Affordable Care Act (ACA) Provider Enrollment Requirements Frequently Asked Questions for Pharmacists

An important requirement of the Affordable Care Act is that prescribing providers must now be individually enrolled in order for claims for pharmacy to pay. In the process of implementing this requirement, the Department is not only receiving inquiries on those changes, but also on the longstanding requirements for prior authorization for certain drugs. The purpose of this Q&A is to provide clarity on some questions that we are hearing frequently.

The Pharmacy Prior Authorization (PA) program has been in place for a number of years. The PA program is a state-mandated pharmacy initiative which allows the Department to assure appropriate prescribing and utilization of prescribed medications in a cost effective manner. All pharmacy PAs (with the exception of Synagis) are handled by the Department's MMIS/fiscal intermediary, Hewlett Packard. Synagis PA requests are handled through the Department's ASO, Community Health Network. All necessary contact information and forms can be found on DSS' website at www.ctdssmap.com.

Current PA requirements apply to the following categories:

- Brand Medically Necessary *
- Early Refill (Over utilization)
- Non-Preferred Medication *
- Optimal Dosage
- High Dose Transmucosal Fentanyl Citrate
- Serostim (for the CADAP program)
- Synagis (handled through Community Health Network)

* Reflects areas where a 14 day one-time temporary fill can be provided at the pharmacy.

What this means is that prior authorization must be requested/obtained prior to a prescription being fully filled for any of the above mentioned categories.

On October 1, 2013, the provider enrollment mandates outlined in the Affordable Care Act (ACA) took effect for pharmacy claims. All prescribers must be enrolled in the CT Medical Assistance Program in order for the pharmacy to get paid for dispensing the medication. Edits have been set up in the claims system to alert pharmacies when a prescriber is not enrolled. Below are Q&A's to help pharmacies address certain scenarios that they may encounter.

Q: What has to be done when a claim denies for a non-enrolled provider (edit 207)?

A: The pharmacy will receive specific messaging for claims that set edit 207 – "Prescribing provider not enrolled" indicating that a one-time temporary supply is available. In order to avoid disruption in medication therapy, pharmacies can obtain this one-time override by entering all 7's in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field, NCPDP 461-EU in order to dispense a 14-day temporary supply of the prescribed medication. The pharmacy should inform the client that they are only receiving a 14 day supply of the medication due to the fact the prescriber is not enrolled in the CT Medical Assistance

Program AND hand out a DSS authorized flier which should have been distributed to pharmacies in an earlier Provider Bulletin (PB 13-49)

Q: What happens at the end of the 14 day supply if the prescribing provider still has not enrolled or begun the enrollment process and/or the client has not been able to obtain a new prescription for the medication from a CMAP enrolled provider?

A: In addition to the one-time 14 day temporary supply, pharmacies will be able to obtain an additional 30 day emergency supply of medication by entering all 4's in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field, NCPDP 461-EU. The pharmacy will receive specific messaging indicating the client is eligible for the 30 day emergency supply.

Q: In a previous Provider Bulletin and Important Message it was communicated that edit 207 – "Prescribing provider not enrolled" would be bypassed if the prescription was written by a resident. What steps need to be taken in order for the claim to bypass edit 207 if written by a resident?

A: The pharmacy does NOT need to take any special steps in order to bypass 207 if the prescription is written by a resident. Submit the claim like you normally would with the prescriber's NPI and our system automatically checks to see if that NPI has the applicable resident taxonomy. If the taxonomy associated with the NPI indicates the prescriber is a resident then the claim will bypass edit 207 and pay. If the claim does not have the applicable resident taxonomy associated with the NPI then the claim will set edit 207 with messaging allowing the one-time 14 day temporary supply.

Q: Many times a prescribing physician will call the pharmacy and indicate they are a resident and are wondering why their prescriptions are still setting edit 207. Why does this continue to be an issue?

A: DSS receives a monthly file from CMS' (Centers for Medicare and Medicaid Services) National Plan and Provider Enumeration System (NPPES) of NPIs with their associated primary taxonomy. Many times residents may think they enrolled in NPPES with a resident taxonomy but in fact they have enrolled with something different. DSS recommends asking the provider who is calling to see why their prescriptions are still setting the edit, to look at CMS' NPPES website to check if they are enrolled with the appropriate primary taxonomy indicating they are a resident/student (390200000X). This can also happen in the reverse, where a prescriber never changed his resident/student taxonomy to his current specialty.

Q: If a resident writes a prescription does the pharmacy need to submit the claim with the supervising attending's NPI or DEA number in addition to or in place of the resident's NPI?

A: No. The pharmacy would submit the claim with the NPI of whoever wrote the prescription whether it is a resident or not. The pharmacy does not need to submit the claim with the supervising attending's NPI.