VERMONT

Department of Vermont Health Access *Agency of Human Services*

Department of Vermont Health Access Pharmacy Benefit Management Program Provider Manual 2012

MedMetrics HealthPartners

Updated December 27, 2011

Table of Contents

Introduction	1
Help Desk Telephone Numbers/Important Addresses	2
Important Pharmacy Program Web Links	3
Drug Coverage and Diabetic Supplies Coverage	5
Prior Authorization	7
Emergency 72-Hour Fill	8
General Assistance	9
Generic Substitution Policy	9
VPharm Pilot Program for Statins & Proton Pump Inhibitors (PPIs)	10
Long-Term Care Claims	11
Special Claims (compounded claims, limited distribution claims)	12
Paper Claims	14
Specialty Pharmacy	15
Return to Stock	15
Record Retention	15
Prospective Drug Utilization Review	16
Timely Filing Limits	19
Dispensing Limits / Days' Supply	20
Quantity Limits	21
Provider Dispensing Fees	22
Recipient Payment Information (Copays)	23
Coordination of Benefits	24
Payer Sheet	27
Medicare	38
Payer Specifications	40
Provider Reimbursement	41
Appendix A: VScript Covered Maintenance Drug Categories	42
Appendix B: VScript Non-Covered Drug Categories	43

Introduction

Pharmacy claims for Vermont's publicly funded programs are processed by our pharmacy benefit management company – **MedMetrics Health Partners (MHP)**.

This Provider Manual consists of a list of contacts, program-specific information, a list of informational resources and web links, and payer specifications. All of this material will be updated periodically as needed. For the most current version go to:

http://dvha.vermont.gov/for-providers

For Vermont's purposes, here and hereafter all references to Vermont Medicaid will mean all publicly funded health assistance programs in current use (Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), PC Plus, VHAP-Pharmacy, VScript, VScript Expanded, VPharm, Healthy Vermonters, General Assistance and HIV/AIDS Medication Assistance).

Help Desk Telephone Numbers

Responsibility	Help Desk	Phone Numbers	Availability
Recipient:			
Beneficiary	Vermont Member Services Unit	800-250-8427	M-F 8:00AM – 4:30PM (excluding holidays)
Provider:			
HP*	Provider Enrollment and Payment	800-925-1706 (in state) 802-878-7871 (out of state)	M-F 8:00AM –5:00PM
MedMetrics Health Partners	Pharmacy Help Desk / Claims-related Pharmacy Call Center	800-918-7545	24/7/365
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365
Michelle Sirois MedMetrics Health Partners	Program Representative	802-879-5940	M-F 8:00AM – 4:30PM (excluding holidays)
Diane Neal, RPh MedMetrics Health Partners	Clinical Staff (Williston, Vermont)	802-879-5605 802-879-5919 (fax)	M-F 8:00AM – 4:30PM (excluding holidays)
Mary Pierce VMAP Coordinator Vermont Department of Health	Prior Authorization (Designated drugs on the HIV/ AIDS Medication Assistance Program list only)	802-527-5576 (phone)	M-F 8:00AM – 4:30PM (excluding holidays)
Nancy Miner, CPhT MedMetrics Health Partners	Account Manager	802-879-5638	M-F 8:00AM – 4:30PM (excluding holidays)

*HP will continue to handle provider enrollments and process and distribute pharmacy provider reimbursements and remittance advices (RAs).

Important Addresses

Provider Paper Claims Billing Address:	**Notes:**
MedMetrics Health Partners Vermont Medicaid Paper Claims Processing Unit 312 Hurricane Lane, Suite 201 Williston, VT 05495 (802) 879-5638	Format: Universal Claim Form (UCF)

MedMetrics (MHP)/Department ofVermont Health Access (DVHA) Operations
312 Hurricane Lane, Suite 201 Williston, VT 05495

Important Vermont Pharmacy Program Web Links

Department of Vermont Health Access (DVHA): http://dvha.vermont.gov/

DVHA/MHP Provider Services and Claims Processing: http://dvha.vermont.gov/for-providers

HP Provider Enrollment and Payment: www.vtmedicaid.com/

Coverage Chart for Pharmacy Only Programs:

http://dvha.vermont.gov/for-providers/2012-coverage-grid.pdf

Medicare Part D Resources:

http://dvha.vermont.gov/for-providers/medicare-part-d-resources

Beneficiary Aid Category List
http://www.vtmedicaid.com/Information/whatsnew.html

Vermont Health Access Pharmacy Benefit Management Program:

http://dvha.vermont.gov/for-providers/pharmacy-benefits-management-program-1

Drug Utilization Review Board:

http://dvha.vermont.gov/administration

Preferred Drug List and Drugs that Require PA: http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Clinical Criteria and Advisories: http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Prior Authorization Forms:
http://dvha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms

Pharmacy Bulletins and Alerts: http://dvha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts

Active Enrolled Provider/Prescriber Listing: www.vtmedicaid.com/Downloads/manuals.html

http://dvha.vermont.gov/for-providers/v-scriptparticipants06-29-07alphabetical.pdf

Pharmacy Provider Manual: http://dvha.vermont.gov/for-providers

Pharmacy Payer Specifications: http://dvha.vermont.gov/for-providers/medmetrics-health-partners-mhp-billing-information

Drug Coverage

General coverage rules are as follows:

Medicaid as a unique program covers most prescription drugs with the exceptions found here. General coverage conditions under Medicaid pharmacy and the pharmacy only programs can be found at:

http://dvha.vermont.gov/for-providers/2012-coverage-grid.pdf

Each beneficiary is assigned an Aid Category Code. This code identifies the program that provides coverage. A crosswalk of programs to codes can be found in the Aid Category List: http://www.vtmedicaid.com/Information/whatsnew.html

The following drugs/drug classes are not covered through the pharmacy benefit:

1. DESI drugs
2. Experimental drugs (DEA = 1)
3. Fertility agents
4. Drugs to treat erectile dysfunction
5. Weight loss drugs
6. OTCs not covered: See below
7. Bulk Powders used in compounding (see page 12)

Over-the-counter (OTC) drugs are covered when medically necessary, prescribed by a qualified Medicaid provider, and a federal rebate agreement with the manufacturer is in force. Covered OTCs are limited primarily to generics, without the option of prior authorization for brand products. A list of covered OTC medication categories is published at http://dvha.vermont.gov/for-providers. A beneficiary's benefit plan may limit OTC coverage further: See DVHA's Program Coverage document at http://dvha.vermont.gov/for providers.

Drug coverage is contingent upon CMS rebate agreements with the manufacturers. For all VPharm programs, Vermont statute requires that manufacturers provide to the State rebates that are at least as favorable as CMS rebates paid to the state for its Medicaid program. Exception: Diabetic supplies will pay regardless of rebate, subject to prior authorization requirements.

Some supplies may be submitted on-line (e.g., diabetic supplies and family planning supplies such as condoms). The supply must have a corresponding NDC.

Claims for all other supplies, including those used for incontinence, should be submitted on a CMS 1500 form to HP.

Nutritional supplements may be submitted online but do require Prior Authorization.

Exceptions to VScript Maintenance List

The VScript drug program provides coverage for prescription medications (and limited OTCs) which are considered maintenance therapies as designated by national drug databases. If a claim denies for a drug because it is not on the VScript Maintenance List (Appendix A) and the beneficiary is utilizing the medication in a maintenance manner (i.e. continuously), the prescriber may contact the Clinical Call Center at 800-918-7549 to request prior authorization.

Custom Program Messaging

In an effort to help pharmacies to better know / understand a beneficiary's program eligibility/coverage, custom messages have been added to the claim processing responses. Messages will appear regardless of how the claim processes (i.e., pays or rejects) and will appear after specific messaging that refers to the cause of a reject.

Prior Authorization

Prior authorization may be required for all programs except General Assistance and Healthy Vermonters.

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List. The List and Criteria for prior authorization can be found at:

http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Prior authorizations may be faxed to the number below.

Responsibility	Help Desk	Phone Numbers	Availability
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365

Emergency 72-Hour Fill

An emergency fill provision can be instituted by MedMetrics when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. If the prescriber cannot be reached to obtain the required prior authorization, the pharmacist may contact MedMetrics for authorization to dispense an emergency supply to last up to 72 hours. If the emergency persists, refills can be available. This emergency 72-hour fill provision is Federal law (Title 19, Section 1927(D)(5)(b)) and is applicable only to medications that are covered by Vermont's pharmacy programs.

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General Assistance

Beneficiaries may be enrolled in General Assistance in one of two ways:

- General Assistance only; i.e., there is no other "primary" Medicaid coverage; *or*
- General Assistance as secondary coverage with another Medicaid program as primary.

Coverage is limited to classes of drugs identified as likely to create an emergency if not covered.

Generic Substitution Policy

Vermont law requires that when available, the equivalent generic product should be dispensed. This requirement may be overridden by the provider in the following conditions:

- The prescriber has mandated brand, noting "Brand Medically Necessary" or "Dispense as Written" on the prescription. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of "1". In many instances, the prescriber will need to contact the Clinical Call Center to request a prior authorization.
- Brand product is dispensed as a generic: When a pharmacy provider dispenses a brand as their "house generic" instead of the generic equivalent, the provider should submit a DAW of "5." Generic pricing will apply.
- DVHA prefers the brand product: In select situations, the state reserves the right to make the determination that a branded product is the preferred product when a new FDA-approved generic equivalent proves more costly to the State than its branded counterpart. These claims should be submitted using a DAW of "6."
- The generic is not available in the marketplace: In this case, the pharmacy provider should submit a DAW of "8". Note that this does not mean that it is not available in the store. DAW8 may only be used when the generic is not generally available in the community. The provider should keep appropriate documentation to support this condition.

Important:

- DAW codes do not override the requirements of the DVHA Preferred Drug List.
- Pharmacy providers should not bill DVHA for multi-source (innovator) brand drugs using a DAW2 code, which indicates that the beneficiary prefers the brand. These claims will be rejected.

VPharm Pilot Program for Statins and Proton Pump Inhibitors (PPIs)

DVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs) for VPharm Part D-eligible beneficiaries.

- Statins – all dosage strengths of simvastatin, lovastatin and pravastatin.
- PPIs – omeprazole RX 10 mg, 20 mg and 40mg
- Most of the drugs no longer covered by VPharm under this pilot do not require prior authorization (PA) from the Part D Plans. However, if a beneficiary obtained a PA from his/her Part D Plan, the drug will be covered by VPharm through the VPharm PA process.
- If no Medicare Part D prior authorization is in place, a VPharm coverage exception may be possible for a non-covered drug but only when a prescriber can detail the conditions that make it strictly medically necessary and/or provide evidence that the VPharm covered drugs are harmful.

Long-Term Care (LTC) Nursing Home Claims

LTC nursing home claims are identified by a value of "3" in the PATIENT RESIDENCE field on the claim.

Some drugs and supplies are not covered for LTC nursing home patients through POS as they are covered in the patient's per-diem. With the exception of insulin, needles and syringes, OTC drugs and products are not covered.

There is no co-pay to the recipient on LTC claims.

Providers submitting LTC claims are limited to one dispensing fee per patient per covered drug per month ("per month" will be considered 75% of a 34-day supply; this allows the provider a limit of one dispense fee per every 25 days). "Per covered drug" will be considered "per GPI" (*Definition:* A GPI, or Generic Product Indicator, includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.) Providers may request an override to the single dispensing fee limit for mitigating circumstances by contacting the Pharmacy Call Center at (800) 918-7545. Acceptable circumstances for overriding the single dispense fee limit are:

- The physician has prescribed a second round of medication within the 25-day period.
- The physician has increased the dose.
- The medication did not last for the intended days supply.
- The drug has been compromised by accident (e.g., contaminated or destroyed).
- The medication is being dispensed due to the patient's LOA (leave of absence) from the institution.
- Note: The dispensing of controlled substances is limited due to concern regarding patient's ability to take appropriately.

Except for controlled substances, unused or modified unit dose medication that are in reusable condition and which may be returned to a pharmacy pursuant to state laws, rules or regulations, shall be returned from LTC facilities to the provider pharmacy. The provider should void or resubmit the claim with the appropriate quantity dispensed.

Special Claims

Multi-Ingredient Compound Claims

- Ingredients will be priced at the lesser of AWP – 14.2%, the MAC, or the FUL.

- The ingredients' costs will be totaled and priced at the lesser of the calculated cost or the claim's U&C cost.
- Containers other than syringes are included in the dispensing fee.

- Syringes must be billed as part of the compounded claim. They are not subject to a separate dispensing fee or compounding fee.

- A dispensing fee of $19.75 for in-state pharmacies and $17.50 for out-of-state pharmacies will be automatically added to all prescriptions submitted with a compound indicator of "2."

- All compounds must contain **more than one ingredient**. Compounds submitted with only one ingredient will reject with a reject code of 76 with local messaging of "Minimum ingredients of 2."

    - **Compound indicator must be "2"** (indicating a multi-ingredient compound).

- **NDC field in claim segment (i.e. Product/Service ID)** (not individual ingredients) must contain **11 zeros**. If an actual individual NDC is submitted in the Product/Service ID, the claim will reject with a reject code of 70 with local messaging of "Submit 11 zeros in the Product/Service ID and complete compound detail – more than 1 ingredient required."

- **Bulk powders/chemicals/products used in prescription compounding are not covered under the pharmacy benefit program.** CMS has clarified that bulk products are not considered covered outpatient drugs because they are not prescription drug products approved under Section 505, 505(j), or 507 of the Federal Food Drug and Cosmetic Act. Pharmacies must utilize other non-bulk, FDA-approved products for the claim to be covered (for example, tablets or capsules). Pharmacies should ask their wholesalers whether products are listed by First Data Bank with a "HIC3" of "U6W," or by MediSpan as 3rd Party Restriction of "B," each of which are designations of "Bulk Chemicals."

- Bulk powders used to compound products for the **prevention of pre-term labor** will continue to be covered after Prior Authorization in certain situations.

- **Oral Vehicles for Multi-Ingredient Compounded Prescriptions**. DVHA can reimburse you for the following oral vehicles used in compounded prescriptions.

Product ID	Type	Mfg	Label Name
00574-0302-16	NDC	PADDOCK	ORA-SWEET SF SYP
00574-0303-16	NDC	PADDOCK	ORA-PLUS LIQ
00574-0304-16	NDC	PADDOCK	ORA-SWEET SYP
00574-0311-16	NDC	PADDOCK	ORA-BLEND SUS CT
00574-0312-16	NDC	PADDOCK	ORA-BLEND SF SUSCT
00395-2662-16	NDC	HUMCO	CHERRY SYP

00395-2662-28	NDC	HUMCO	CHERRY SYP
00802-3959-28	NDC	HUMCO	CHERRY SYP

- **Submission Clarification Code 08.** Multi-ingredient compound claims will reject if any of the ingredients used in the compound are from a manufacturer that does not offer federal rebate. ***If the pharmacy is willing to only be reimbursed for the approvable products, the claim can be resubmitted with a submission clarification code 08.***

Any questions about the submission of claims for compounded medications should be directed to the MedMetrics Clinical Call Center at 1-800-918-7549.

Limited Distribution Drugs

Limited Distribution Pharmacies dispense medications that may have special requirements for dosing or close lab monitoring. Because of these special requirements, drug manufacturers sometimes choose to limit the distribution of their drugs to only one or a few select pharmacies or, as part of the drug approval process, the Food and Drug Administration (FDA) may recommend this type of distribution. This type of restricted distribution allows the manufacturer to properly control the inventory of the drug; educate the dispensing pharmacists about the monitoring required; and ensure any risks associated with the medication are minimized.

Drugs dispensed by limited distribution pharmacies are paid, as of 07/01/11, as follows:
(a) "Multiple Source" drugs are paid at the lowest of:

- AWP-16.5% + dispensing fee;
- CMS Federal Upper Limit (FUL) + dispensing fee;
- State Maximum Allowable Cost (MAC) + dispensing fee; or
- The pharmacy's Usual and Customary (U&C) (includes dispensing fee).

(b) "Single-source" limited distribution drugs are paid at the lowest of: AWP-16.5% + dispensing fee; or Usual and Customary (U&C) (includes dispensing fee).

Paper Claims

- The Universal Claim Form (UCF) will be required for all paper claims.
- The UCF should be submitted to MHP for processing.
- UCFs may be obtained from Moore Document Solutions:

Moore Document Solutions
410 N. 44th Street, Suite 300
Phoenix, AZ 85008
800-635-9500

Specialty Pharmacy

The Department of Vermont Health Access (DVHA) has selected two specialty pharmacies to serve Medicaid beneficiaries (where Medicaid is the primary insurer).

- Wilcox Home Infusion is the specialty pharmacy for Synagis®, which is administered to prevent respiratory syncytial virus (RSV).

- ICORE Healthcare, LLC, partnering with MedMetrics Health Partners, is currently the specialty pharmacy for other select specialty drugs. On 2/01/12, DVHA will transition from ICORE to Ascend Specialty Rx. ICORE will continue refilling prescriptions through 2/15/12 during this transition. After 2/15/12, D Ascend Specialty Rx will be the specialty pharmacy for select specialty drugs.

  This includes, but is not limited to:
  - Crohn's disease injectibles
  - Cystic fibrosis medications (Tobi® and Pulmozyme®)
  - Drugs used to treat rheumatoid arthritis, psoriasis, psoriatic arthritis, and ankylosing spondylitis. These include Humira (adalimumab), Enbrel (etanercept) and Kineret.
  - Elaprase® (for Hunter's Syndrome)
  - Hemophilia factors
  - Hepatitis C (ribavirin, Incivek®, Victrelis® and injectables)
  - Growth hormones
  - Multiple sclerosis self-injectables
  - Oral oncology drugs:, Gleevec®, Hexalen®, Mesnex®, Sprycel®, Sutent®, Tarceva®, Temodar®, Tretinoin, Vesanoid®, Xeloda®.

Other drugs will be added to the specialty program periodically.

Dispensing of these medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer.

Return to Stock

When a beneficiary or the beneficiary's representative fails to pick up a prescription, pharmacies must reverse the claim submitted to DVHA within fourteen (14) calendar days of the date the prescription is filled. The date of service (e.g. the date the prescription is filled) is considered day one. The pharmacy must retain a record of the reversal on file for audit purposes.

Record Retention

Pharmacy records (including prescriptions) must be retained by the pharmacy for seven (7) years at a minimum.

Prospective Drug Utilization Review (ProDUR)

ProDUR is an integral part of the Vermont Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists pharmacists in ensuring that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because ProDUR examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. While the pharmacist uses his/her education and professional judgment in all aspects of dispensing, ProDUR is intended an informational tool to aid the pharmacist.

Therapeutic Problems

The following ProDUR Reason of Service types will deny for the Vermont Medicaid program:

- Drug-to-Drug Interaction
- Therapeutic Duplication
- Ingredient Duplication

ProDUR Edits that deny may be overridden at POS using the interactive NCPDP DUR override codes (see below).

DUR Override Processing (NCPDP Reject Code 88)

When a claim is rejected for a DUR edit, pharmacies may override the denial by submitting the appropriate DUR Reason for Service, Professional Service, and Result of Service codes. In addition, the following information is required on the claim: PA type code: 01, and the PA number of 00000000003**.**

Below you will find a chart that details the Professional Service and Result of Service codes that will override a claim that has been denied for Drug-to-Drug Interaction, Ingredient Duplication and/or Therapeutic Duplication. Note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated in the chart to allow the override.

DUR REJECT OVERRIDE PROCESSING (NCPDP Reject Code 88)

The valid DUR Reason for Service Codes for Vermont Medicaid are:

DD - Drug-Drug Interaction
ID - Ingredient Duplication
TD - Therapeutic Duplication

The only acceptable Professional Service Codes are:

MR – Medication Review
M0 – Prescriber Consulted
R0 – Pharmacist Consulted Other

Please note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated below to allow the override:

DUR REASON FOR SERVICE (Conflict)	PROFESSIONAL SERVICE CODE (Intervention)		RESULT OF SERVICE CODE (Outcome)	
	CODE	**DESCRIPTION**	**CODE**	**DESCRIPTION**
DD, ID, TD				
	MR	Medication review	**1B**	Filled prescription as is
	M0	Prescriber consulted		
	R0	Consulted other		
	M0	Prescriber consulted	**1C**	Filled with different dose
	R0	Consulted other		
	MR	Medication review	**1D**	Filled with different directions
	M0	Prescriber consulted		
	R0	Consulted other		
	MR	Medication review	**3E**	Therapy changed
	M0	Prescriber consulted		
	R0	Consulted other		

Days Supply

Accurate days supply reports are required on all claims. Submitting incorrect days supply information in the days supply field can cause false ProDUR messages or claim denial for that particular claim and/or for drug claims that are submitted in the future.

ProDUR Support

MHP's Pharmacy Call Center is available 24 hours per day, seven days per week. The telephone number is 800-918-7545. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about ProDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Pharmacy Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. MHP has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, MHP staff pharmacists are available for consultation.

ProDUR Alert/Error Messages

All messages appear in the claims adjudication transmission. See Payer Specifications for more information.

Timely Filing Limits

Most providers submitting point of sale submit their claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after the fact.

- For all original claims, reversals and re-bills, the timely filing limit is **183 days** from the date of service (DOS).

- Claims that exceed the prescribed timely filing limit will deny.

- When appropriate, contact MHP for consideration of an override to timely filing limits.

- Requests for overrides will be considered for:
  1. Retroactive beneficiary eligibility
  2. COB delay
  3. Denial date (depending on original adjudication date)
  4. At the State's request

- Overrides for timely filing limits exceeded greater than two years from the date of service will not be authorized.

Requests for overrides should be mailed to:

MedMetrics Health Partners
Vermont Medicaid Paper Claims Processing Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495

Call the MHP Program Representative with any questions at (802) 879-5940.

Dispensing Limits and Days Supply:

- Non-maintenance drugs (Definition: medications used on an "as needed" basis) are subject to a per claim days' supply maximum limit of 34. There is no days supply minimum.

- "Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle.

  Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days, to which one dispensing fee will be applied. Excluded from this requirement are medications which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances. In these circumstances, regardless of whether or not extenuating circumstances permit more frequent dispensing, only one dispensing fee may be billed.

- Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day refills. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Department of Vermont Health Access.

- The first time a prescription is filled is referred to as the "initial fill" or "first fill," while subsequent fills are referred to as "refills." Up to five refills are permitted if allowed by federal or state pharmacy law.

- Claims will deny if the days' supply limit is exceeded. Exceptions to standard days supply limits:
  - Oral Contraceptives may be dispensed in a quantity not to exceed a 92-day supply.
  - Drugs provided to residents of a long-term care facility are not subject to the 90-day refill requirement. Resident of community care homes are not considered residents of long-term care facilities and therefore are subject to the 90-day refill requirement.
  - Requests for overrides should go to the MHP Clinical Call Center.

Quantity Limits:

All Quantity Limits are identified in the Preferred Drug List. The Preferred Drug List can be found at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Refills:

- All refills must be dispensed in accordance with State and Federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the date of the original prescription.
- Refills must not exceed 5 refills (plus one original).
- For DEA code = "3", "4", "5": allow up to 5 refills (plus one original) or 6 months, whichever comes first.
- For DEA code = "2" no refills are allowed; a new prescription is required for each fill.

Early Refill Overrides (NCPDP Reject Code 79):
Claims will reject for refill requests when more than 25% of the previous days' supply still remains. For some drugs, primarily controlled medications, claims will reject when more than 15% of the previous days' supply still remains. Pharmacies may request an override for claims that reject for early refill. To request an override, pharmacies must contact the Pharmacy Call Center at (800) 918-7545.

Pharmacy Representatives should be prepared to provide the appropriate submission clarification code (reason) for the early refill request. See below:

Submission Clarification Code / Description	
00/ not specified	**Not acceptable for early refill override**
01/ no override	**Not acceptable for early refill override**
02/ other override	**Not acceptable for early refill override**
03/ vacation supply	Acceptable; use for vacations and LTC leave of absence
04/ lost prescription	Acceptable
05/ therapy	Acceptable; use when prescriber changes dose
06/ starter dose	**Not acceptable for early refill override**
07/ medically necessary	**Not acceptable for early refill override**

Provider Dispensing Fees

- The dispensing fee for in-state pharmacies is $4.75.
- The dispensing fee for out-of-state pharmacies is $2.50.

- For compounded drugs:
    - The dispensing fee for in-state pharmacies is $19.75.
    - The dispensing fee for out-of-state pharmacies is $17.50
    - (See page 12)

- Exceptions:
    - There is a limited dispensing fee for LTC claims; i.e. one per every 25 days per patient per covered drug (per GPI).
    - No dispensing fee for glucometers.

Recipient Payment Information

Vermont programs have no deductibles and no benefit maximums.

When traditional Medicaid coverage is primary, copayments are:

- $1 if allowed amount is equal to or less than $29.99.
- $2 if allowed amount is greater than or equal to $30.00 but less than or equal to $49.99.
- $3 if allowed amount is equal to or greater than $50.00.

VHAP, VPharm and VScript plans include a copayment from the beneficiary. Copayments are:

Population affected	**Prescriptions with DVHA cost share of $29.99 or less**	**Prescriptions with DVHA cost share of $30.00 or more**
VHAP beneficiaries at or above 100% of the federal poverty guideline	$1.00 Co-pay	$2.00 Co-pay
VPharm beneficiaries		
VScript/VScript Expanded beneficiaries		

Exceptions (no copayments apply):

- Patient is 20 years old or younger (based on Eligibility File)
- VHAP patients whose income is less than 100% of the Federal Poverty Level (FPL)
- Drug is a family planning drug
- Patient is pregnant or in the 60-day post-pregnancy period (requires a prior authorization obtained by calling MedMetrics Clinical Call Center at 800-918-7549)
- Claim is licensed nursing home (LTC) claim (**requires PATIENT LOCATION = "03" on the claim to indicate licensed nursing home LTC)**
- Medical supplies

Note: A pharmacy may not refuse to dispense a prescription to a Medicaid beneficiary who does not provide the copayment. However, the beneficiary will still owe the pharmacy any copayment that is not paid. The pharmacy may tell the beneficiary that any later prescriptions may not be filled if the beneficiary does not pay what is owed.

When Healthy Vermonter coverage applies, the beneficiary pays the full allowed amount. Full-benefit dual eligible beneficiaries (those who have both Medicaid and a Medicare Part D Plan) are responsible for copayments up to $6.50 charged by the Part D Plan for 2012. For beneficiaries who are enrolled in a VPharm (Part D wrap) program, Part D plan deductibles and coinsurance should be billed to VPharm, with the beneficiary paying the co-pay outlined above. The maximum Part D Plan co-pay for 100% Low-income Subsidy (LIS) VPharm beneficiaries is $6.50. For further clarification on how VPharm plans interact with Medicare Part D, see: http://dvha.vermont.gov/for-providers/2012-coverage-grid.pdf

Coordination of Benefits

The following provides information on submitting COB claims.

Claim segment and field requirements are detailed in the Consolidated Payer Specification Sheet.

Required information on a secondary claim may include:

- Submitted Patient Pay
- Other Coverage Code
- Other Payer Amount
- Other Payer Date
- Other Payer ID Qualifier
- Other Payer ID

The state-assigned Other Payer IDs can be found on the Active Payer and PDP Sponsor Lists found at http://dvha.vermont.gov/for-providers. These lists are:

- Insurance carriers / sponsors for COB claims filed under PCN VTM
- Medicare Part D Plan Sponsors for COB claims filed under PCN VTD

Providers may submit up to three segments of information when there are multiple other payers.

Other Payer Coverage Codes (OCC)

Please see the following two OCC billing instruction grids outlining the correct use of OCC codes when billing for members enrolled in Vermont's publicly funded pharmacy programs. The Other Payer Coverage Code indicates the type of coverage the other insurer is providing for the claim. (See charts below for possible scenarios and circumstances.)

Other Payer Coverage Code (NCPDP Field #308-C8): Required on all secondary claims.

These OCC codes **are not** appropriate for claims billed to DVHA on a secondary basis (a primary payer(s) was billed prior to coinsurance being billed to DVHA.

Other Coverage Code / Description	Processing Policy Vermont Coverage Secondary to Alternate Insurance	Processing Policy Vermont Coverage Secondary to Medicare Part D Plan
0 = Not Specified	Claim will reject	Claim will reject.
1 = No other coverage identified	Claim will reject	Claim will reject.
5 = Managed Care Plan denial	Claim will reject	Claim will reject.
6 = Other coverage Denied, not a participating provider	Claim will reject	Claim will reject.
8 = Copay Only	Claim will reject	Claim will reject.

These OCC codes **<u>are</u>** appropriate for claims billed to DVHA on a secondary basis (a primary payer(s) was billed prior to coinsurance being billed to DVHA

OCCURRANCE	CORRECT OTHER COVERAGE CODE TO USE	(DVHA – VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(DVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance plan pays a portion of the claim.	2 = Other coverage exists, payment collected from primary insurance.	Requires COB Segment including Other Payer ID and Other Payer Paid Amount, Other Payer-Patient Responsibility Amount fields. Claim will process based on Medicaid allowed amount. <u>Leaving these fields blank is not permitted as it will result in the State paying the claim incorrectly. These claims will be subject to recoupment.</u>	Requires COB Segment including Other Payer ID and Other Payer Paid Amount, Other Payer-Patient Responsibility Amount fields, and Benefit Stage Fields – claim will pay based on member cost share from PDP. OCC2 does not apply to full-benefit duals (except for Part B claims). <u>Leaving these fields blank is not permitted as it will result in the State paying the claim incorrectly. These claims will be subject to recoupment.</u>
The primary insurance rejects the claim.	3 = Other coverage exists, claim rejected by primary insurance.	**<u>Only to be used for over-the-counter drugs.</u>** Claims submitted with an OCC = 3 will be subject to an edit to determine if drug is OTC; if so, the state will pay claim if all other state criteria is met. State would prefer Other Payer Reject Code, but field is not currently required. **<u>For non-OTC drugs:</u>** If the primary payer denies a claim because the drug requires a prior authorization or it is a non-formulary drug, then the primary carrier's prior authorization procedures must be followed.	Claims submitted with an OCC = 3 will be subject to an edit to determine if drug class is Excluded from Part D coverage by CMS; if so, state will pay claim if all other state criteria is met. If product is not an Excluded Drug from CMS for Part D coverage, state will reject claim. State would prefer Other Payer Reject Code, but field is not currently required. OCC=3 does not apply to Medicare Part B.
The primary insurance carrier processes the claim but does not make a payment because: **a) The member is in a deductible period,** **b) The payment is less than the patient's copayment.**	4 = Other coverage exists, payment not collected from primary	Requires COB Segment including Other Payer ID and Other Payer Paid Amount, Other Payer-Patient Responsibility Amount fields Claim will pay based on Medicaid allowed amount. <u>OCC = 4 is not to be used when the primary claim has been denied by the primary insurance plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.</u>	To be used when member has deductible or "donut hole" and primary payer is not making payment on claim; requires Other Payer-Patient Responsibility Amount fields, and Benefit Stage Fields and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible. OCC4 does not apply to Part D claims for full-benefit duals (but may be used for Part B claims). <u>OCC = 4 is not to be used when the primary claim has been denied by the Part D Plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.</u>

Other Payer ID Qualifier (NCPDP Field #339-6C): Required on claims where the Other Coverage Code (OCC) = "2". The Other Payer ID Qualifier will always be "99 – Other", since the list is a state-issued list of payers.

Other Payer ID (NCPDP Field #339-7C: Required on claims where the Other Coverage Code (OCC) = "2". The Other Payer ID is a unique three-digit carrier code that identifies the other insurer; the state issues and maintains that list of codes. For Medicare Part D secondary claims, the state maintains a list of the Part D plan sponsors. For other Medicaid secondary claims, the state maintains a complete list of potential insurers.

Other Payer Amount Paid (NCPDP Field #431-DV): Required on claims where the Other Coverage Code (OCC) = "2". The Other Payer Amount Paid is the dollar amount of the payment received from the primary payer(s).

Other Payer Date (NCPDP Field #443-E8): Required on all secondary claims. The Other Payer Date is the payment or denial date of the claim submitted to the other payer.

Other Payer Reject Code (NCPDP Field #472-6E): The Other Payer Reject Code is required when the Other Coverage Code (OCC) = 3.

Vermont Medicaid / DVHA
Consolidated Payer Sheet for VT Pharmacy Use
Updated – 9/26/11

Bin #: 610593
States: Vermont
Destination: SXC Health Solutions / RxClaim
Accepting: Claim Adjudication, Reversals
Format: NCPDP Version D.0
Effective: 1/1/2012
ECL: NCPDP External Code List Version Date: October 2009

BILLING (B1), REVERSAL (B2), and REBILLING (B3) TRANSACTION DATA ELEMENTS

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) are excluded from the template.

ELIGIBILITY VERIFICATION (E1) TRANSACTION DATA ELEMENTS
This client does NOT SUPPORT eligibility verification transactions.

PRIOR AUTHORIZATION (P1, P2, P3) TRANSACTION DATA ELEMENT
This client does NOT SUPPORT prior authorization transactions.
The use of the Prior Authorization Segment is NOT SUPPORTED.

INFORMATION (N1, N2, N3) TRANSACTION DATA ELEMENTS
This client does NOT SUPPORT informational transactions.

CONTROLLED SUBSTANCE REPORTING (C1, C2, C3) TRANSACTION DATA ELEMENTS
This client does NOT SUPPORT controlled substance reporting transactions
PARTIAL FILL TRANSACTION REPORTING
USE OF PARTIAL FILE DATA ELEMENTS is NOT SUPPORTED
Reverse original partial claim and resubmit with final dispensed quantity.

COORDINATION OF BENEFITS REPORTING

COB is fully supported.

- **COB is required by this client for claims that are secondary to Part D or commercial insurance.**
- **Claims secondary to Part D:** Include Other Payer: Patient Responsibility fields and Benefit Stage Fields
- **Claims secondary to commercial insurance**: Include Patient Responsibility fields
- Submission of Part B drugs require Other Payer: Patient Responsibility Fields

COUPON REPORTING

USE OF THE COUPON SEGMENT DATA ELEMENTS is NOT FULLY SUPPORTED

MULTIPLE-INGREDIENT COMPOUND CLAIMS SUBMISSION

The COMPOUND SEGMENT for multi-ingredient compound claims is supported

Single-ingredient compound claims are no longer accepted by this client.

-

CLAIM BILLING/CLAIM REBILL TRANSACTION

Transaction Header Segment	**Check**	**Claim Billing/Claim Rebill**
This Segment is always sent	**X**	**Required for B1, B2 & B3 Transactions.**

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	610593	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1,B2, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	VTM or VTD	M	Members with Medicare Part D use VTD Testing: VTMTEST or VTDTEST for Medicare Part D Members
1Ø9-A9	TRANSACTION COUNT	Up to 4 allowed	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Use 01 - NPI ID	M	
2Ø1-B1	SERVICE PROVIDER ID	NPI ID	M	
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Use value for Switch's requirements.	M	

Insurance Segment	**Check**	**Claim Billing/Claim Rebill**
This Segment is situational	**X**	**Required for B1 & B3 Transactions. Not required for B2**

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	Payer Requirement: Required
312-CC	CARDHOLDER FIRST NAME		RW	Payer Requirement: Complete if present
313-CD	CARDHOLDER LAST NAME		RW	Payer Requirement: Complete if present
314-CE	HOME PLAN		RW	Payer Requirement: Complete if present
524-FO	PLAN ID		RW	Payer Requirement: Complete if present
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		RW	Payer Requirement: As needed to override reject
3Ø1-C1	GROUP ID	VTMEDICAID	M	Payer Requirement: Required
3Ø3-C3	PERSON CODE		RW	Payer Requirement: Complete if present
3Ø6-C6	PATIENT RELATIONSHIP CODE		RW	Payer Requirement: Complete if present

Patient Segment		**Check**		**Claim Billing/Claim Rebill**
This Segment is always sent		**X**		**Required for B1, B2 & B3 Transactions.** **Segment required to Locate patient**
	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	***Payer Situation***
331-CX	PATIENT ID QUALIFIER	06	R	**Payer Requirement: Required**
332-CY	PATIENT ID		R	**Payer Requirement: Required - Medicaid ID**
3Ø4-C4	DATE OF BIRTH		R	**Payer Requirement: Required – Correct DOB will be returned if incorrect DOB submitted**
3Ø5-C5	PATIENT GENDER CODE		R	**Payer Requirement: Required**
31Ø-CA	PATIENT FIRST NAME		R	**Payer Requirement: Required**
311-CB	PATIENT LAST NAME		R	**Payer Requirement: Required**
322-CM	PATIENT STREET ADDRESS		RW	**Payer Requirement: Complete if present**
323-CN	PATIENT CITY ADDRESS		RW	**Payer Requirement: Complete if present**
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	**Payer Requirement: Complete if present**
325-CP	PATIENT ZIP/POSTAL ZONE		RW	**Payer Requirement: Complete if present**
326-CQ	PATIENT PHONE NUMBER		RW	**Payer Requirement: Complete if present**
333-CZ	EMPLOYER ID		RW	**Payer Requirement: Complete if present**
335-2C	PREGNANCY INDICATOR		RW	**Payer Requirement: Complete if present**
384-4X	**PATIENT RESIDENCE**		**RW**	**Payer Requirement: Required for Nursing Home Claims – Value of "03"**

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	**X**	**Required for B1 B2 & B3 Transactions.**
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	01	M	Payer Requirement: Only value of "01" is accepted
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Payer Requirement: Supports 12-digit Rx Number Example: 000001234567 (leading zeros)
436-E1	PRODUCT/SERVICE ID QUALIFIER	03	M	Payer Requirement: Only value of 03 accepted
4Ø7-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	Payer Requirement: Complete if present
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	Payer Requirement: Complete if present
458-SE	PROCEDURE MODIFIER CODE COUNT	Maximum count of 1Ø.	RW	Payer Requirement: Complete only if 459-ER PROCEDURE MODIFIER CODE is completed
459-ER	PROCEDURE MODIFIER CODE		RW	Payer Requirement: Complete if present
442-E7	QUANTITY DISPENSED		RW	Payer Requirement: Required for B1 & B3 claims
4Ø3-D3	FILL NUMBER		RW	Payer Requirement: Required for B1 & B3 claims
4Ø5-D5	DAYS SUPPLY		RW	Payer Requirement: Required for B1 & B3 claims
4Ø6-D6	COMPOUND CODE		RW	Payer Requirement: Required for B1 & B3 claims Use "1" if product not a compound "2" if product is a compound
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		RW	Payer Requirement: Required for B1 & B3 claims
414-DE	DATE PRESCRIPTION WRITTEN		RW	Payer Requirement: Required for B1 & B3 claims
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	Payer Requirement: Complete if present
419-DJ	PRESCRIPTION ORIGIN CODE		R	Payer Requirement: Required
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Payer Requirement: Complete only if 42Ø-DK SUBMISSION CLARIFICATION CODE is completed
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	Payer Requirement: As needed to override reject
3Ø8-C8	OTHER COVERAGE CODE		R	Payer Requirement: Required

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	**X**	**Required for B1 B2 & B3 Transactions.**
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill

429-DT	SPECIAL PACKAGING INDICATOR		RW	Payer Requirement: Complete if present
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER		RW	Payer Requirement: Complete if present Partial Fills not supported
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	Payer Requirement: Complete if present. Partial Fills not supported
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	Payer Requirement: Complete if present Partial Fills not supported
454-EK	SCHEDULED PRESCRIPTION ID NUMBER			Payer Requirement: Complete if present
6ØØ-28	UNIT OF MEASURE		RW	Payer Requirement: Complete if present
418-DI	LEVEL OF SERVICE		RW	Payer Requirement: Complete if present
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	Payer Requirement: Complete if present
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	Payer Requirement: Complete if present
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID		RW	Payer Requirement: Complete if present
464-EX	INTERMEDIARY AUTHORIZATION ID		RW	Payer Requirement: Complete if present
343-HD	DISPENSING STATUS		RW	Payer Requirement: Complete if present Partial Fills not supported
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	Payer Requirement: Complete if present Partial Fills not supported
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	Payer Requirement: Complete if present Partial Fills not supported
995-E2	ROUTE OF ADMINISTRATION		RW	Payer Requirement: Required If 406-D6 Compound Code is a "2"

Pricing Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	**X**	**Required for B1 & B3 Transactions. Not required for B2**

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	Payer Requirement: Submit only if Actual payment to pharmacy before submission Should use fields 351-NP and 352-NQ for Patient responsibility
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Payer Requirement: Complete if present
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Payer Requirement: Required in applicable locations
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	Payer Requirement: Required in applicable locations
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	Payer Requirement: Required if 482-GE PERCENTAGE SALES TAX AMOUNT SUBMITTED is submitted.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	Payer Requirement: Required if 482-GE PERCENTAGE SALES TAX AMOUNT SUBMITTED and Percentage Sales Tax Rate Submitted (483-HE) are submitted
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Payer Requirement: Required
43Ø-DU	GROSS AMOUNT DUE		R	Payer Requirement: Required
423-DN	BASIS OF COST DETERMINATION		RW	Payer Requirement: Complete if present

Pharmacy Provider Segment	Check	Claim Billing/Claim Rebill
This Segment is situational – Not required	**X**	**Required for B1 & B3 Transactions. Not required for B2**

	Pharmacy Provider Segment **Segment Identification (111-AM) = "Ø2"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
465-EY	PROVIDER ID QUALIFIER		RW	Payer Requirement: Required if Provider ID (444-E9) is Submitted.
444-E9	PROVIDER ID		RW	Payer Requirement: Complete if present and segment is used

Prescriber Segment	Check	Claim Billing/Claim Rebill
This Segment is situational		**Required for B1 & B3 Transactions. Not required for B2**

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
ield #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	01	M	Payer Requirement: Required.- Use only 01
411-DB	PRESCRIBER ID		M	Payer Requirement: NPI ID
427-DR	PRESCRIBER LAST NAME		RW	Payer Requirement: Complete if present
498-PM	PRESCRIBER PHONE NUMBER		RW	Payer Requirement: Complete if present
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER		RW	Payer Requirement: Complete if present
421-DL	PRIMARY CARE PROVIDER ID		RW	Payer Requirement: Complete if present
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		RW	Payer Requirement: Complete if present

Coordination of Benefits/Other Payments Segment Questions		
This Segment is situational		**Required only for secondary**
		Required for B1 B2 & B3 Transactions.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	01 if other payer was Primary, 02 if other payer was Secondary, 03 if other payer was Tertiary
339-6C	OTHER PAYER ID QUALIFIER		RW	Payer Requirement: Use 99 – Other for state-issued ID
34Ø-7C	OTHER PAYER ID		RW	Payer Requirement: Refer to state lists of other payer IDs
443-E8	OTHER PAYER DATE		RW	Payer Requirement: Date of Service of other payer claim
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Payer Requirement: If Other Coverage Code is 2; # of claims paid
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	Payer Requirement: Required if Other Coverage Code is 2; Use 07 – Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID		RW	Payer Requirement: Required if Other Coverage Code is 2; COB Amount- Do Not leave this field Blank

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Payer Requirement: Required if Other Coverage Code is 3. # of claims rejected by other payer
472-6E	OTHER PAYER REJECT CODE		RW	Payer Requirement: Required if Other Coverage Code is 3. NCPDP Reject Code received from other payer
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Payer Requirement: Required if Other Payer Responsibility Amount Qualifier is used Maximum 25
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Payer Requirement: Required if Other Payer Responsibility Amount is used Use Blank, 01…13 accepted. **06 Patient Resp Amount Qualifier is value used to price Part D (VTD) secondary claim. Should represent 505-F5 Patient Pay from previous payer response.**
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Payer Requirement: Required if Other Coverage Code is 2,4; Do not leave this field Blank
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	Payer Requirement: Required if Benefit Stage Amount is used Maximum of 4 with no repetition of qualifiers
393-MV	BENEFIT STAGE QUALIFIER		RW	Payer Requirement: Required if Benefit Stage Amount is used
394-MW	BENEFIT STAGE AMOUNT		RW	Payer Requirement: Required if Other Coverage Code is 2,4; Required if previous payer has financial amounts that apply to Medicare Part D

DUR/PPS Segment	Check	Claim Billing/Claim Rebill
This Segment is situational		

	DUR/PPS Segment **Segment Identification (111-AM) = "Ø8"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Payer Requirement: Required if segment used. Up to 9 occurrences are supported.
439-E4	REASON FOR SERVICE CODE		RW	Payer Requirement: Required if segment used. DD, ID, and TD accepted.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW	Payer Requirement: Required if segment used. MR, MO, and RO accepted.
441-E6	RESULT OF SERVICE CODE		RW	Payer Requirement: Required if segment used. 1B, 1C, 1D, and 3E accepted.
474-8E	DUR/PPS LEVEL OF EFFORT		RW	Payer Requirement: Complete if present
475-J9	DUR CO-AGENT ID QUALIFIER		RW	Payer Requirement: Complete if present
476-H6	DUR CO-AGENT ID		RW	Payer Requirement: Complete if present

Compound Segment	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is situational		**Compound code is 02**
		Required for B1 & B3 Transactions. Not required for B2

	Compound Segment **Segment Identification (111-AM) = "1Ø"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	Payer Requirement: 03 Required
489-TE	COMPOUND PRODUCT ID		M	Payer Requirement: NDC of each ingredient
448-ED	COMPOUND INGREDIENT QUANTITY		M	Payer Requirement: Quantity of each ingredient
449-EE	COMPOUND INGREDIENT DRUG COST		RW	Payer Requirement: Complete if present
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	Payer Requirement: Complete if present

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		**Submitted Only for B1 or B3 Transactions if required for specific claim.**
This Segment is situational		

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Payer Requirement: Complete if present
492-WE	DIAGNOSIS CODE QUALIFIER		RW	Payer Requirement: Complete if present
424-DO	DIAGNOSIS CODE		RW	Payer Requirement: Complete if present
493-XE	CLINICAL INFORMATION COUNTER	Maximum 5 occurrences supported.	RW	Payer Requirement: Complete if present
494-ZE	MEASUREMENT DATE		RW	Payer Requirement: Complete if present
495-H1	MEASUREMENT TIME		RW	Payer Requirement: Complete if present
496-H2	MEASUREMENT DIMENSION		RW	Payer Requirement: Complete if present
497-H3	MEASUREMENT UNIT		RW	Payer Requirement: Complete if present
499-H4	MEASUREMENT VALUE		RW	Payer Requirement: Complete if present

GENERAL INFORMATION

Live Date: 01/01/2006 (Payer Sheet revisions 08/15/11)

Maximum prescriptions per transaction: 4

Plan specific information, customer service: (802) 878-7871 VT Member Services Unit

Technical assistance, pharmacy help desk: (800) 918-7545 SXC Health Solutions, Inc.

Vendor certification required: Yes

Pharmacy Registration with Payer Required: No

Switch Support: NDC Health Emdeon/WebMD eRx

OTHER INFORMATION

- NPI Provider ID required for adjudication and reimbursement. Client transitioned to use of NPI ID for Prescribers beginning May 23, 2008.
- Vermont Medicaid requires that compound claims be submitted using the COMPOUND SEGMENT for multi-ingredient compound claims. Single-ingredient compound claim submission is no longer supported.

Medicare

Part B:

Vermont program coverage is always secondary to Medicare Part B Coverage. Medicare Part B coinsurance and deductible prescription drug claims with NDCs are processed by MedMetrics Health Partners.

Medicare Part B Covered Drugs:

- Oral Cancer Drugs
- Immunosuppressants
- Nebulizer Solutions
- Diabetic Supplies

To override the "Medicare as primary" requirement, pharmacies must first bill Medicare B, receive a denial, and then contact the MedMetrics Clinical Call Center at 1-800-918-7549. Pharmacies are no longer able to override at point of sale by entering 88888 in the other payer ID field.

Part D:

Effective January 1, 2006, Vermont beneficiaries who were also Medicare-eligible were enrolled in a Part D plan for primary coverage, with only a secondary benefit provided by Vermont programs.

Use an E1 request to determine if the member is enrolled in a Part D plan. If the member is enrolled in a Part D Plan, the E1 response will identify where to send the primary payment request as well as the processing information to submit to Medicaid for any secondary claim.

Vermont Medicaid members who have Part D coverage are eligible for a "wrap" benefit by the state. Depending on a member's eligibility and the product that you are dispensing, this benefit may be a financial or a formulary wrap to the Part D vendor's (PDP's) benefit. Generally, coverage parallels coverage in Vermont programs (Medicaid, VHAP, VHAP Pharmacy, VScript, and VScript Expanded). See the Vermont Pharmacy Programs Coverage Chart for the most current information: http://dvha.vermont.gov/for-providers/2012-coverage-grid.pdf

See the MedMetrics Health Partner Consolidated Payer Sheet for claims submittal information.

Medicare/Medicaid Eligibles without a Part D Plan:

Point-of-Sale Facilitated Enrollment (POS FE) Process & Limited Income Newly Eligible Transition Program (LI NET):

The POS FE process was designed to ensure that individuals with both Medicare and Medicaid, "dual eligibles," who are not enrolled in a Medicare Part D prescription drug plan, and do not have other insurance that is considered creditable coverage, are still able to obtain immediate

prescription drug coverage when evidence of Medicare and Medicaid eligibility are presented at the pharmacy. Other individuals who qualify for the Part D low-income subsidy (LIS) are also able to use the POS FE process. To ensure coverage and allow for billing to a Medicare Part D Plan, follow these steps:

Step 1) Submit an E1 Transaction to the TROOP Facilitator. Note: If you are uncertain about how to submit an E1 or enhanced E1 query, please contact your software vendor.

If the E1 query returns a BIN/PCN indicating the patient has current drug plan coverage, **do NOT submit a claim to the POS FE process**. If the E1 query returns a help desk telephone number, this indicates the individual has been enrolled but the 4Rx data is not yet available. Please contact that plan for the proper 4Rx data.

If the E1 query does not return a BIN/PCN indicating the individual has current drug plan coverage, go to step 2.

Step 2) BIN/PCN to submit claims for the 2012 Limited Income Newly Eligible Transition (LI NET) Program:

BIN: 015599 (Claims billed for the remainder of the 2011 benefit year, should use 610649)
PCN: 05440000
ID Number: Medicare HIC Number
Group Number: may be left blank

More information on the LI NET program is available online at the following location: https://www.cms.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp or by calling the LI NET help desk at 1-(800)-783-1307.

Part C:

Medicare Part C consists of several Medicare Advantage Plan choices that are Medicare-approved and administered by private insurance companies.

- The Medicare Advantage Plans will replace Part A and Part B for members who choose to join. Some Medicare Advantage Plans also include drug coverage (Part D).

- For those plans that do not include Part D drug coverage, the member will need to have a separate Part D Plan in order to receive a pharmacy benefit.

When a beneficiary is covered by both Medicare B and D, drug claims must be processed by the appropriate insurer prior to submitting any balances to MedMetrics. DVHA will closely monitor this process.

Payer Specifications

Payer specifications can be found below; however, to ensure full compliance please refer to the most current Payer Specifications document on the website for the Department of Vermont Health Access on the Provider Services and Claims Processing Page at: http://dvha.vermont.gov/for-providers/vermontd0v5120211.pdf

The Payer Specifications include details on claims submissions, host information, claims processing messages, submission clarifications, DUR information, DUR service codes, and COB messages.

BIN/PCN Numbers

Claims for Vermont Members	
ANSI BIN #	**610593**
Processor Control #	**VTM**
Group #	VTMEDICAID
Carrier	MPSOVHA
Provider ID #	NPI Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

Claims for Vermont Medicaid Members w/Part D Coverage	
ANSI BIN #	**610593**
Processor Control #	**VTD**
Group #	VTMEDICAID
Carrier	MPSOVHAD
Provider ID #	NPI Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

Provider Reimbursement

Provider Payment Algorithm

- Vermont Medicaid is the payer of last resort after other insurers.

- Vermont Medicaid programs price claims at the lesser of:

    1. AWP – 14.2% + dispensing fee
    2. HCFA FUL + dispensing fee
    3. MAC + dispensing fee
    4. U/C (includes dispensing fee)

*Secondary Claims (claims when other insurance is primary)**

1. Part D: For secondary claims when the Part D plan is the primary payer, Vermont Medicaid pays the amount designated in the claims "Patient Pay" field, reduced by any copayment made by the beneficiary.

2. Non-Part D: When other insurance is the primary payer, Vermont Medicaid pays the allowed amount as determined in the above payment algorithm reduced by the primary insurance payment, reduced by any copayment made by the beneficiary.

* See Coordination of Benefits, pages 24-26

Provider Reimbursement Schedule

The payment and Remittance Advice schedule is weekly.

Appendix A

VScript/VScript Expanded/VPharm2/VPharm3 Covered Maintenance Drug Categories

- ADD/ADHD Treatments
- Adrenergic Agents
- Alzheimer's Disease Medications
- Angina(Chest Pain) Treatments
- Anticoagulants/Blood Thinners
- Anticonvulsants/Epilepsy Treatments
- Antidepressants
- Anti-Inflammatory Agents
- Antimalarials
- Antipsychotics/Schizophrenia Treatments
- Antiretrovirals
- Anti-ulcer/Reflux Treatments
- Anxiety Treatments
- Arthritis Treatments
- Asthma/COPD Treatments
- Bipolar Treatments
- Blood Cell Stimulators
- Cancer meds
- Cholesterol-Lowering Agents
- Contraceptives (oral/systemic)
- Diabetic Therapy
- Digestive Enzymes
- Diuretics
- Electrolytes & Miscellaneous Nutrients
- Estrogens
- Folic Acid Preparations
- Gall Stone/Kidney Stone Treatments
- Heart Arrhythmia Treatments
- Heart Failure Treatments
- Hypertension Treatments
- Irritable Bowel Treatments
- Local (topical) Anesthetics
- Non-Narcotic analgesics
- Ophthalmic preparations
- Other Cardiovascular Treatments
- Other CNS Treatments
- Overactive Bladder Treatments
- Parkinson's Disease Medications
- Progesterone
- Systemic Steroids (Glucocorticoids/Mineralocorticoids)
- Testosterone Replacement Therapy
- Thyroid Preparations
- Tuberculosis (TB) Treatments
- Urinary Antibacterials

Appendix B

VScript VScript Expanded/VPharm2/VPharm3
Non-Covered Drug Categories

Non-Coverage Based Upon General Use for the Treatment of Acute Conditions

- Antibiotics (most classes)
- Antidotes **(agents used to treat accidental poisoning or overdose)**
- Antihistamines
- Antiseptics
- Antithyroid preparations
- Antivirals
- Biologicals
- Coal tar **(tar-based skin treatments for conditions like psoriasis or flakey skin)**
- Cough & cold preparations
- Dermatologic treatments
- Diagnostic meds
- Diarrhea Medications
- Digestants
- Emollients protectives **(topical treatments for dry skin)**
- Fertility treatments
- Fungal treatments
- Hemorrhoidal preparations
- Iodine therapy **(iodine-based expectorants used to decrease mucus in various respiratory conditions)**
- Laxatives
- Medical supplies
- Multivitamins
- Muscle relaxants
- Narcotic analgesics
- Nasal preparations
- Nausea treatments
- Obesity preparations
- Otic (ear) preparations
- Parasite treatments
- Sedative/hypnotics
- Vaginal products
- Vitamins (fat-soluble)
- Vitamins (water-soluble)