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**Department of Vermont Health Access**

*Agency of Human Services*

**Department of Vermont Health Access  
Pharmacy Benefit Management Program  
Provider Manual  
2015**



Updated January 1, 2015

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## **Introduction**

Pharmacy claims for Vermont's publicly funded programs are processed by our pharmacy benefit management company Goold Health Systems (GHS).

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, PC Plus, VPharm, Healthy Vermonters, and General Assistance and HIV/AIDS Medication Assistance).

## Help Desk Telephone Numbers

<b>Responsibility</b>	<b>Help Desk</b>	<b>Phone Numbers</b>	<b>Availability</b>
<b>Recipient:</b>			
Beneficiary	Vermont Member Services Unit	800-250-8427	M-F 8:00AM – 4:30PM (excluding holidays)
<b>Provider:</b>			
HP*	Provider Enrollment and Payment	800-925-1706 (in state) 802-878-7871 (out of state)	M-F 8:00AM – 5:00PM
GHS	Pharmacy Help Desk / Claims-related Pharmacy Call Center	844-679-5362	24/7/365
GHS	Clinical Call Center /Prior Authorizations	Phone: 844-679-5363 Fax: 844-679-5366	24/7/365
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)

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

## Important Addresses

<p><b><u>Provider Paper Claims Billing Address:</u></b>  GHS  Vermont Medicaid Paper Claims Processing Unit  312 Hurricane Lane, Suite 201  Williston, VT 05495  (802) 879-5638</p>	<p><b><u>Notes:</u></b>   Format:  Universal Claim Form (UCF)</p>
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<p><b><u>GHS/Department of Vermont Health Access (DVHA) Operations</u></b>  312 Hurricane Lane, Suite 201  Williston, VT 05495</p>
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## 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>

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. Some OTC's covered
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 POS (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 POS but do require 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.

### **1. VT\_PBMS-BR-30 Influenza Vaccines**

DVHA-enrolled pharmacies may be reimbursed for specific injectable influenza vaccinations administered by pharmacists to adults 19 years and older that are enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the state of Vermont and must be in compliance with all Vermont laws governing vaccine administration.

Children age 0 through 18 years presenting for flu vaccination at pharmacies should be referred to their health care provider for State-supplied vaccine.

**Reimbursement and billing:** Pharmacies are reimbursed for the ingredient cost of the flu vaccine as well as the administration fee.

Vaccine administration fee current total amount is \$20.65.

The same Administration Fee is applied to In-State and Out-of-State pharmacies.

Through the pharmacy POS system the pharmacy must submit:

The code "MA" in the Professional Service Code field and the Administration Fee amount for the influenza vaccine claims tagged with 'FLU', in order to receive full reimbursement.

There will be NO member co-pay for all influenza vaccines.

### **Required NCPDP Fields:**

<u>NCPDP Field Number</u>	<u>NCPDP Field Description</u>	<u>Required Code</u>
440-E5	Professional Service Code	MA
407-D7	Product/Service ID	NDC for Flu Vaccine
438-E3	Incentive Amount Submitted	\$20.65

### **2. VT\_PBMS-BR-49 Vaccines**

The member needs to be 19 or older for the vaccine claims to process. Vaccine claims for members under 19 years old will reject: 70 - 'PRODUCT SERVICE NOT COVERED Member age less than 19.'

## **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.

<b>Responsibility</b>	<b>Help Desk</b>	<b>Phone Numbers</b>	<b>Availability</b>
GHS	Clinical Call Center /Prior Authorizations	844-679-5363	24/7/365

### **Emergency 72-Hour Fill**

An emergency fill provision can be instituted by GHS 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 dispense an emergency supply to last up to 72 hours.

- The pharmacy should send in PA Type Code (461-EU) = 2 and PA# (462-EV) = 72 on the claim, in which case an emergency 72-hour fill is allowed.
- Limit emergency fill to 1 per member/per drug for each calendar month.
- If the emergency persists, additional emergency overrides can be done by the GHS HelpDesk.
- Dispensing Fee applies to Emergency Fills
- 'Lost and stolen' is different from Emergency Fill. See "Refill Too Soon" on page20 for details.

### **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.

Insert list here

### **Generic Substitution Policy**

Vermont law requires that when available, the equivalent generic product should be dispensed.

### **Statins and Proton Pump Inhibitors (PPIs)- VPharm**

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 program 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 Help Desk at 844-679-5362. 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 3<sup>rd</sup> 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.

<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.*

Any questions about the submission of claims for compounded medications should be directed to the GHS Clinical Call Center at 1-844-679-5363.

### ***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 GHS for processing.

Goold Health Systems, Inc  
1 Green Tree Lane  
South Burlington, VT 05403

- 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<sup>®</sup>, which is administered to prevent respiratory syncytial virus (RSV).
- BriovaRx<sup>™</sup> is currently the specialty pharmacy for other select specialty drugs.

These include, but are not limited to:

- Crohn's/Ulcerative Colitis disease injectables (Humira, Cimzia)
- Cystic fibrosis medications (Kalydeco, Tobi<sup>®</sup> and Pulmozyme<sup>®</sup>)
- Drugs used to treat rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, and ankylosing spondylitis. These include Humira (adalimumab), Enbrel (etanercept), Simponi subcutaneous, Cimzia<sup>®</sup>, Kineret<sup>®</sup>, Orencia<sup>®</sup> Subcutaneous, and Xeljanz) as well as Simponi Aria<sup>®</sup> (if obtained through Pharmacy POS).
- Hemophilia factors
- Hepatitis C (ribavirin, Incivek<sup>®</sup>, Victrelis<sup>®</sup>, Olysio, Sovaldi, and pegylated interferon injectables)
- Growth hormones
- Multiple sclerosis self-injectables (Avonex<sup>®</sup>, Betaseron<sup>®</sup>, Copaxone<sup>®</sup>, Extavia<sup>®</sup> and Rebif<sup>®</sup>) and certain orals (Aubagio, Gilenya, Tecfidera)
- Oral oncology drugs: Gleevec<sup>®</sup>, Hexalen<sup>®</sup>, Mesnex<sup>®</sup>, Sprycel<sup>®</sup>, Sutent<sup>®</sup>, Tarceva<sup>®</sup>, Temodar<sup>®</sup>, Tretinoin, Vesanoid<sup>®</sup>, Xeloda<sup>®</sup>.
- Hereditary Angioedema Medications (select) (Firazyr)
- Psoriasis Injectables (Humira, Enbrel, and Stelara (if obtained through Pharmacy POS))

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

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 Professional Service and Result of Service codes.

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 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
- 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, 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*

GHS' Call Center is available 24 hours per day, seven days per week. The telephone number is 844-679-5362. 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. GHS 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, GHS 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 GHS 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:

Goold Health Systems  
1 Green Tree Dr.  
South Burlington, VT 05403

Call the GHS Help Desk with any questions at 844-679-5362

### **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 GHS 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 the percentage of the previous days’ supply still remains (see chart below). Pharmacies may request an override for claims that reject for early refill. To request an override, pharmacies must contact the Pharmacy Call Center at 1-844-679-5362

Proposed Days Supply	Proposed % of Days Supply Used
1-4	50
5-13	75
14-39	85
10-60	90
61-102	92

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	<b>Not acceptable for early refill override</b>
01/ no override	<b>Not acceptable for early refill override</b>
02/ other override	<b>Not acceptable for early refill override</b>
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	<b>Not acceptable for early refill override</b>
07/ medically necessary	<b>Not acceptable for early refill override</b>

## **Provider Dispensing Fees**

- The dispensing fee for in-state pharmacies is \$4.75.
- The dispensing fee for out-of-state pharmacies is \$2.50.
- The dispensing fee for administering influenza (Flu) vaccine is \$20.65.
  
- For compounded drugs:
  - The dispensing fee for in-state pharmacies is \$19.75.
  - The dispensing fee for out-of-state pharmacies is \$17.50
  
- For drugs eligible under the 340B discount drug program:
  - The dispensing fee for all pharmacies is \$15.00.
  - The dispensing fee for 340B compounded drugs is \$30.00

More provider information about the 340B Program can be found in the 340B Medicaid Manual, which can be found at <http://www.vtmedicaid.com/Downloads/forms/340-B%20Medicaid%20Carve%20In%20Program%20-%20FINAL.pdf>

- 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.

VPharm plan include a copayment from the beneficiary. Copayments are:

<b>Population affected</b>	<b>Prescriptions with DVHA cost share of \$29.99 or less</b>	<b>Prescriptions with DVHA cost share of \$30.00 or more</b>
VPharm beneficiaries	\$1.00 Co-pay	\$2.00 Co-pay

Exceptions (no copayments apply):

- Patient is 20 years old or younger (based on Eligibility File)
- Drug is a family planning drug
- Patient is pregnant or in the 60-day post-pregnancy period (requires a prior authorization obtained by calling GHS Clinical Call Center at 1-844-679-5363)
- Claim is licensed nursing home (LTC) claim (**requires PATIENT LOCATION = “03” on the claim to indicate licensed nursing home LTC**)
- Medical supplies
- Influenza (flu) vaccine

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.

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 \$6.60 charged by the Part D Plan for 2015. 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 \$6.360. 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 Medicare Part D Plan Sponsors for COB claims filed under PCN

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.

#### **1. VT\_PBMS-BR-11 COB3 - VTM**

**VT applies COB 3 option for their Coordination of Benefits for VTM plans.**

Vermont Medicaid is the payer of last resort after other insurers. The following provides information on submitting COB claims. Claim segment and field requirements are detailed in VT Payer Sheet.

Required information on a secondary claim includes but is not limited to:

- Other Payer ID Qualifier (NCPDP Field #339-6C)
- Other Payer ID (NCPDP Field #339-7C)
- Other Payer Amount Paid Qualifier (NCPDP Field #342-HC): Required if OCC = 2; Use 07 – Drug Benefit.
- 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-Patient Responsibility Amount Qualifier (NCPDP Field #351-NP): Required on claims where the Other Coverage Code (OCC) = “2” or “4”. Accept only 06 = Patient Pay Amount.
- Other Payer-Patient Responsibility Amount (NCPDP Field # 352-NQ): Payer Requirement: Required if Other Coverage Code is 2 or 4; Do not leave this field blank.
- 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.

**Other Payer Coverage Codes (OCC)**

Please see the following two OCC billing instruction grids outlining the correct use of OCC codes when billing for member enrolled in Vermont Medicaid Plans. The OCC 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 (NCPCP Field #308-C8): Required on all secondary claims.

The following OCC codes **are not** appropriate for claims billed to VT Medicaid on a secondary basis.

OCC/Description	Processing Policy Vermont Coverage Secondary to Alternate Insurance
0 = Not Specified	Claim will reject
1 = No other coverage identified	Claim will reject
5 = Managed Care Plan denial	Claim will reject
6 = Other coverage Denied, not a participating provider	Claim will reject
7 = Other coverage exists-not in effect on DOS	Claim will reject
8 = Co-pay Only	Claim will reject

VT applies COB 2 option for their Coordination of Benefits Part D plans. The following provides information on submitting COB claims. Claim segment and field requirements are detailed in VT Payer Sheet.

Required information on a secondary claim includes but is not limited to:

- Other Payer ID Qualifier (NCPDP Field #339-6C)
- Other Payer ID (NCPDP Field #339-7C)
- Other Payer-Patient Responsibility Amount Qualifier (NCPDP Field #351-NP): Required on claims where the Other Coverage Code (OCC) = “8”. Accept only 06 = Patient Pay Amount.

- Other Payer-Patient Responsibility Amount (NCPDP Field # 352-NQ): Payer Requirement: Required if Other Coverage Code = 8; Do not leave this field Blank
- Other Payer Date (NCPDP Field #443-E8): 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.

**Other Payer Coverage Codes (OCC)**

Please see the following two OCC billing instruction grids outlining the correct use of OCC codes when billing for member enrolled in **Vermont Part D plans**. The OCC 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 (NCPCP Field #308-C8): Required on all secondary claims. The following OCC codes **are not** appropriate for secondary claims for VTPartD:

OCC/Description	Processing Policy Vermont Coverage Secondary to Medicare Part D Plan
0 = Not Specified	Claim will reject
1 = No other coverage identified	Claim will reject
2 = Other coverage exists, payment collected from primary insurance.	Claim will reject
4 = Other coverage exists, payment not collected from primary	Claim will reject
5 = Managed Care Plan denial	Claim will reject
6 = Other coverage Denied, not a participating provider	Claim will reject
7 = Other coverage exists-not in effect on DOS	Claim will reject

- The above rejections will produce reject error: NCPDP 13: M/I Other Coverage Code.

These OCC codes **are** appropriate for secondary claims for VT PartD:

OCCURANCE	CORRECT OTHER COVERAGE CODE TO USE	(DVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance rejects the claim.	3 = Other coverage exists, claim rejected by primary insurance	<p>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 are met. If product is not an Excluded Drug from CMS for Part D coverage, state will reject claim. Other Payer Reject Code is required (472-6E)</p> <p>OCC=3 does not apply to Medicare Part B.</p>
Claim is billing for patient financial responsibility only	8 = Co-pay Only	Requires COB Segment including Other Payer ID and Other Payer-Patient Responsibility Amount fields, and Benefit Stage Fields. 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.

FIELD #	FIELD NAME	PAYER SHEET INSTRUCTIONS
423-DN	Basis of Cost Determination	GHS utilizes the NCPDP standard and will require 2 digits on the claim (example: '00'), claims with other than 2 digits will reject.
2Ø1-B1 4Ø1-D1 4Ø2-D2	Service Provider ID Date of Service Prescription/Service Reference Number	GHS does not allow duplicate prescription number and will validate a duplicate transaction by the combination of 201-B1, 401-D1 and 402-D2
335-2C	Pregnancy Indicator	GHS will allow pharmacies the option of sending the claim with the pregnancy indicator of 2 in the 335-2C payment segment. This can be used if the member is newly pregnant and their eligibility does not reflect this.
42Ø-DK	Submission Clarification Code	Pharmacies will be able to send in Submission Clarification Code = 02 on Ebox claims for Long-Term Care members which will override the Reject 79 – Refill Too Soon error message. The Submission Clarification Code of 02 will not override 75 PA required message. The pharmacy will have to call for a special PA.
461-EU 462-EV	PA Type Code PA Number	GHS will allow pharmacies to send in 461-E = 2 and 462-EV = 72 on the claim for an on-line override when it is necessary to allow an emergency 72 hour supply of a medication. This function is only allowed off hours when the call center is not available.
522-FM	Basis of Reimbursement Determination	Pricing logic considers submitted U&C, Gross Amount Due, Ingredient Cost Submitted and the State calculated rates including State MAC, and FUL. The processor will pay the lesser of logic for all prices considered. The maximum provider payment is set at \$99,999.99. Any claim exceeding this amount will reject. Contact the POS Helpdesk for a special PA if the claim amount is higher.
341-HB 342-HC 431-DV 353-NR 351-NP 352-NQ	OTHER PAYER AMOUNT PAID COUNT OTHER PAYER AMOUNT PAID QUALIFIER OTHER PAYER AMOUNT PAID OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	VT POP (previously VTM) uses COB Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount

	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	VT Part D (previously VTD) uses COB Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	
352-NQ	QUALIFIER OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	

## GENERAL INFORMATION AND GUIDANCE

### *Transmissions*

Refer to the NCPDP Telecommunication Standard Implementation Guide Version D. Ø for the structure and syntax of the transaction(s) within the transmission.

### *Segments*

Each segment is listed as mandatory, situational, or optional for a given transaction in the NCPDP *Telecommunication Standard Implementation Guide*. If the segment is mandatory for a given transaction, that segment must be sent. If the segment is situational, the situations outlined in the guide must be followed for use.

## **Payer Sheets**

GHS encourages providers to go to the website at [www.ghsinc.com/payer-sheets](http://www.ghsinc.com/payer-sheets) to view all recent changes to the payer sheet.

## 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 GHS.

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 GHS Call Center at 1-844-679-5362. 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 program (Medicaid). See the Vermont Pharmacy Programs Coverage Chart for the most current information: <http://dvha.vermont.gov/providers/2012-coverage-grid.pdf>

See the GHS 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, “dualeligibles,” 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](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 GHS. 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**

<b>Claims for Vermont Members</b>	
ANSI BIN #	017795
Processor Control #	VTPOP
Group #	N/A
Carrier	N/A
Provider ID #	NPI Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

<b>Claims for Vermont Medicaid Members w/Part D Coverage</b>	
ANSI BIN #	017795
Processor Control #	VTPARTD
Group #	VTMEDICAID
Carrier	N/A
Provider ID #	NPI Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

## **Provider Reimbursement**

### **VT\_PBMS-BR-40 Pricing Methodology**

VT uses the following price calculation methodology for all drugs and plans unless otherwise specified in separate business rules:

#### **For Non-Compound Brand Drugs**

***Lower of:***

AWP-14.2% + Dispensing Fee  
Ingredient Cost Submitted + Dispensing Fee  
U&C Charge  
Gross Amount Due

#### **For Non-Compound Generic Drugs**

***Lower of:***

AWP-14.2% + Dispensing Fee  
MAC + Dispensing Fee  
HCFA FUL + Dispensing Fee  
Ingredient Cost Submitted + Dispensing Fee  
U&C Charge  
Gross Amount Due

#### **For Compound Brand Drugs**

***Lower of:***

AWP-14.2% + Dispensing Fee  
Ingredient Cost Submitted + Dispensing Fee  
U&C Charge  
Gross Amount Due

#### **For Compound Generic Drugs**

***Lower of:***

AWP-14.2% + Dispensing Fee  
MAC + Dispensing Fee  
HCFA FUL + Dispensing Fee  
Ingredient Cost Submitted + Dispensing Fee  
U&C Charge  
Gross Amount Due

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

***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

\*\* More provider information about the 340B Program can be found in the 340B Medicaid Manual, which can be found at <http://www.vtmedicaid.com/Downloads/forms/340-B%20Medicaid%20Carve%20In%20Program%20-%20FINAL.pdf>

***Provider Reimbursement Schedule***

The payment and Remittance Advice schedule is weekly.

**Appendix A**  
**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

### 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)