispense medications in quantities reasonably calculated to meet the predictable needs of the participant. Participants who are on maintenance therapy should be issued prescriptions for a one-month supply or a 90 day supply unless prepackaging constraints prevent this practice. Items such as eye drops, inhalers, nasal spray and multidose vial injectables are examples of prepackaged items that may contain more than a one-month supply. An accurate day supply should be billed for these items even if it exceeds one month. See P-204.11 for information on the Department's 90 day supply reimbursement policy. In addition, the Department allows providers to bill greater than a one-month supply of certain products, including contraceptives and prenatal vitamins.

Repeated filling of prescriptions for the same participant in quantities less than the quantity identified by the prescriber on the prescription will be considered a deviation from policy unless the prescribed quantity is a 90 day supply and the Department's maximum quantity is a one month supply. This could result in recoupment of any excess professional fees paid and further sanctions as deemed appropriate by the Department.

The Department sets maximum and minimum quantities based on the manufacturer's recommended dose. In situations where the Department's maximum quantity is less than that ordered by the prescriber or the minimum quantity is more than that ordered by the prescriber, prior approval must be obtained in order to dispense the prescribed amount. Drugs shall, in no event, be dispensed more frequently or in larger amounts than the prescriber ordered without direct prescriber authorization by way of a new prescription order.

P-204.5 Daily Dose Limits

The Department edits claims to ensure that the patient's daily dose doesn't exceed recommended maximum daily dose limits. Prescriptions that exceed the maximum daily dose limits will reject and require prior approval.

P-204.6 Durable Medical Equipment (DME)

Certain Durable Medical Equipment (DME) and supply items must be billed through the Department's Pharmacy Program. Those items are identified in a document entitled, "[DME Supplies Required to be Billed Through the Pharmacy System \(pdf\)](#)", posted on the Department's [Durable Medical Equipment \(DME\) Web-page](#).

In addition, non-drug family planning supplies such as condoms, diaphragms and cervical caps may be billed through the Pharmacy System.

DME and supply items not covered under the pharmacy program may be covered under the Department's DME program. Providers should reference [Chapter M-200, Durable Medical Equipment \(pdf\)](#), Handbook for Providers of Medical Equipment and Supplies, for a listing of these items. A pharmacy wishing to provide this scope of service must enroll as a DME provider and follow the policies and procedures applicable to that program.

DME and supply items are not subject to the rebate provisions of [Section 1927 of the Social Security Act](#). Accordingly, pharmacies may dispense non-drug items in the above-listed categories made by manufacturers that have not signed a rebate agreement with the federal government, provided that the item is a covered product. The pharmacy must submit claims using the correct eleven-digit [National Drug Code \(NDC\)](#) number.

P-204.7 Emergency Contraceptives

The Food and Drug Administration (FDA) approved the emergency contraceptive (EC) drug levonorgestrel 1.5mg, one tablet packet, as a non-prescription option for women of childbearing potential. The Department covers this product without a prescription for all women of childbearing potential. The Department will continue to cover other EC products without a prescription consistent with the FDA approval.

Refer to [Topic P-208.2](#) for documentation requirements.

Because the Prescriber Name and Prescriber ID are required fields, the Department provides data elements to use in these fields:

NCPDP D.0 Claim Segment Field	Valid Value
Prescriber ID Qualifier (466 EZ)	Value = 01
Prescriber ID (411 DB)	Value = 2223334444
Prescriber Last Name (427 DR)	Value = Plan B
Prescriber First Name (364 2J)	Value = Plan B

For instances where a prescription is required, the prescriber's ID should be used.

P-204.8 Copay Only Billing

Under Medicare Part D Dual Eligible (Medicare and Medicaid) participants residing in skilled or intermediate care facilities have no copayments.

In addition, participants residing in Supportive Living Facilities (SLFs) or Community Integrated Living Arrangements (CILAs) who are also in a Home and Community Based Waiver (HCBW) program have no copayments. Certain Dual Eligible CILA residents are not enrolled in a HCBW program, and therefore, are responsible for copayments under Medicare Part D. These participants are eligible for the full low-income subsidy, so their copayments are minimal.

The Department will allow pharmacies to bill Medicare Part D copayments to the Department for CILA residents who are not HCBW participants.

Co-pay only claims may not be submitted for residents of other long term care facilities, or SLF or CILA residents who are also in a HCBW. Those residents should already be exempt from copayments in Medicare Part D.

The pharmacy should first bill Medicare Part D in order to determine the copay amount charged to the participant for that drug. The pharmacy may then submit the claim to HFS with the appropriate copayment amount.

In addition to the pharmacy and client-specific information required on the NCPDP D.0 claim submission, the claim must also contain the following elements:

NCPDP D.0 Claim Segment Field	Valid Value
Other Coverage Code (308-C8)	Value = 08

NCPDP D.0 Pricing Segment Field	Valid Value
Other Amount Claims Submitted Count (478-H7)	Value = 1
Other Amount Claims Submitted Qualifier (479-H8)	Value = 04
Other Amount Claimed Submitted (480-H9)	Value = Copay amt (\$1 - \$6.50)
Gross Amount Due (430-DU)	Value = Copay amt (\$1 - \$6.50)
Usual and Customary Charge (426-DQ)	Value = Amount charged cash customers for the prescription exclusive of sales tax or other amount claimed.

Copay-only claims must not contain a NCPDP D.0 COB/Other Payments Segment.

P-204.9 Administration of Vaccines

The Department reimburses pharmacies for the administration of flu vaccine to adults. The Department's reimbursement to pharmacies for the administration of influenza vaccine is limited to adults age 19 and over. The Department does not reimburse pharmacies for the administration of flu vaccine to children. Children's vaccines are covered under the Vaccine for Children program, and are provided by health care providers who participate in that program. For dual eligible individuals, pharmacies must bill Medicare for influenza vaccine.

Pharmacies must bill the influenza vaccine administration fee as a separate transmission using the NCPDP D.0 S1 transaction. Please refer to the NCPDP D.0 Companion Guide and Payer Sheets available in the Chapter 300, [5010 Companion Guide](#).

The pharmacy must enter their usual charge for the administration of the vaccine.

P-204.10 Blood Clotting Factor

Providers who dispense blood clotting factor to Medical Assistance participants must have a signed [Standards of Care Agreement \(SOCA\) \(pdf\)](#), found on the Department's [Hemophilia Care Management Program Web-page](#), on file with the Department.

The purpose of the SOCA is to ensure that providers who dispense blood factor dispense only that which is necessary to meet the patient's needs and meet certain standards of care. If the Department receives a claim for blood factor from a pharmacy that has not signed a SOCA, the claim will reject with the message: S03-SOCA not on file.

The SOCA also requires that pharmacies dispense blood clotting factor to Participants within a variance in assay to prescription/target dose that does not exceed +/- 5%.

Each dispensing of blood factor requires prior approval before the Department will reimburse a pharmacy for the product. For the initial prior approval, the prescriber or pharmacy must provide the Department with a copy of the original prescription, which includes the current dosing schedule. Approval will be for a specific date of service. Prior to each refill of the prescription, the pharmacy must request prior approval for the date of service of the refill.

Each time a prescription changes, including changes in brand of factor, dose of factor, or dosing schedule, the prescriber or pharmacy must submit a new prior approval request for the new prescription, and include a copy of the new prescription. The prior approval request form specific to blood factor is available on the [Hemophilia Care Management Program](#) Web-page.

If the Department receives a prior approval request for blood factor from a provider who has not signed a SOCA, the prior approval will be denied.

P-204.11 Ninety (90) Day Supply

The Department allows billing of a 90 day supply for certain generic, oral, non-narcotic, maintenance medications for certain disease states including hypertension, diabetes and hypothyroidism. A listing of the medications may be found on our [Website](#).

P-204.12 Fourteen (14) Day Supply for Long Term Care Facility Residents

The Department requires that specific brand-name, solid oral drugs dispensed to patients residing in any facility that provides medical group care services as defined in [89 Ill. Adm. Code 140.500](#), except Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and supportive living facilities (SLF), must be dispensed in 14-day supplies. Solid oral doses of antibiotics and drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information, or that are customarily dispensed in their original packaging to assist patients with compliance, are excluded from this requirement and may be dispensed in supplies greater than 14 days.

A list of the drugs required to be dispensed to nursing facility residents in a 14-day supply is available on the [Long Term Care Pharmacy Information Website](#). Pharmacy claims that contain a quantity greater than a 14-day supply for drugs on the list will reject with the error message G58 - "LTC Limited to 14 Day Supply per Fill." The Department will pay only one dispensing fee per 28 days' supply for drugs dispensed in accordance with this requirement.

P-204.13 Four Prescription Policy

The Department requires adults and children to obtain a prior authorization to fill prescriptions beyond four in a thirty day period. The purpose of the four prescription policy is to have providers review their patients' maintenance medications and, where possible and clinically appropriate, reduce duplication, unnecessary

medications, polypharmacy, etc. This policy applies to both brand and generic prescription drugs.

A prior approval request for an exception to the four prescription policy may be submitted by the prescriber or pharmacy if the prescriber determines that a patient needs a prescription that rejects as a result of the prescription policy. Refer to [Topic P-205.2](#) for information regarding requesting prior approval.

The following classes of drugs will not require prior approval as a result of the four prescription policy:

- Oncolytics
- Anti-Retroviral Agents
- Contraceptives
- Immunosuppressives
- Over-the-Counter Drugs
- Non-Drug Items such as blood glucose test strips and monitors
- Antipsychotics

[Compound drugs](#) will count as only one prescription. Providers can request notification of a determination on a prescription policy prior authorization request by submitting a status inquiry on the Department's [Four Prescription Policy Override Request Status Inquiry Web-page](#). Department staff will respond with the status of the request(s) that a provider has made on behalf of the patient.

P-205 Prior Approval Information

P-205.1 Prior Approval – General Information

The Department requires prior approval for certain drugs and pharmacy items in order to control utilization. Typical reasons that a drug will require prior approval are:

- The drug, or a particular formulation of the drug, is more expensive than alternatives available without prior approval.
- For safety reasons, the Department has determined that utilization should be controlled through the prior approval process.
- The drug is multi-source and the prescription is written for the brand ([innovator](#)) product.
- The drug should only be used second-line after other first-line products have been tried and failed.
- The drug has abuse potential.

The Department provides tools to assist providers in determining drugs that do not require prior approval. The Department's [Preferred Drug List \(PDL\)](#) is discussed in further detail at [Topic P-204.2](#).

In addition, the Department provides a search engine through which providers can search for the prior approval status of a particular product. Providers can enter a drug name, and the [MEDI Drug Prior Approval search engine](#) will return information on whether the drug requires prior approval.

P-205.2 Prior Approval Requests

Prior approval requests may be submitted by either the prescriber or the dispensing pharmacy. The Department's clinical review staff will make a decision based upon the information provided on the request, medical necessity, appropriateness, and anticipated participant benefits. It is of utmost importance that prior approval requests contain adequate information upon which to make an informed decision.

The specific information needed will vary depending on the item requested and the medical condition of the participant, but the process described below is designed to cover the general information that is needed for all requests. Generally speaking, the provider will need to provide clinical justification supporting the participant's need for the requested drug rather than an alternative that does not require prior approval.

Regardless of the mode of transmission of the prior approval request, submitting a complete request with justification of the medical necessity of the requested drug, as well as any other pertinent information, at the time of request will prevent delays in reviewing the prior approval request.

Pharmacies can request prior approval through the NCPDP D.0 P4 (Prior Approval Request Only) real time Prior Approval transaction. The pharmacy may need to

obtain client-specific clinical information from the prescriber in order to provide thorough clinical justification on the NCPDP D.0 Prior Approval transaction. Prior approval requests may also be submitted to the Department by electronic transmission through [Medical Electronic Data Interchange \(MEDI\)](#), mail, fax or telephone.

Pharmacies may use the electronic NCPDP D.0 P3 (Prior Approval Inquiry) to check the status of a prior approval request, regardless of the medium through which it was submitted. The Prior Authorization Number Assigned (498-PY) is required to check status using the NCPDP D.0 P3 transaction.

Regardless of the medium through which the prior approval request is transmitted, the provider should provide all information requested on the Form [HFS 3082 \(pdf\)](#), Request for Drug Prior Approval. Certain drugs require drug-specific prior approval forms that are designed to gather specific information needed for requests for that particular drug. The list of these drugs and the various prior authorization request forms can be found on the Department's [Criteria and Forms Web-page](#).

Electronic Transmission through NCPDP D.0

Information on submittal of NCPDP D.0 Prior Approval transactions can be found in [Chapter 300](#), NCPDP.

Specific programming instructions are contained in [Chapter 300](#) at NCPDP Payor Sheets for Input Transactions and NCPDP Provider Payor Sheets for Response Transactions. The P4 (Prior Approval Request Only) transaction contains a 500 character Supporting Documentation Area. Providers must use the Supporting Documentation Area to detail the justification for the prior approval.

Electronic Transmission through Medical Electronic Data Interchange (MEDI)

The Department provides a web-based Drug Prior Approval/Refill Too Soon Entry System through our [Medical Electronic Data Interchange \(MEDI\) System](#). This feature allows providers to submit drug prior approval and refill too soon requests directly to the Department electronically. In addition, providers will be able to use this system to check the disposition of their requests using the prior approval request number.

Electronic submission via the Department's [MEDI System](#) is available to enrolled providers and their authorized staff, claim submitting agents and payees. Providers who are not currently enrolled in the MEDI System will need to access the MEDI System [Getting Started Web-page](#) and complete the registration process.

Telephone

Drug prior approval requests can be submitted by telephone by calling 1-800-252-8942 Monday through Friday, 8:30 am to 5:00 pm Central Time, excluding state holidays.

Telefacsimile

The provider must thoroughly complete the appropriate prior authorization request form on the [MEDI Drug Prior Approval Program Website](#) for the type of request needed. The completed form, along with any other documentation the provider feels is necessary to substantiate the prior approval request, should be faxed to either of the numbers shown on the form. Completed forms may be faxed 24 hours a day. Requests faxed during non-business hours are considered received on the next business day.

The pharmacist or his or her designee, or the prescriber or his or her designee, must sign the Form.

Mail

The completed Form along with any other documentation the provider feels is necessary to substantiate the prior approval request, should be mailed to

Department of Healthcare and Family Services
Bureau of Pharmacy Services, Prior Approval Unit
607 E Adams, 4th Floor
Springfield, IL 62701

The pharmacist or his or her designee, or the prescriber or his or her designee, must sign the Form.

P-205.3 Documentation Required for Prior Approval Requests

Prior approval requests must contain clinical information that substantiates the need for the item. Certain pharmacy items require specific documentation, e.g., test results, patient weight, or clinical updates.

P-205.4 Notification of Disposition of Prior Approval Request

Whether a prior approval request is approved or denied, the participant will receive a computer-generated notification letter.

If a request is denied, and the provider has additional information that may justify the request, a new prior approval request containing the supporting medical information may be submitted.

A provider cannot file an appeal of the denial. Only participants may file an appeal of a prior approval denial. Participants should contact their caseworker at their local Department of Human Services (DHS) Family Community Resource Center to file an appeal. Alternatively, participants may call 1-800-435-0774 to file an appeal. The participant has 60 days from the mailing date of the denial letter to file an appeal.

P-205.5 Timeliness of Prior Approval Determinations

The Department is required to make a decision or request additional information on prior approval requests within 24 hours of receipt. On weekends and holidays, the Department is required to make a decision on prior approval requests on the Department's next working day.

During non-business hours such as evenings, weekends, and state holidays when Department staff are not available to accept a prior approval request, the pharmacy can dispense, and the Department will pay for, an **emergency** 72-hour supply of a covered prescription drug to an eligible recipient in an **emergency** situation. The pharmacy is responsible for following up with a prior approval request for the emergency supply.

In order to receive reimbursement for the emergency 72-hour supply, the pharmacy must submit a separate prior approval request that clearly states the request is for the emergency 72-hour supply of the drug. The request must include the quantity dispensed for the 72-hour supply.

P-205.6 Post Approvals

Post approval may be requested in cases where prior approval could not have been obtained. Post approval may be granted upon consideration of individual circumstances, such as:

- The participant's eligibility for Medical Assistance had not been issued as of the date of service. In such a case, the post approval request must be received no later than 90 days following the Department's Notice of Decision approving the participant's application.
- Items dispensed in an emergency outside the Department's normal business hours, so prior approval could not be requested from the Department. In such a case, the post approval request must be received on the first business day after the pharmacy item is dispensed.
- There was a reasonable expectation that other third party resources would cover the pharmacy item and those third parties denied payment after the pharmacy item was dispensed. To be considered under this exception, documentation that the provider submitted a claim to a third party payer within six months following the date of service, as well as documentation of the denial from that third party payer, must be supplied with the request for post approval. The request for post approval must be received no later than 90 days from the date of final adjudication by the third party payer.
- The participant did not inform the provider of his or her eligibility for the Department's Medical Assistance programs. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, the provider must submit dated documentation demonstrating an attempt to collect payment from the participant with the request for approval.

P-206 Non-Covered Services

Services for which medical necessity is not established are not covered by the Department's Medical Assistance Programs. Refer to [Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures](#), for a list of pharmacy items and services for which payment will not be made.

The Department cannot make payment to providers for the following:

P-206.1 Returned Pharmacy Items

When a pharmacy item or a portion of a pharmacy item is returned to the dispensing pharmacy, and the unused quantity can be reused by the pharmacy in accordance with applicable federal and state laws and regulations, the pharmacy must credit the Department for the unused drug product.

P-206.2 Medicare Part D Covered Drugs

Medicare Part D, a federal program enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), helps pay the costs of prescriptions for Medicare beneficiaries. MMA prohibits Medicaid from reimbursing for any prescription that is covered by Medicare Part D for Medicaid eligible persons who also have Medicare, called Dual Eligibles. Most prescription drugs are covered under Medicare Part D. However, Dual Eligibles may continue to receive Medicaid coverage for the limited set of drugs excluded from coverage under Medicare Part D, such as Over-the-Counter items.

P-206.3 Certain Prescription Pharmacy Items

Prescription pharmacy items that are not covered under the Medical Assistance Program are:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government
- Weight loss drugs
- Agents to promote fertility
- Agents used for cosmetic purposes, e.g., hair growth or wrinkle-removal
- Drugs identified by the FDA as being in Drug Efficacy Study Implementation (DESI) status
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services
- Drugs indicated only for the treatment of erectile dysfunction

P-206.4 Certain Items Dispensed to Long Term Care Facility Residents

Certain items provided to residents of skilled and intermediate care long term care (LTC) facilities are the responsibility of the facility. Pharmacies cannot bill the Department for these items when provided to participants living in these facilities. The pharmacy is responsible for ensuring that it does not bill the Department for these items when dispensed to residents of these facilities.

Additionally, Long Term Care (LTC) facilities are required to provide durable medical equipment and supply items, including wound care dressings, to participants as a part of the per diem reimbursement paid to the facilities by the Department. Certain drug items are considered the responsibility of the LTC facility as a part of their per diem reimbursement. Those drug items are:

- Acetaminophen
- Aspirin
- Milk of Magnesia
- Multivitamins
- Zinc Oxide Ointment
- Over-the-Counter drugs, prescribed by the participant's health care provider, which are not covered under the Department's Medical Assistance Program

P-206.5 Certain Items Dispensed to Hospice Patients

Drugs considered palliative in nature, or related to the illness for which the patient is receiving hospice care, are the responsibility of the hospice. These drugs should be billed to the hospice.

P-206.6 OTC Items Dispensed to [All Kids](#) Premium Level 2 Participants

The Department does not cover most OTC items for [All Kids](#) Premium Level 2 participants. There are some exceptions to this policy. For example, the following OTC items are covered for [All Kids](#) Premium Level 2 participants: Insulin, diabetic testing supplies, compounding vehicles, emergency contraceptives, and some other OTC items that are generally covered under private insurance.

P-206.7 Limited Coverage Over-the-Counter Items

Certain OTC items are covered for children through age 20, but are not covered for adults age 21 and over. These items include antacids/acid reducers, laxatives, lice treatment, topical antifungal preparations, except clotrimazole 1% cream, topical hydrocortisone preparations, except hydrocortisone 1% cream and ointment. Pediatric formulations of acetaminophen such as liquid, drops and suppositories used for fever in children through six (6) years of age will be covered.

The Department does not cover OTC analgesics, allergy medications, including non-sedating antihistamines, cough and cold products and vitamin/minerals including calcium supplements/Tums regardless of the participant's age.

The items listed above may be covered when prescribed for adults age 21 and over residing in group living arrangements where the participant is allowed to retain only a certain portion of their income, and the rest of their income must be used toward their care. These include Supportive Living Facilities (SLFs) and other group living arrangements such as Community Integrated Living Arrangements (CILAs), and a few other types of small group living arrangements. These items are not covered when dispensed to residents of skilled nursing facilities or intermediate care facilities. The facility is responsible for providing Over-the-Counter items, prescribed by the participant's health care provider, which are not covered by the Medical Assistance Program.

P-206.8 Durable Medical Equipment (DME) and Supply Items

Most Durable Medical Equipment (DME) and Supplies, with the exception of those items listed in P-204.6, are not covered under the Department's Pharmacy Program. These items may be covered under the Department's DME Program. Providers should reference [Chapter M-200, Handbook for Providers of Medical Equipment and Supplies](#), to determine whether DME items are covered.

P-208 Filling of Prescriptions

Prescriptions for allowable pharmacy items may be dispensed when they are in full compliance with all applicable state and federal laws and regulations, and Department requirements. Blank, pre-signed prescription forms are not to be accepted or obtained by a pharmacy from a prescriber.

P-208.1 Prescription Forms

The practitioner is to use his/her own prescription form when prescribing both prescription medications and OTC pharmacy items and is responsible for entering the following minimal information on the form:

- Participant's name
- Date prescription was written
- Name of pharmacy item being prescribed
- Dosage form and strength or potency of drug (or size of nondrug item)
- Quantity
- Directions for use
- Refill directions
- Legible Signature in ink
- Prescriber NPI

P-208.2 Verbal Prescriptions

Pharmacies are expected to receive and process verbal (telephoned) prescriptions in compliance with the [Illinois Pharmacy Practice Act](#) and [Illinois Controlled Substances Act](#). When filling verbal prescriptions, the pharmacist must create an unalterable transcript of the prescription with all of the above-identified information. Plan B requests will not require refill directions, legible signature in ink or prescriber's [NPI](#) as noted above. Every prescription filled shall contain the unique identifiers of the persons authorized to practice pharmacy under the Pharmacy Practice Act. A "unique identifier" means an electronic signature, handwritten signature or initials, thumbprint, or other acceptable biometric or electronic identification process as approved by the [Illinois Department of Financial and Professional Regulation](#).

The Department expects a pharmacy to use judgment in the acceptance of verbal prescriptions; i.e., the pharmacy is responsible for verifying and documenting the identity of prescribers (or individuals acting under the direct supervision of the prescriber) from whom they receive verbal prescriptions.

Furthermore, if, after reviewing the dispensing patterns of a pharmacy, the Department has sufficient evidence to establish that prescribers identified on claims did not prescribe the pharmacy items dispensed for which charges were made to the Department, the pharmacy will be held responsible and recoupment action taken.

A pharmacist is under no obligation to dispense a drug that, in his or her professional opinion, should not be dispensed. A pharmacist must exercise professional judgment in the rendering of service to participants.

P-208.3 Tamper Resistant Prescription Pads

Federal law requires that all non-electronic Medicaid prescriptions be written on [tamper-resistant prescription pads](#). The federal requirement does not apply to electronic prescriptions. An electronic prescription is one that is transmitted from the prescriber to the pharmacy via telephone, telefacsimile, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission. The Department strongly encourages providers to use an electronic method to transmit prescriptions to pharmacies.

P-208.3.1 Tamper Resistant Characteristics

To be considered tamper-resistant, a prescription pad must contain at least one of each of the following characteristics one or more industry-recognized features designed to prevent the:

- Unauthorized copying of a completed or blank form
- Erasure or modification of information written on the prescription by the prescriber
- Use of counterfeit prescription forms

P-208.3.2 Managed Care Participants

The Integrated Care Program and Medicaid managed care plans are responsible for prescription drug coverage for their enrolled beneficiaries. This policy does not apply to prescriptions when the claim is billed to the beneficiary's managed care plan.

P-208.3.3 Medicaid as a Secondary Payer

This requirement applies to all prescriptions regardless of whether HFS is the primary or secondary payer.

If a patient presents at a pharmacy with a prescription written on a prescription pad that is not tamper-resistant, and the pharmacist contacts the prescriber via telephone, telefax, or other electronic communication device, and the prescriber verifies the validity of the prescription, the prescription is then considered "electronic," and therefore, exempt from the requirement that the prescription be written on a tamper-resistant pad. In such cases, the pharmacist shall note on the original prescription that the prescriber was contacted and the prescriber verified the validity of the prescription.

P208.3.4 72-Hour Grace Period

If a patient presents at a pharmacy with a non-electronic prescription written on a pad that is not tamper-resistant, and the pharmacist is unable to contact the prescriber to verify the validity of the prescription, and the pharmacist, in using his or her professional judgment, determines that not filling the prescription poses a health risk to the patient, the pharmacist may fill the prescription and the Department will reimburse for the prescription, provided that the patient is eligible for coverage of the drug and provided that the drug is covered by the Department. The pharmacist must obtain from the prescriber a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled.

P208.3.5 Computer-Generated Prescriptions

Computer generated prescriptions or Electronic Medical Record (EMR) generated prescriptions must contain at least one feature from each of the three categories detailed above in order to be considered tamper-resistant. While special paper may be used to achieve copy resistance, it is not necessary. Computer or EMR generated prescriptions may be printed on plain paper, and be fully compliant with all three categories of tamper resistance.

Examples of tamper-resistant features of computer or EMR generated prescriptions are as follows:

Category #1 – Copy Resistance: Microprint signature line*

Category #1 – Void/Illegal/Copy Pantograph with or without Reverse Rx

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out). Example:
Dispense: ***30*** Thirty; Refill: ***12*** Twelve

Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper

Category #3 – Counterfeit Resistance: Listing of security features

P-208.4 Refills

A prescription must be refilled in accordance with state laws and regulations. An original prescription is never valid for greater than one year from the date of origin. The pharmacy must maintain a daily refill log as required by state law or regulation. The refill log must contain, at a minimum, the following: information:

- RX number
- Date of refill
- Drug and strength of drug
- Quantity of drug
- Number of refills remaining
- Registered pharmacist's initials or name
- Technician's initials (if involved)
- Participant name

- Prescriber name
- [NDC](#) number

A prescription may not be refilled for more refills than authorized by the prescriber on the original unaltered prescription. The pharmacy must obtain a new prescription from the prescriber and issue a new prescription number if the number of refills authorized on the original prescription has been exhausted.

The use of automatic refills by a pharmacy is not allowed. All prescription refills must be initiated by a request from the physician, recipient, or other person acting as an agent of the recipient, e.g., a family member. The possession of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. The Department will not reimburse a pharmacy for any prescription claim that has been auto filled. Any claim for a prescription filled without a request from the physician, recipient or agent of the recipient, including but not limited to claims for any prescription service provided after the client's date of death will be subject to recovery. Claims for prescriptions that have been filled using auto refill and inadvertently billed to the Department must be reversed by the pharmacy. The auto refill prohibition does not apply to medications that are dispensed to residents of LTC facilities or community based living arrangements such as CILA, SLF or sheltered care facilities.

P-208.5 Pharmacists Ineligible to Participate in the Medicaid Program

Services provided by terminated or barred providers from all governing Federal and State entities are considered "non-covered services" and recoupment will be pursued for these services. For additional information refer to [89 Ill. Adm. Code 140.16](#).

P-209 Documentation and Record-Keeping Requirements

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits.

All records must be maintained for a minimum of three years.

The pharmacy must maintain its financial, business, and professional records for at least the 12 previous calendar months and those records must be available for inspection without prior notice by authorized Department personnel or designees on the provider's premises of the provider. Department personnel shall make requests in writing to inspect records more than 12 months old at least two days in advance of the date they must be produced.

P-209.1 Invoices

Pharmacies must have detailed invoices to substantiate all drug acquisitions. Records must identify products by manufacturer, product name, dosage form, strength, and package size. Records listing products' [NDC](#) numbers are strongly recommended.

P-209.2 Transfer of Stock

When a provider owns multiple stores or borrows or loans stock to other non-owned pharmacies, the provider is responsible for maintaining detailed records of any transfers of pharmaceutical stocks between stores. Each transfer must be documented with the following information:

- Product name
- Dosage form
- Strength
- Quantity transferred
- National Drug Code Number
- Date of transfer

These records are subject to the same retention limits as invoices and other documents subject to Department audit.

P-209.3 Prescription Record Requirements

Pharmacies must retain the following basic records:

- All prescription forms for HFS participants in an unalterable form
- All signature logs, including for mail order, the shipping log and confirmation of receipt; or in the case of delivery to the participant, the pharmacy's delivery signature log which must contain the signature of the participant or the person who received the medication on behalf of the participant
- The method of verification of [usual and customary charges](#) to the general public
- Record of any and all refills made to an existing prescription

P-210 Recipient Restriction Program

This section refers to pharmacy-specific information regarding the Recipient Restriction Program (RRP). Complete information regarding the Recipient Restriction Program is available in the [Chapter 100, Handbook for Providers of Medical Services](#).

The Department identifies participants who misuse medical services. When the Department determines that a participant has received pharmacy services and/or medical services in excess of need or in such a manner as to constitute an abuse and/or quality of care issue of the program, the Department restricts the participant to a Primary Care Pharmacy and/or a Primary Care Physician.

When a participant is restricted, the recipient is initially assigned a Primary Care Physician and/or a Primary Care Pharmacy. The participant will be notified in writing of the assignment and given the opportunity to select a different Primary Care Pharmacy and/or a different Primary Care Physician. The participant can contact the RRP staff and select a different Primary Care Physician and/or Primary Care Pharmacy. The option to select a different Primary Care provider is offered once during a twelve-month calendar year period.

If the participant is restricted to a Primary Care Physician and the prescribing physician refers the client to another physician/specialist who prescribes medications to the participant, then the referring physician (physician to whom the participant is restricted) must complete the [Form HFS 1662 \(pdf\)](#) part A and fax to the physician/specialist who complete part B of the form. The completed [Form HFS 1662 \(pdf\)](#) is then given to the dispensing pharmacy which is required to retain the HFS1662 form (paper or electronic copy), for auditing purposes, for a period of 7 years. The pharmacy can then bill electronically NCPDP D.O standard as follows:

- The referred physician/specialist should be identified on the claim as the prescribing physician in the Prescriber ID field (411-DB) and the referring physician (physician to whom the participant is restricted) should be identified on the claim as the primary care physician in the Primary Care Provider ID field (421-DL).
- If the client is restricted to a clinic, the prescribing physician should be identified in the Prescriber ID field (411-DB) and the clinic (clinic to which the participant is restricted) should be identified on the claim as the primary care physician in the Primary Care Provider ID field (421-DL).

If a problem occurs with the submission of the claim, the pharmacy should contact a Department Pharmacy Billing Advisor at 877-782-5565, option 7 for assistance.

Providers who have questions about a participant's RRP status or whether a given service to a restricted participant requires authorization should check the [Medi system](#). If additional information is needed they may call the Department's toll-free RRP hotline at 1-800-325-8823.

The Department will not pay for restricted services that are provided on a non-emergency basis without prior written authorization of the designated Primary Care Physician. This authorization will be in the form of a completed [Form HFS 1662 \(pdf\)](#).