RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Drug Shortages
(LAC 50:XXIX.105)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.105 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§105. Medicaid Pharmacy Benefits Management System Point of Sale—Prospective Drug Utilization Program

A. – C. ...

D. Drug Shortages. Drugs that are not on the list of covered drugs, including drugs authorized for import by the Food and Drug Administration (FDA), may be covered when deemed medically necessary during drug shortages identified by the FDA.

E. Reimbursement Management. The cost of pharmaceutical care is managed through NADAC of the ingredient or through wholesale acquisition cost (WAC) when no NADAC is assigned, and compliance with FUL regulations, the establishment of the professional dispensing fee, drug rebates and copayments. Usual and customary charges are compared to other reimbursement methodologies and the "lesser of" is reimbursed.

F. Claims Management. The claims management component is performed through the processing of pharmacy claims against established edits. Claim edit patterns and operational reports are analyzed to review the effectiveness of established edits and to identify those areas where the development of additional edits are needed.

1. – 3. Repealed.

G. Pharmacy Program Integrity. Program integrity is maintained through the following mechanisms:

1. retrospective drug utilization review;

2. Lock-In Program for patient education; and

3. Surveillance and Utilization Review Systems (SURS) Program processes which provide for on-going review for mis-utilization, abuse and fraud and audits of the pharmacy providers.

H. Pharmacy Provider Network. Enrolled Medicaid pharmacy providers are required to comply with all applicable federal and state laws and regulations.

I. Point-of-Sale Prospective Drug Utilization Review System. This on-line point-of-sale system provides electronic claims management to evaluate and improve drug utilization quality. Information about the patient and the drug will be analyzed through the use of therapeutic modules in accordance with the standards of the National Council of Prescription Drug Programs. The purpose of prospective drug utilization review is to reduce duplication of drug therapy, prevent drug-to-drug interactions, and assure appropriate drug use, dosage and duration. The prospective modules may screen for drug interactions, therapeutic duplication, improper duration of therapy, incorrect dosages, clinical abuse/misuse and age restrictions. Electronic claims submission inform pharmacists of potential drug-related problems and pharmacists document their responses by using interventions codes. By using these codes, pharmacists will document prescription reporting and outcomes of therapy for Medicaid recipients.

1. – 5. Repealed.

J. POS/PRO-DUR Requirements Provider Participation.

1. Point-of-sale (POS) enrollment amendment and certification is required prior to billing POS/PRO-DUR system. Annual recertification is required.

2. All Medicaid enrolled pharmacy providers will be required to participate in the Pharmacy Benefits Management System.

3. Eligibility verification is determined at the point of sale.

4. Pharmacy providers and prescribing providers may obtain assistance with clinical questions from the University of Louisiana at Monroe.

5. Prescribers and pharmacy providers are required to participate in the educational and intervention features of the pharmacy benefits management system.

K. Recipient Participation. Pharmacy patients are encouraged to take an active role in the treatment or management of their health conditions through participation in patient counseling efforts with their prescribing providers and pharmacists.

L. Disease and Outcomes Management. Disease management will be focused on improving the drug therapy for certain disease states by developing procedures to assure direct interventions and increasing compliance of patients. Patient

populations will be targeted for disease therapy monitoring and educational efforts.

M. Peer Counseling and Conference Management. The department will analyze data for individual prescribers and pharmacists. Quality management strategies will be used for peer counseling and conferences with prescribers and/or pharmacists to assure appropriate prescribing and dispensing.

AUTHORITY NOTE: Promulgated in accordance with R.S, 36:254, Title XIX of the Social Security Act, and the 1995-96 General Appropriate Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), LR 45:570 (April 2019), amended LR 45:665 (May 2019), LR 50:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medical Transportation Program
Elevated Level of Care
(LAC 50:XXVII.Chapter 5 and Chapter 7)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXVII.Chapter 5 and Chapter 7 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program

Chapter 5. Non-Emergency Medical Transportation

Subchapter A. General Provisions

§501. Introduction

A. Non-emergency medical transportation (NEMT) is provided to Medicaid beneficiaries to and/or from a Medicaid covered service or value-added benefit (VAB) when no other means of transportation is available.

NOTE: Repealed.

B. Medicaid covered transportation is available to Medicaid beneficiaries when:

1. the beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services;

2. the beneficiary or their representative has stated that they have no other means of transportation; and

3. the beneficiary may utilize the elevated level of care (ELOC) transportation services, often referred to as door through door transportation, which provides assistance beyond the capacity of the beneficiary. ELOC is a higher level of care for beneficiaries with mobility limitations requiring assistance with ambulating independently when using a wheelchair.

C. This Chapter applies to the fee-for-service and managed care programs for the provision of NEMT to and/or from medically necessary Medicaid covered services.

1. ...

2. An elevated level of care NEMT service utilizes fully credentialed NEMT providers who have complied with any advanced training and insurance required by the department, to transport fee-for-service beneficiaries and managed care enrollees to and/or from covered Medicaid services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1638 (November 2021), amended LR 50:

§503. Prior Approval and Scheduling

A. – A.2. ...

B. Elevated level of care wheelchair services require additional approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 50:

§505. Requirements for Coverage

A. Payment shall only be authorized for the least costly means of transportation available. The least costly means of transportation shall be determined by the department or its designee and considered the beneficiary’s choice of transportation, the level of service required to safely transport the beneficiary (e.g., ambulatory, wheelchair, transfer), and the following hierarchy:

1. – 3. ...

4. for-profit providers who are enrolled in the Medicaid Program.

B. Beneficiaries shall be allowed a choice of transportation for-profit providers as long as it remains the least costly means of transportation.

C. Beneficiaries may request NEMT elevated level of care services to and/or from a Medicaid covered service if medically eligible.

1. – 2. Repealed.

D. Beneficiaries are encouraged to utilize healthcare providers of their choice in the community in which they reside when the beneficiary requires Medicaid reimbursed transportation services.

1. Beneficiaries may seek medically necessary services in another state when it is the nearest option available.

2. In the managed care program, transportation will only be approved to and/or from a healthcare provider within the department’s geographic access standards, unless granted an exception by the department or its designee.

E. Beneficiaries and healthcare providers should give advance notice when requesting transportation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 49:877 (May 2023), LR 50:

Subchapter C. Provider Responsibilities

§517. Provider Enrollment

A. ...

B. Non-emergency medical transportation for-profit providers shall have a minimum liability insurance coverage of $25,000 per person, $50,000 per accident and $25,000 property damage policy.

1. – 3. ...

C. As a condition of reimbursement for transporting Medicaid beneficiaries to and/or from healthcare services, gas reimbursement providers must maintain a current valid vehicle registration, the state minimum automobile liability insurance coverage, and a current valid driver’s license. Proof of compliance with these requirements must be submitted to the department or its designee during the enrollment process. Gas reimbursement providers are allowed to transport up to five specified Medicaid beneficiaries or all members of one household across all contracted managed care organizations. The provider may not reside at the same physical address as the beneficiary being transported. Individuals transporting more than five Medicaid beneficiaries or all members of one household shall be considered for-profit providers and shall be enrolled as such and comply with all for-profit provider requirements.

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 49:877 (May 2023), LR 50:

Subchapter D. Reimbursement

§523. General Provisions

A. – B. ...

C. Reimbursement for NEMT elevated level of care claims shall be allowed only when accompanied by the completed prior approval form documenting the need for the enhanced level of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 50:

Chapter 7. Non-Emergency Ambulance Transportation

§705. Prior Approval and Scheduling

A. The department or its designee must review and approve or deny the transportation requests, prior to scheduling, for beneficiary eligibility and verification of the following:

1. ...

2. that a completed certification of ambulance transportation form is received for the date of service and

medical necessity has been determined by a licensed medical provider.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1640 (November 2021), amended LR 50:

§707. Reimbursement

A. ...

B. Reimbursement for NEAT claims shall be allowed only when accompanied by the completed certification of ambulance transportation form justifying the need for ambulance services.

C. Medicaid covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a certificate of ambulance transportation dated no earlier than 180 days before the date the service is furnished.

D. Reimbursement will not be made for any additional person(s) who must accompany the beneficiary to the medical provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1640 (November 2021), amended LR 50:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Michael Harrington, MBA, MA

Secretary