



DVHA Pharmacy Bulletin

News and Updates in support of our Pharmacy Partners

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Non-covered ingredients for Compounded Prescriptions March 2011 Changes

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

<u>Product ID</u>	<u>Type</u>	<u>Mfg</u>	<u>Label Name</u>
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.***

IMPORTANT: Information on Pharmacy Discount Cards

We have recently noticed that some pharmacies are billing discount cards such as **VermontRx Card** or **Family Wize** in place of a Qualified Medicare Part D plan (PDP). As a reminder:

- **These discount cards are not insurance plans.**
- If the pharmacy staff member does not know which PDP the member is enrolled in, he or she should ask the member to provide this information or do an E1 transaction.
- **If a PDP rejects a claim due to formulary issues, substituting a discount card in place of a PDP is not acceptable.** Claims found to be processed in this manner will be subject to recoupment.

Maximum Annual Pharmacy Benefit for VPharm Members For Claims Billed Using Other Coverage Code = 4

OCC4 indicates to DVHA that the member is in the deductible period with his or her Part D Plan or Part B Benefit and that the claim was processed but no payment was made.

Due to changes passed in the Affordable Care Act (ACA) last year, effective January 1, 2011, Part D plans will be making payments on brand drugs (50% of ingredient cost) and generic drugs (7% of ingredient cost) as part of the phased-in elimination of the donut hole by 2020. Therefore, OCC4 should only need to be used for the period that members are in the deductible period for either Part B or Part D.

Please note:

- 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 or non-covered drug. **These claims will be subject to recoupment.**
- Some Part D Plans may have expanded benefits and cover certain CMS excluded drugs (e.g. benzodiazepines, barbiturates, etc). OCC4 should only be used for CMS excluded drugs when those drugs are covered by the PDP but have not been paid by the PDP because the member is in his or her Part D Plan deductible.

New Member Unique ID Numbers

New **Green Mountain Care** health plan ID cards were mailed to all beneficiaries in September 2010.

- While DVHA has been returning claims submitted with member's social security numbers with the member's new Unique ID number via POS, **this interim process will end** on May 16th, 2011.
- We do have other resources for you to obtain a Member's Unique ID number in the absence of a Green Mountain Care health plan ID card. Our automated eligibility verification system allows providers to check eligibility using a Social Security number or the unique ID number. ***If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim.***
 - Online Transaction Services
<http://www.vtmedicaid.com/Interactive/login2.html>
 - HP Voice Response System/Malcolm
1-800-925-1706 (instate) or 802-878-7871.

Important Information about VPharm Members with 100% Low-Income Subsidy (LIS)

Some VPharm members are eligible for a federal low-income subsidy (LIS) that allows them to receive Part D Plan medications with no deductible and a maximum per-prescription “patient pay amount” of \$6.30. DVHA refers to these members as “VPharm 100% LIS” members. **Please note that:**

- ❖ VPharm pays the Part D patient pay amount for its VPharm 100% LIS members, up to \$6.30.
- ❖ VPharm members should not be charged an amount greater than \$6.30 by Part D Plans for Part D covered drugs.

Occasionally, a VPharm member’s LIS status will not be applied appropriately or timely at the VPharm member’s Part D Plan (PDP). For these VPharm 100% LIS members, two problems can result from incorrect processing of the claim by the PDP:

- ***Secondary claims submitted to DVHA with an Other Coverage Code of 2 (payment received by primary insurer) with a “patient pay” amount greater than \$6.30.***
 - VPharm pays the patient pay for its members up to \$6.30.
 - If an amount greater than \$6.30 is submitted to DVHA, the claim will reject with the following message: “VPHARM LIS member responsible for PDP co-pay up to \$6.30. For PDP co-pays greater than \$6.30, advise Member to contact Maximus.”
- ***Secondary Part D claims submitted with an Other Coverage Code of 4 (no payment received by primary insurer with a reject code indicating that the member is in a deductible period).*** If this occurs, the claim will reject with the following message: “Deductible not applicable for VPharm 100% LIS. OCC4 not allowed. Advise Member to contact Maximus.”

Pharmacy staff may also contact Maximus (DVHA’s Member Services Unit) directly on behalf of the Member. You may reach Maximus at 800-250-8427. A member services representative will work with you and DVHA’s Part D resolution team to facilitate a corrective process.

Vermont Medicaid Rule Change: Prescriptions for Scabicides and Pediculicides (delousing products)

- Pharmacies may no longer dispense multiple bottles of delousing products such as Permethrin to a single member to share with other household members.
- When the same drug in the same strength is prescribed for more than one member of a family at one time, the pharmacist must submit one prescription for each family member for payment purposes.
- Pharmacists are also reminded that Permethrin quantities are typically billed by ml, not by numbers of bottles. Generally, a single treatment for a single member will be one or two bottles depending on the area to be covered.

PLEASE NOTE: This rule change applies to any drug that previously would have been dispensed for family use.

Other Coverage Codes (OCC)

Please see the following helpful OCC billing instructions grid. Although we have provided this information in the past, it's always helpful to be periodically reminded of the correct use of OCC codes when billing for members enrolled in Vermont's publicly funded pharmacy programs.

Note that DVHA is no longer accepting OCC 8 (billing for co-pay). Please use OCC2 for claims with a payment from the patient's primary insurer.

OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(PCN=VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(PCN= 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 Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount. Claim will process based on Medicaid allowed amount.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount – claim will pay based on member cost share from PDP. Limitations: 1) OCC2 does not apply to full-benefit duals except in the event that the PDP makes a payment for a CMS Part D excluded drug (e.g. benzodiazepine). 2) Payment limited to \$6.30 for VPharm 100% LIS members.
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 or a covered OTC; 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 or a covered OTC, 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.

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OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(PCN=VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(PCN= VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
<p>The primary insurance carrier processes the claim but does not make a payment because:</p> <ul style="list-style-type: none"> a) The member is in the Part D deductible period, b) The member is in the Part B deductible, or c) The payment is less than the patient's copayment 	<p>4 = Other coverage exists, payment not collected from primary.</p>	<p>Requires Submitted Patient Pay field and complete COB segment. Claim will pay based on Medicaid allowed amount.</p> <p>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. These claims will be subject to recoupment.</p> <p>OCC = 4 may be used if the total cost of the claim is less than the copayment from the primary insurer, resulting in zero payment from the primary plan.</p>	<p>To be used when member is in deductible period and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible.</p> <p>Limitations for OCC4: 1) Does not apply to Part D claims for full-benefit duals, and 2) Payment limited to \$6.30 for VPharm 100% LIS members.</p> <p>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 or non-covered drug. These claims will be subject to recoupment.</p> <p>OCC = 4 may be used if the total cost of the claim is less than the copayment from the primary insurer, resulting in zero payment from the primary plan.</p>
<p>The primary insurance plan rejects the claim because coverage no longer exists.</p>	<p>7 = Other coverage exists, not in effect on Date of Service (DOS)</p>	<p>To be used if member's other coverage no longer exists; state will process claim.</p>	<p>Claim will reject.</p>



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