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
- Discarded drugs and biologicals waste
- Generic vs Brand availability
- Usual, customary, and reasonable billed charges
- Undocumented medication charges or discrepancies between administration records and billing

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

Upon review, if it is determined that a high-cost drug(s) is not medically necessary, all associated charges to the drug(s) will be disallowed from the final claim payment calculation.

Discarded Drug(s) and Biological Waste

Molina Healthcare will evaluate any drug and or biological billed to ensure that it corresponds with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose to the patient. Any associated charges that exceed the smallest dose (vial) billing procedure outlined above will be disallowed from the final claim payment calculation.

For Example: Drug XYZ is available from the manufacturer in 50mg and 100 mg vials. The amount prescribed for the patient is 35 mg. If the provider uses a 100 mg vial to administer the dose, the provider may only submit charges for the 50 mg vial as the doses available from the manufacturer allow the prescribed amount to be administered with a 50 mg vial. page 2 of 3 PI_ Approval Date Revision Date(s): Molina Healthcare does not reimburse for discarded or wasted amounts of drugs from multi-dose vials/multi-dose packages. Any charges determined to be associated with multi-dose vial/multi-dose package waste, per the medical record and/or itemized bill, will be disallowed from the final claim

payment calculation.

Generic vs Brand

Where appropriate and in alignment with regulatory guidance, 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

According to CMS' Provider Reimbursement Manual – Part 1, Chapter 21- Costs Related to Patient Care, 2102.1 Reasonable Costs, actual costs are to be paid to the extent they are reasonable. It is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Also, if costs exceed the level that such buyers incur, without clear evidence that the higher costs were unavoidable, the 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 reimburse for billed medications not documented as being provided/administered to the patient in the medical record. Any charges that are determined to be associated with an undocumented medication or at a dosage that differs from that in the record will be disallowed from 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
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

Type	Date	Action
Effective Date	06/09/2023	
Revised Date	12/12/2024	Updated state expections