



# DVHA Pharmacy Bulletin

News and Updates in support of our Pharmacy Partners

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## **IMPORTANT: NEW DAYS SUPPLY AND REFILL CHANGES TO BE IMPLEMENTED IN JUNE AND JULY 2012**

In the coming months, the Department of Vermont Health Access (DVHA) will be implementing several changes in claims processing to reduce waste and improve the safety of our beneficiaries.

You are probably aware of the high level of attention that prescription drug abuse has been receiving in our state.

In an effort to minimize abuse and stockpiling of controlled substances, the DVHA's Drug Utilization Review (DUR) Board recently voted to:

- ❖ lower the allowed maximum days' supply for controlled substances, and
- ❖ raise the early refill thresholds for all drugs.

These changes are explained below:

### **MAXIMUM DAYS' SUPPLY FOR SCHEDULE II-V MEDICATIONS**

- **Effective June 11, 2012, all Schedule II through V medications will have a maximum days' supply of one month, regardless of whether or not they are considered a maintenance medication.**
  - Although not a scheduled medication, **all formulations of tramadol** will have the same restrictions due to its abuse potential.
  - Federal and state laws allow prescribers with patients on Schedule II maintenance medications, such as opiates and stimulants used to treat ADHD, to write three separate one-month prescriptions on the same date with future fill date indicated on the face of the prescriptions.
  - Please note: These changes do not affect the current 14-day supply maximum for Suboxone<sup>®</sup>/buprenorphine already in place.

## **REJECT 79: EARLY REFILL LIMITS**

- Previously, early refill percentages were set at 75% depletion of the current fill for all days' supply and all DEA classes.

**Effective June 11, 2012, DVHA will implement a new early refill table that is dependent both on the days' supply of the fill and the DEA class.** In all cases, every attempt has been made to give beneficiaries sufficient time to pick up a refill prescription:

- Generally 3 -5 days for DEA class III – V and tramadol. This reflects an 85% refill percentage.
- Generally 5 - 7 days for non-scheduled medications. This reflects a 78% refill percentage for a one-month supply and a 92% refill percentage for 90-day supplies.
- The pharmacy will receive a message indicating the date that the prescription may be refilled.
- **VERY IMPORTANT: This will continue to be a hard (reject) edit. If an early refill is required, the pharmacy should contact the SXC Pharmacy Help Desk at 800-918-7545 to make that request.**

## **DUR 88: INGREDIENT DUPLICATION (SAME DRUG, DOSAGE FORM, AND STRENGTH)**

To be consistent with the changes in “early refill” percentages, the same limitations in refill percentages will apply to the “ingredient duplication” edit, which applies to new prescriptions for the same drug, dosage form, and strength.

This edit will apply to Schedule II medications in the same percentages as described above for Schedule III – V medications.

**Effective June 11, 2012, DVHA will be applying a hard edit to claims rejecting for Ingredient Duplication (ID). This means that:**

- Pharmacies will no longer have the ability to submit the DUR “Reason for Service” codes to override ID denials.
- **If an early refill is required, the pharmacy should contact the SXC Pharmacy Help Desk at 800-918-7545 to make a request.**
- Vacations, changes in therapy, and lost or stolen medications may be considered valid reasons overriding the ID denial.
- All other DUR 88 rejections will continue to be able to be overridden by the pharmacy as appropriate.

This is not expected to significantly impact pharmacies as overrides should be needed only on a limited basis.

## \* OTHER IMPORTANT CHANGES \*

### **CHANGE TO DVHA'S MANDATORY 90-DAY SUPPLY MAINTENANCE MEDICATION PROGRAM**

Based on feedback from our pharmacy and provider community that a one-month period of time may not be long enough to ensure that a patient is stabilized and tolerating a new maintenance medication, **effective July 9, 2012, DVHA will allow two shorter fills before requiring that a 90-day supply for certain maintenance medications be dispensed.**

As always, a list of these select maintenance drugs can be found on the DVHA website at <http://dvha.vermont.gov/for-providers/190day-maintenance-list.pdf>

### **NCPDP VERSION D.0 TRANSITION**

**Effective July 1, 2012, DVHA will no longer accept NCPDP version 5.1 transactions.**

DVHA has seen excellent compliance with the transition to NCPDP Version D.0, and does not expect pharmacies in the Vermont Medicaid Network to be adversely impacted.

### **PHARMACY DISCOUNT CARDS**

It has been identified that pharmacies are still billing discount cards (such as Vermont Rx and FamilyWize) in place of billing commercial insurance policies or Medicare drug plans. As a reminder:

- These discount cards are not insurance plans. Discount card programs are designed to help patients who do not have prescription drug coverage and cannot be used in conjunction with State programs.
- If primary insurance such as commercial or Medicare drug plans reject claims due to deductibles, large copays, formulary limitation, dosing limitations, coverage gaps or any out-of-pocket cash expenses, it is not acceptable to replace the billing with a discount card. ***Claims found to be processed in this manner will be subject to recoupment.***
- Pharmacy staff should ask to see a copy of the member's card. These cards are identified by statements such as "DISCOUNT CARD" or a "CARD/COUPON."

## **OTHER COVERAGE CODES**

Please see the following OCC billing instructions grid. Although we have provided this information in the past, it is 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.

These OCC codes are appropriate for claims billed to DVHA on a secondary basis (a primary payer(s) was billed prior to coinsurance being billed to DVHA).

| OCCURRENCE  | CORRECT OTHER COVERAGE CODE TO USE                                   | (DVHA – VTM)<br>Processing Policy<br>Vermont Coverage Secondary to Alternate Insurance   | (DVHAD – VTD)<br>Processing Policy<br>Vermont Coverage Secondary to Medicare Part B and Part D  |
|---|--|--|---|
| <b>The primary insurance plan pays a portion of the claim.</b>  | 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.<br><br><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).<br><br><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>  |
| <b>The primary insurance rejects the claim.</b>   | 3 = Other coverage exists, claim rejected by primary insurance.      | <b><u>Only to be used for over-the-counter drugs.</u></b><br>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.<br><br><b><u>For non-OTC drugs:</u></b><br>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.<br><br>OCC=3 does not apply to Medicare Part B.  |
| <b>The primary insurance carrier processes the claim but does not make a payment because:</b><br><br>a) <b>The member is in a deductible period,</b><br>b) <b>The payment is less than the patient’s copayment.</b> | 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.<br><br><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).<br><br><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> |



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