MOLINA® HEALTHCARE

Reimbursement Policy for High Dollar Pharmacy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Reimbursement Guidelines

This policy focuses on payment review practices for inpatient claims with high-dollar pharmacy charges, affecting the overall claim reimbursement amount. This encompasses various review types, including but not limited to:

- Individual drug medical necessity assessments.
- Disposal of drugs and biological waste.
- Generic versus brand availability evaluations.
- Review of usual, customary, and reasonable billed charges.
- Scrutiny of undocumented medication charges.

Medical Necessity Determination

Molina Healthcare will conduct individualized assessments of high-cost drugs to determine their medical necessity. This evaluation will be based on the following criteria:

- Molina Drug and Biologic Coverage Criteria
- Molina Clinical Policies (MCP's)
- FDA (Food and Drug Administration) Regulations
- New Century Health drug policies
- CMS National and Local Coverage Determination Criteria
- Any other relevant state, federal, or industry standards

If, upon review, it is found that a high-cost drug (or drugs) does not meet the criteria for medical necessity, all associated charges related to the drug(s) will be excluded from the final calculation of claim payment.

Discarded Drug(s) and Biological Waste

Molina Healthcare will conduct a thorough evaluation of any drugs and biologicals billed to ensure they align with the smallest available dose (vial) from the manufacturer that can effectively deliver the prescribed dosage to the patient. Charges that exceed the billing procedure based on the smallest dose (vial) will not be included in the final claim payment calculation.

For instance, consider Drug XYZ, which comes in 50mg and 100mg vials. If the patient is prescribed 35mg, and the provider uses a 100mg vial for administration, charges for only the 50mg vial will be accepted. This is because the manufacturer's vial options permit the prescribed dose to be administered using a 50mg vial.

It's important to note that Molina Healthcare does not reimburse for the wastage of drugs from multi-dose vials or packages. Any charges associated with waste from multi-dose vials or packages, as substantiated by the medical record and itemized bill, will be excluded from the final claim payment calculation.

Generic vs Brand

Unless there is a documented medical necessity that justifies the use of the brand name drug, Molina Healthcare will only consider charges for the final claim payment calculation that are in line with the reasonable cost of the generic drug.

Usual, Customary, and Reasonable Billed Charges

In accordance with CMS' Provider Reimbursement Manual – Part 1, Chapter 21, which deals with Costs Related to Patient Care (Section 2102.1 - Reasonable Costs), the principle applied is that actual costs are eligible for payment to the extent they are reasonable. Providers are expected to make efforts to minimize their costs, ensuring that their actual costs do not surpass what a prudent and cost-conscious buyer would pay for the same item or service. Additionally, if costs exceed the level typically incurred by such buyers, and there is no clear evidence that higher costs were unavoidable, these excess costs are not reimbursable under the program.

Molina Healthcare uses two methods to determine the reasonable costs of inpatient pharmacy drugs and biologicals: the CMS rate (Average Sales Price (ASP) + 6%) and/or 110% of the Wholesale Acquisition Cost (WAC).

If a drug or biological has an established CMS rate, any charges exceeding that rate will not be included in the final claim payment. However, for drugs or biologicals without an associated CMS rate, charges exceeding 110% of the WAC rate will be disallowed from the final claim payment."

Undocumented/Erroneously Entered Medication Charges

Molina Healthcare does not provide reimbursement for medications that have not been documented as being administered to the patient in the medical record. This policy applies to cases of unit errors in the data entry process as well. Charges associated with undocumented medications will not be included in the final claim payment calculation.

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid
FDA	Food and Drug Administration
ASP	Average Sales Price
WAC	Wholesale Acquisition Cost
Reasonable Cost	CMS rate (Average Sales Price [ASP] + 6%) and/or 110% of the Wholesale Acquisition Cost (WAC)
Brand Drug	A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Example Motrin
Generic Drug	A copy of an approved brand name drug which contains the same active ingredient, and is the same in terms of strength, route of administration, dosage form, safety, and quality. It may be manufactured and marketed after the brand name drug loses patent protection and competition can come onto market (commonly referred to as loss of exclusivity). In general, a generic medication will work in the same way as the brand drug and provide the same clinical benefit.
MCP	Molina Clinical Policies

References

This policy was developed using.

- Additional relevant CMS regulatory guidance as applicable
- State Medicaid Regulatory Guidance
- State Contracts

State	Reference
CMS	Provider Reimbursement Manual – Part 1, Chapter 21- Costs Related to Patient Care, 2102.1 Reasonable Costs
FL	Chapter 409 Section 908 - 2018 Florida Statutes - The Florida Senate (flsenate.gov)

State Exceptions

State	Exception
MI	**Generic vs Brand** Protected Drug Class via Senate bill 412
FL	**Generic vs Brand** Medicaid National Drug Rebate Agreement (NDRA) | Medicaid **Usual, Customary, and Reasonable Billed Charges** For the state of Florida "Molina Healthcare utilizes the CMS rate (Average Sales Price (ASP) + 6%) and/or 101.5% of the Wholesale Acquisition Cost (WAC) to determine reasonable costs of inpatient pharmacy drugs and biologicals."

Documentation History

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