VERMONT

Department of Vermont Health Access *Agency of Human Services*

Department of Vermont Health Access (DVHA)

Pharmacy Benefit Management (PBM) Program

Pharmacy Provider Manual

Updated 10/03/2023

CHANGE HEALTHCARE

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Introduction

Pharmacy claims for Vermont's publicly funded drug benefit programs are processed by the State's pharmacy benefit management company, **Change Healthcare®.** These programs include:

Program	***Benefit***
Medicaid	Medicaid provides low-cost or free health coverage for adults.
Dr. Dynasaur	Dr. Dynasaur provides low-cost or free health coverage for children, individuals under age 19 and pregnant women.
VPharm	Vermont offers prescription assistance to those enrolled in Medicare. Eligibility is based on income, disability status and age. VPharm helps pay for prescription medicines with affordable monthly premiums.
Healthy Vermonters	Healthy Vermonters provides a discount on prescription medicines with no monthly premiums.
General Assistance	General Assistance helps individuals and families to meet their emergency basic needs. This may include help paying for medical, dental, prescriptions, medical supplies, and equipment.
Vermont Medication Assistance Program (VMAP)	VMAP provides financial assistance for purchasing prescription medications to Vermonters living with HIV who meet specific income guidelines. This program may help pay for medications, insurance premiums, co-pays and/or deductibles.

This Pharmacy Provider Manual provides information about DVHA's drug policies, coverage rules, pharmacy claims-submission requirements and NCPDP payer specifications. It also provides a list of contacts, program-specific information and a list of informational resources and web links. These materials are updated periodically as needed. For the most current version go to: https://dvha.vermont.gov/providers/manuals.

In addition to this pharmacy-specific provider manual, all pharmacies should review the guidance provided in the general provider manual. Claims payment and remittance advices are issued by the State's fiscal agent, Gainwell Technologies For information on payments to pharmacies and electronic remittance advices, please refer to the Vermont Medicaid general provider manual at:
http://www.vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf.

Pharmacy Program Contact Information

Help Desk Information

Responsibility	Help Desk	Phone Numbers	Availability
Recipient:			
Beneficiary	Green Mountain Care Member Services Unit	800-250-8427	M-F 8:00AM – 4:30PM (excluding holidays)
Provider:			
Gainwell Technologies	Provider Enrollment and Payment	800-925-1706 (in state) 802-878-7871 (out of state)	M-F 8:00AM –5:00PM
Change Healthcare	Pharmacy Help Desk PBA_VTHelpdesk@changehealthcare.com	844-679-5362	24/7/365
Change Healthcare	Prescriber Help Desk PBA_VTHelpdesk@changehealthcare.com	Phone: 844-679-5363 Fax: 844-679-5366	24/7/365
Robyn Airoldi VMAP Coordinator Vermont Department of Health	Prior Authorization (Designated drugs on the HIV/ AIDS Medication Assistance Program list only)	802-951-4005(phone)	M-F 6:00AM – 2:30PM (excluding holidays)

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

Manual Claims Billing Address

Provider Paper Claims Billing Address:	**Notes:**
Change Healthcare 1 Green Tree Lane South Burlington, VT 05403	VTPOP and VTPARTD manual forms can be found online: https://dvha.vermont.gov/providers/pharmacy/change-healthcare-billing-information

DVHA Pharmacy Unit Contact Information

Department of Vermont Health Access (DVHA) Pharmacy Operations Unit
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
AHS.DVHAPH@vermont.gov

Drug Coverage

Medicaid covers most prescription drugs, with exceptions outlined in this provider manual and the DVHA preferred drug list, which can be found here: https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria.
In addition to these exceptions, federal rules specify that Medicaid may not pay for drugs whose manufacturers do not participate in the federal rebate program.

Other DVHA programs offer more limited coverage, such as VPharm I, II and III, which offer secondary coverage of Part D drugs. General coverage conditions for Vermont's publicly funded drug benefit programs can be found below.

General Assistance

Beneficiaries may be eligible for General Assistance. "General Assistance" means financial aid to provide the necessities of life including food, clothing, shelter, fuel, electricity, medical care, and other items as the Commissioner may prescribe by regulation when a need is found to exist, and the applicant is otherwise found eligible.

DVHA covers most prescription drugs, with exceptions outlined in this provider manual and the DVHA preferred drug list, which can be found at:
https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria

Drug Benefit Program Designs

Of the DVHA programs that include full health insurance coverage, all of them include a pharmacy benefit. These programs are described below by a summary table produced by the Office of Health Care Advocate for ease of visualization.

Overview of Green Mountain Care and Vermont Health Connect Programs as of 7/14/22 Created by Vermont Legal Aid's Office of Health Care Advocate 1-800-917-7787			
PROGRAM	**WHO IS ELIGIBLE**	**BENEFITS**	**COST-SHARING**
MABD Medicaid[1] **Medicaid Working Disabled** **MCA**[2] **(Expanded Medicaid)**	Aged, blind, disabled at or below the PIL[3]. Disabled working adults at or below 250% FPL[4]. Vermonters at or below 138% of FPL who are: • Parents or caretaker relatives of a dependent child; or • Adults under age 65 and not eligible for Medicare	• Covers physical and mental health, dental ($1000 cap/yr), prescriptions, chiro (limited), transportation (limited). • Not covered: eyeglasses (except youth 19-20); dentures. • Additional benefits listed under Dr. Dynasaur (below) covered for youth 19-20. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals.	• No monthly premium. • $1/$2/$3 prescription co-pay if no Medicare Part D coverage. • $3.60 -$8.95 co-pays if have Part D. (if beneficiary is under 100% FPL $1.30 to $3.90) Medicare Part D is primary prescription coverage for dual-eligible individuals. • $3 dental co-pay. • $3/outpatient hospital visit.
Dr. Dynasaur	Pregnant women at or below 213% FPL.	Same as Medicaid, but with full dental.	No premium or prescription co-pays.
Dr. Dynasaur	Children under age 19 at or below 317% FPL.	Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	• Up to 195% FPL: no premium. • Up to 237% FPL: $15/family/month. • Up to 317% FPL: $20/family/month . ($60/family/mo. w/out other insurance) • No prescription co-pays.
VPharm1 150% FPL **VPharm2 175% FPL** **VPharm3 225% FPL**	Medicare Part D beneficiaries	• VPharm1, 2 & 3 cover Part D cost-sharing & excluded classes of Part D meds, diabetic supplies, eye exams.	• VPharm1: $15/person/mo. pd to State • VPharm2: $20/person/mo. pd to State • VPharm3: $50/person/mo. pd to State • $1/$2 prescription co-pays. • VPharm1 must apply for Part D Low Income Subsidy.
Medicare Savings Programs: **QMB 100%FPL** Qualified Medicare Beneficiaries **SLMB 120% FPL** Specified Low-Income Beneficiaries **QI-1 135% FPL** Qualified Individuals	• QMB & SLMB: Medicare beneficiaries w/ Part A • QI-1: Medicare bens. who are not on other fed. med. benefits e.g. Medicaid (LIS for Part D OK).	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing. • SLMB and QI-1 cover Medicare Part B premiums only.	No cost / no monthly premium.
Healthy Vermonters 350% FPL/ 400% FPL if aged or disabled	Anyone who has exhausted or has no prescription coverage	• Discount on medications. (NOT INSURANCE)	Beneficiary pays the Medicaid rate for all prescriptions.

[1] MABD: Medicaid for the Aged, Blind, and Disabled. MABD is the only program w/ resource limits: $2000/person, $3000/couple (Medicaid for the Working Disabled is $$10,000/person, $15,000/couple). Long Term Care Medicaid (nursing home care; waiver services) is not included in this chart.
[2] MCA: Medicaid for Children and Adults
[3] PIL: Protected Income Limit.
[4] FPL: Federal Poverty Level
[5] Lawfully present non-citizens with FPL below 138% FPL are also eligible for APTC, since they are not eligible for Medicaid until they have lived in the United States for at least 5 years. ARPA removed the 400 FPL upper limit for APTC 2022.
[6] "Affordable": employee's contribution for a self-only plan is less than 9.61% of household's MAGI (Modified Adjusted Gross Income).
[7] MEC: Minimum Essential Coverage. Vermont Health Connect (VHC) will disregard offers of certain insurance, including student health plans, TRICARE, and Medicare coverage that requires the beneficiary to pay a Part A premium.

Pharmacy Reimbursement

Effective 4/1/2017 and in compliance with CMS-2345FC, the Covered Outpatient Drug Rule, DVHA uses the following price calculation methodology for all covered drugs billed to Vermont when Vermont is the primary payer.

For claims submitted to Vermont on a secondary basis, when other insurance is the primary payer, reimbursement is described in the section entitled "Coordination of Benefits."

Payment of covered outpatient drugs, including over-the-counter (OTC) drugs, billed to DVHA on a primary basis and dispensed by an enrolled pharmacy, will be reimbursed at the lower of the following (less the Member's copay, if applicable):

a. The National Drug Average Acquisition Cost (NADAC) + Professional Dispensing Fee;
b. The Wholesale Acquisition Cost (WAC) + 0% + Professional Dispensing Fee;
c. The State Maximum Allowable Cost (SMAC) + Professional Dispensing Fee;
d. Federal Upper Limit (FUL) + PDF
e. AWP-19% + Professional Dispensing Fee;
f. Submitted Ingredient Cost + Professional Dispensing Fee;
g. The provider's Usual and Customary (U&C) charges; or
h. The Gross Amount Due (GAD)

Professional Dispensing Fees

The professional dispensing fee for all retail pharmacies is $11.13 The Specialty dispensing fee for specialty pharmacies dispensing specialty drugs is $17.03.

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.

See Section entitled "Specialty Claims" for more information on Specialty Drugs.

340B Eligible Drugs

340B designated claims can process at Point of Sale (POS) for pharmacies enrolled in the Medicaid 340B program. Although we do not require pharmacies to identify 340B claims at the point of dispensing, we encourage this practice to minimize the burden of manual claim adjustments. Pharmacies who choose to identify 340B claims at POS should submit those claims with a Submission Clarification Code=20 and Basis of Cost= 8.

When using the SCC=20, pharmacies MUST submit their 340B acquisition cost on the claim. The "lower of" logic will apply when calculating the price of the claim using our current pricing

methodology and will pay no more than the pharmacy's 340B acquisition cost plus a dispensing fee of $11.13 retail and $17.03 for specialty drugs.

Payer sheets can be found at https://dvha.vermont.gov/providers/pharmacy/change-healthcare-billing-information

DVHA does not allow contract pharmacies to enroll in its 340B drug program.

Information on how to enroll as a 340B Provider and details on reimbursement for drugs covered under the 340B Drug Discount program can be found at this link: http://www.vtmedicaid.com/#/forms

Questions about the 340B program can be directed to AHS.DVHAPH@vermont.gov

Non-Covered Drugs

The following drugs/drug classes are not covered:

- DESI drugs
- Investigational or Experimental drugs
- Fertility agents
- Drugs to treat erectile dysfunction
- Weight-loss drugs
- Some OTCs (primarily brands)
- Some bulk powders used in compounding
- Drugs whose manufacturers do not participate in the Medicaid drug rebate program

Rebate Requirements

Drug coverage is contingent upon CMS rebate agreements with the manufacturers. The VPharm program (Part D "wrap" coverage) is a qualified State Pharmaceutical Assistance Program (SPAP). Vermont statute requires that manufacturers pay prorated SPAP rebates that are at least as favorable as the CMS rebates paid to the state for its Medicaid program.

Over-the-Counter (OTC) Drugs

Select OTC drugs may be covered when medically necessary and prescribed by an enrolled DVHA provider, and an appropriate rebate agreement with the manufacturer is in force. Covered OTCs are limited primarily to generics. The list of covered OTC drugs and medication categories is published athttps://dvha.vermont.gov/providers/pharmacy/drug-coverage-lists.

As of 08/01/2023, coverage for OTC melatonin, vitamin D, and antihistamine products are no longer covered for members age 21 and older. This change will include Medicare members enrolled in Pharm plans.

Coverage will remain in place, as medically necessary, for Vermont Medicaid members under the age of 21 in accordance with Health Care Administrative Rule 4.106: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

Select medical supplies may be submitted through POS (e.g., diabetic supplies and family planning supplies). The medical supply must have a corresponding NDC.

Nutritional supplements (liquid nutritional products) may be submitted via the POS system, these products require prior authorization. The Vermont Medicaid Preferred Drug List and Nutritional Prior Authorization form contain the criteria needed for medical necessity.

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

EPSDT is a federally mandated benefit **under the age of 21**. Medically necessary health care services are covered, including all mandatory and optional services that can be covered under the Medicaid Act, even if the service is not covered or coverage is limited for adults. The provider must submit a prior authorization request with documentation of medical necessity for the member. Prior authorization forms can be found here:

Medical:
https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms

Non-Covered Drug (use General Prior Authorization Form for most requests):
https://dvha.vermont.gov/forms-manuals/forms/pharmacy-prior-authorization-request-forms-and-order-forms

Reimbursement **under the age of 21**: Payment will be made for any service or item when it is within the scope of the categories of optional and mandatory services in the Medicaid Act, and is medically necessary. For Medicaid members **under the age of 21**, medical necessity includes a case-by-case determination that a service is necessary to correct or ameliorate a diagnosis or health condition. It also includes a determination of whether a service is needed to achieve proper growth and development or prevent the worsening of a health condition.

Reimbursement for **age 21 and over**: No payment will be made for non-covered drugs unless authorized through the exception request process.

Durable Medical Equipment (DME) Products

Most DME supplies should be submitted to DVHA on DVHA's DME prior authorization form, which can be found at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms . These DME product requests are reviewed by the DVHA Clinical Operations Unit and should be faxed to 802-879-5963.

Exceptions are continuous glucose monitors, portable/tubeless insulin pumps (e.g., Omnipod®), lancets, test strips, syringes, and spacers, which can be submitted through the pharmacy benefit. If a PA is required, those are reviewed by the Change Healthcare PA Call Center. PA request forms can be found here: https://dvha.vermont.gov/forms-manuals/forms/pharmacy-prior-authorization-request-forms-and-order-forms . A complete list of preferred diabetic supplies can be found on the DVHA website at: https://dvha.vermont.gov/providers/pharmacy/drug-coverage-lists

The Omnipod® DASH PDM system must be obtained directly from the manufacturer, Insulet. Other Omnipod® supplies can be dispensed by pharmacies using the following national drug codes (NDCs):

- Omnipod® DASH 5 Pack Pods 08508-2000-05
- Omnipod® DASH Intro Kit 08508-2000-11 (expected to launch late summer 2021)

Incontinence Supplies

As of 8/15/23, select medically necessary incontinence products are supplied by a single vendor, ActivStyle. https://www.activstyle.com/vermont-medicaid-incontinence-program/

This includes:

- Diapers
- Briefs (either pull-up or pull-on)
- Underpads (i.e. Chux)
- Underwear liners (guard or shield)

Diaper and incontinence supply requests should be faxed to (802) 879-5963. Providers should send prescriptions, standard written orders, and any other intake-related documentation via email to NewOrderCM@activstyle.com or via fax to 1-888-614-4635

Vaccines and Vaccine Administration

1. Vaccines for Adults

DVHA-enrolled pharmacies may be reimbursed for the administration of specific injectable vaccinations. These vaccines must be administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the state of Vermont and must comply with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment.

Reimbursement and billing for adults 19 years and older: Pharmacies are reimbursed for the ingredient cost of the vaccine as well as an administration fee. The administration fee will be equivalent to the physician fee schedule for vaccine administration, which is $17.45. The vaccine administration fee may apply to adult vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP). This includes, but is not limited to: Herpes Zoster, HPV, MMR, Pneumococcal, and Tdap. A complete list of ACIP vaccines can be found on this link: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#vacc-adult. No dispensing fee is paid for these claims.

Reimbursement will be based on either a written prescription or non-patient-specific written Protocols (collaborative practice agreements), per state and federal laws. These orders must be kept on file at the pharmacy. Through the pharmacy POS system, the pharmacy must submit the code "MA" in the Professional Service Code field for the vaccine claim to receive full reimbursement. There will be NO member co-pay for administered vaccines.

Please refer to the Preferred Drug List https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria for preferred Influenza Vaccines for which DVHA reimburses pharmacies for administration.

Required NCPDP Fields		
NCPDP Field Number	**NCPDP Field Descrpiton**	**Required Code**
440-E5	Professional Service Code	MA
407-D7	Product/Servcie ID	NDC

2. Vaccines for Children

Children aged 6 months through 18 years presenting for vaccinations at pharmacies should be referred to their health care provider for State-supplied vaccines. The member needs to be 19 or older for vaccine claims to process at the pharmacy POS. Vaccine claims for members under 19 years old will reject: 70 - 'PRODUCT SERVICE NOT COVERED Member age less than 19.

Pharmacies interested in vaccinating children must participate in the Vermont Child Vaccine Program (VCVP). This is mandatory for providers who wish to provide vaccinations to children under age 19 insured by Vermont Medicaid. Pharmacies who wish to get reimbursed for administering vaccines to Medicaid-eligible children must enroll in the VCVP program.

Pharmacies may outreach the Vermont Child Vaccine Program ahs.vdhimmunizationprogram@vermont.gov.

3. COVID Vaccines
DVHA-enrolled pharmacies may be reimbursed for injectable COVID-19 vaccinations administered to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be enrolled with Vermont Medicaid, certified to administer vaccines in the State of Vermont, and must be compliant with all Vermont laws governing vaccine administration.

Pharmacies are reimbursed for the ingredient cost and administration fee for COVID-19 vaccines.
Effective 10/5/23, The Department of Vermont Health Access is updating the administration fee for the 2023-2024 commercial COVID-19 vaccines to $40.00, to align with Medicare reimbursement. This change will be retroactive to 9/11/2023.

No dispensing fee is paid for vaccine claims. Basis of Cost and Submission Clarification Codes are no longer required.

Prior Authorization

Prior authorization may be required for all programs except Healthy Vermonters. All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List. The list and criteria for prior authorization is periodically updated and can be found at:

Preferred Drug List (PDL):
https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria

Prior Authorization (PA) Forms:
https://dvha.vermont.gov/forms-manuals/forms/pharmacy-prior-authorization-request-forms-and-order-forms

All prior authorizations must be either faxed to the number below or submitted electronically through the State's provider portal.

Responsibility	Help Desk	Fax Numbers	Availability
Change Healthcare	Prescriber Help Desk	844-679-5366	24/7/365

For updates on the status of a requested PA, you can call the Change Healthcare Prescriber Help Desk at 1-844-679-5363. If you are enrolled with the eWebs Provider Portal, you can check the status of your prior authorization online. If you would like to enroll, please see instructions in the section of this manual that addresses the eWebs Provider Portal.

Emergency 72-Hour Fill

An emergency fill can be dispensed 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.
- Emergency fills are limited to one 72-hour supply per member/per drug for each calendar month.
- If the emergency persists, additional emergency overrides can be done by the Change Healthcare Pharmacy Help Desk.
- Dispensing fees apply to emergency fills.
- "Lost and stolen" is different from "emergency fill." See **"Refill Too Soon."** for details.

Generic and Biosimilar Substitution Policy

Vermont law requires that when available, the lowest-cost equivalent generic or interchangeable biologic product should be dispensed. However, when a pharmacist receives a prescription for a Medicaid member, the pharmacist shall select the preferred brand, generic, biological, or interchangeable biological product from the Department of Vermont Health Access's preferred drug list. The Preferred Drug List (PDL) may require a branded product or biological product to be dispensed in lieu of a generic or interchangeable biological product in limited circumstances when net cost to the state is lower.

Special Claims

Long-Term Care (LTC) Nursing Home Claims

LTC nursing home claims are identified by a value of "03" in the "Patient Residence" field on the claim. The following rules will apply when a LTC claim for a Medicaid Member is submitted for processing to the pharmacy POS system. It is the LTC eligibility and residence code that drives the co-pay responsibility for members.

- If the member has a valid LTC segment in eligibility and the pharmacy sends the patient residence code of 03, the claim will pay without a co-pay.
- If the member has a valid LTC segment in eligibility and the pharmacy does NOT send a patient residence code of 03, the claim will pay with a co-pay.
- If the member does NOT have a valid LTC segment in eligibility and the pharmacy sends a residence code of 03, the claim will pay with a co-pay.

VPharm members residing in LTC facilities are not exempt from copays because they do not have Medicaid LTC eligibility.

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 dispensing 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 Change Healthcare Pharmacy Help Desk at 844-679-5362. Acceptable circumstances for overriding the single dispensing fee limit are:

- 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 leave of absence (LOA) from the institution.

Except for controlled substances, unused or unmodified 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 pharmacy. The pharmacy should void or resubmit the claim with the appropriate quantity dispensed.

Multi-Ingredient Compound Claims

Most 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. Whenever possible, 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."

- Multi-ingredient compounds prescribed for pain require prior authorization
- Individual ingredients in a compounded medication may require prior authorization
- Each ingredient will be priced at the "lower of" methodology described below:
    - Pharmacy reimbursement is defined as the lower of:

        a. The National Drug Average Acquisition Cost (NADAC) + PDF;
        b. The Wholesale Acquisition Cost (WAC) + 0% + PDF;
        c. The State Maximum Allowable Cost (SMAC) + PDF;
        d. The Federal Upper Limit (FUL) + PDF
        e. AWP-19% + PDF;
        f. Submitted Ingredient Cost + PDF;
        g. The provider's Usual and Customary (U&C) charges; or
        h. The Gross Amount Due (GAD)

- The ingredients' costs will be totaled and priced at the lower of the calculated cost or the pharmacy's submitted 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.

- A professional dispensing fee will be automatically added to all prescriptions submitted with a compound indicator of "2."

- All compounds must contain **more than one ingredient**. A diluent for a powdered dosage form will not be considered a compounded drug. 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."

- **Submission Clarification Code 08**

  Multi-ingredient compound claims will reject if any of the ingredients used in the compound deny for any reason. If the pharmacy is willing to only be reimbursed for the payable 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 Change Healthcare Prescriber Help Desk at 1-844-679-5363.

DVHA covers a limited list of Bulk Powders which can be found at https://dvha.vermont.gov/providers/pharmacy/drug-coverage-lists . Some may require prior authorization.

Paper Claims

VTPOP and VTPARTD manual claim forms can be found online at: https://dvha.vermont.gov/providers/pharmacy/change-healthcare-billing-information

These forms should be submitted to Change Healthcare for processing at:

Change Healthcare, Inc.
1 Green Tree Lane
South Burlington, VT 05403

Specialty Drugs

Dispensing of specialty medications to Medicaid beneficiaries where Medicaid is the primary insurer is limited to specialty pharmacies that have nationally recognized specialty certification. DVHA requires any Specialty Pharmacy dispensing Specialty Drugs to DVHA members to be Certified by either the Utilization Review Accreditation Commission (URAC); the Accreditation Commission for Health Care (ACHC); or the Center for Pharmacy Practice Accreditation (CPPA).

The following link is a list of pharmacies that are currently authorized to dispense specialty drugs for DVHA members https://dvha.vermont.gov/providers/provider-network-info

If your pharmacy is not on this list and you are enrolled and specialty certified, please contact Provider Enrollment at vtproviderenrollment@gainwelltechnologies.com, 802-879-4450 and select option 4 or contact Suellen Bottiggi in Provider and Member Service at 802-241-9305.

A specialty drug must meet a minimum of (2) of the following requirements:

- The cost of the medication exceeds $5000 per month.
- The medication is used in the treatment of a complex, chronic condition. This may include but is not limited to drugs which require administration, infusion, or injection by a health care professional.
- The manufacturer or FDA requires exclusive, restricted, or limited distribution. This includes medications which have REMS requirements requiring training, certifications, or ongoing monitoring for the drug to be distributed.
- The medication requires specialized handling, storage, or inventory reporting requirements.

Limited Distribution Drugs

Limited Distribution (LD) drugs are specialty drugs that are restricted by the manufacturer to be dispensed only by a select number of specialty pharmacies or distributors. These LD drugs often have special requirements for dosing, administration or close patient and laboratory 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.

eWEBS Pharmacy Provider Portal

The **eWEBS Pharmacy Provider Portal** developed by our Pharmacy Benefits Manager, Change Healthcare, is designed for use by prescribers and pharmacies to simplify access to member and drug information. It provides a secure way for registered users to look up member eligibility, member drug history and preferred drug list (PDL) information.

In addition, providers can **electronically submit prior authorization requests, and track the progress of PA requests online**. Prescribers are guided through preferred and non-preferred drug selections and potential step therapy, dose limits or other coverage restrictions, giving them the ability to make informed drug choices.

It's easy to sign up. The portal is web-based, and you only need internet access and a browser such as Internet Explorer, Chrome, or Firefox. You can access the portal immediately via this link: https://providerportal.vtgov.emdeon.com/vtpp/application/login.joi. Simply click on the link and follow the directions to submit the enrollment form. You will be issued a user ID and password once your registration information has been submitted and validated.

Features that will be available to all registered users include:
• **Member Inquiry** – The ability to look up demographic information for any Medicaid enrolled individual, including member eligibility, member prior authorizations, or their current and historic pharmacy claims
• **Pharmacy Inquiry** – The ability to find pharmacy information such as location and phone information
• **Formulary Inquiry** – The ability to look up drug information, including Vermont Medicaid coverage status, Preferred Drug List (PDL) preferred step order, and PA criteria
• **Diagnosis Inquiry** – Ability to look up diagnosis code definitions
• **Program alerts, announcements, and updates** – Will be made available through the portal

Prescribers have additional capabilities through the eWEBS Provider Portal:
• **Prior Authorization** – The ability to submit electronic prior authorizations, track current PA submissions, view determination results, and submit electronic prescriptions through the fax submission.
• **Delegate Management** – The ability to designate and manage other office staff access to the eWEBS Portal for PA submission, eligibility inquiries and member drug profile history.

Pharmacists have additional capabilities through the eWEBS Provider Portal:
Delegate Management – The ability to designate and manage other pharmacy technician staff access to the eWEBS Portal for member PA look up, eligibility inquiries and member drug profile history. The application also has a user guide for you to review.

Return to Stock

When a Member or the Member'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 a minimum of seven (7) years.

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 (Highest Severity Levels)
- 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.

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		

ProDUR Alert/Error Messages
All messages appear in the claims adjudication transmission. See Payer Specifications for more information.

ProDUR Support

The Change Healthcare Pharmacy Help Desk is available 24 hours per day, seven days per week. If you need assistance with any alert or denial messages, it is important to contact the Help Desk about ProDUR messages at the time of dispensing. The Change Healthcare Pharmacy Help Desk can provide claims information on all error messages which are sent by the ProDUR system.

The Pharmacy Help Desk is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. Change Healthcare 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, Change Healthcare staff pharmacists are available for consultation.

Days' Supply

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

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. A pharmacy is responsible for assuring that all coverage rules are met when dispensing a drug that has not been submitted to the POS system for processing. This includes PA and utilization management criteria and limitations.

- For all original claims, reversals and re-bills, the timely filing limit is **180 days** from the date of service (DOS). One month equals 30 days, 6 months equals 180 days.

- When Medicaid is the primary insurer, providers have 6 months from the date of service to submit a claim
- When Other Insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim
- Claims that exceed the prescribed timely filing limit will deny.
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim
- Providers must make any adjustment to a paid claim within 12 months from the original paid date when the adjustment would **result in a positive financial outcome for the provider**
- Providers must make any adjustment to a paid claim within 3 years from the original date of service when the adjustment would **result in a negative financial outcome for the provider**
- When appropriate, contact Change Healthcare for consideration of an override to timely filing limits.
- If a timely filing request is denied, providers have 3 months from the initial timely filing denial to submit a reconsideration request
- Requests for overrides will be considered for:

    1. Retroactive beneficiary eligibility
    2. Coordination of benefits delays
    3. Requests by the State

Requests for timely filing overrides can be faxed 1-844-679-5366 or mailed to:

Change Healthcare®
1 Green Tree Dr.
South Burlington, VT 05403

Call the Change Healthcare Pharmacy Help Desk with any questions at 844-679-5362 or Email at PBA_VTHelpdesk@changehealth.com

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 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 if 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 Member and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the Member's record the prescriber's justification of extenuating circumstances. In these circumstances, regardless of whether extenuating circumstances permit more frequent dispensing, only one dispensing fee may be billed.

- ***Mandatory 90-Day Supply Program****:* Select drugs used for maintenance treatment must be prescribed and dispensed in no less than 90-day supply increments. The drug utilization review board makes recommendations to the Department on the drugs to be selected. This limit shall not apply to the first TWO fills (the original and one refill) of the medication to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the Member'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 faxed to the Change Healthcare Prescriber Call Center at 844-679-5366. A list of drugs subject to this mandatory 90-day supply limit can be found here: http://dvha.vermont.gov/for-providers/drug-coverage-lists-1

- Claims will deny if the days' supply limit is exceeded. Exceptions to standard days' supply limits include:

    - Contraceptives including oral, patch, and rings may be dispensed in a quantity not to exceed a 365-day supply. This does not apply to emergency contraceptives.
    - Under certain conditions, acute opioid prescriptions for patients 18 years and older will be limited to 50 MME per day and a maximum of 7 days' supply. Patients 17 years of age and younger will be limited to 24 MME per day and maximum of 3 days' supply.
    - Drugs provided to residents of a long-term care (LTC) facility are not subject to the mandatory 90-day supply requirement. Residents of community care homes are not considered residents of LTC facilities and therefore are subject to the 90-day refill requirement.

Requests for overrides should go to the Change Healthcare Prescriber Help Desk 1-844-679-5363.

Quantity Limits

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

Auto Refills

Vermont Medicaid does not pay for prescriptions that are not medically necessary or for individuals who are no longer eligible for Vermont Medicaid. Providers may not use automatic refill systems to deliver or provide prescriptions to members. Members and providers may not agree to waive the requirements of this section. Providers may contact members to initiate a

refill, but members must choose to fill each prescription, and providers must determine that the member remains eligible for Vermont Medicaid before providers deliver or dispense the prescription. Providers may not assume that, because a member's prescription authorizes refills, the member has implicitly requested that the provider refill the prescription.

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 11 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.
- The Department will not cover lost, stolen, or destroyed prescription medications for controlled substances.
- The Department will grant approval for lost, stolen, or destroyed medications no more than once a year. (this is applied as a 'rolling year' not a calendar year. For example, if a patient had an override for a lost/stolen medication March 1, 2020 they could not get an override for it in January 2021.

Early Refill Overrides (NCPDP Reject Code 79):
Claims will reject for refill requests when more than the percentage of the previous days' supply remains (see chart below). Pharmacies may request an override for claims that reject for early refill. To request an override, pharmacies must contact the Change Healthcare Pharmacy Help Desk at 1-844-679-5362.

Day's Supply	Percent (%) of Day's Supply Used
1-4	50
5-13	75
14-39	85
40-60	90
61-102	92

*Please note there is a cumulative edit in place for controlled substances that counts early refills. A maximum accumulation of seven (7) extra days of medication will be allowed at any given time.

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 allowable for early refill override
01/ no override	Not allowable for early refill override
02/ 02/ another override	Not allowable for early refill override
03/ vacation supply	**Allowable; use for vacations and LTC leave of absence (requires call to Pharmacy Help Desk at** 844-679-5362**)**
04/ lost prescription	**Allowable (requires call to Pharmacy Help Desk** at 844-679-5362.) **Not allowed for controlled substances.**
05/ therapy	**Allowable; use when prescriber changes dose, (requires call to Pharmacy Help Desk at 844-679-5362)**
06/ starter dose	Not acceptable for early refill override
07/ medically necessary	Not acceptable for early refill override

Member Cost-Share Information (Copayments)

Vermont's publicly funded drug benefit programs have no deductibles and no benefit maximums.

Traditional Medicaid:

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.

Members with Medicare Part D Plans:

1) Full-Benefit Duals: Full-benefit dual eligible members (those who have both Medicaid, and a Medicare Part D Prescription Drug Plan (PDP) are responsible for copayments up to $9.85 charged by the PDP for 2022. If a member's PDP is returning copayments greater than $9.85, the member should call Green Mountain Care Support Center at 1-800-250-8427 or go to www.vermonthealthconnect.gov.

2) VPharm: For members who are enrolled in VPharm, PDP deductibles and coinsurance should be billed to VPharm.

   There are two types of VPharm members: standard VPharm members and VPharm members with Low Income Subsidy (LIS).

   - For members with LIS coverage, the PDP should return a maximum patient cost share of $9.85. VPharm will wrap this LIS cost share and leave the member with a $1 or $2 co-pay as described below.

- For Members without LIS coverage, there is no maximum patient cost share (as described above for Members with LIS). VPharm will wrap this LIS cost share and leave the member with a $1 or $2 co-pay as described below.

Population affected	**Prescriptions with DVHA cost share of $29.99 or less**	**Prescriptions with DVHA cost share of $30.00 or more**
VPharm 1, 2 and 3 beneficiaries (VD, VE and VF): DVHA wraps copays from Medicare PDP. There is no dollar limitation as with LIS plans described below.	$1.00 Co-pay	$2.00 Co-pay
VPharm 1, 2 and 3 LIS beneficiaries: DVHA wraps the Medicare Part D LIS copay amount up to $9.85. If a member's PDP is returning copayments greater than $9.85 for LIS members, the member should call Green Mountain Care Member Services at 1-800-250-8427	$1.00 Co-pay	$2.00 Co-pay

Copay Exceptions (no copayments apply):

- Patient is 20 years old or younger (based on Eligibility File)
- Family planning drugs
- Patient is pregnant or in the 60-day post-pregnancy period (requires a prior authorization obtained by calling Change Healthcare Prescriber Help Desk at 1-844-679-5363)
- Claim is licensed nursing home (LTC) claim (requires Patient Location = "03" on the claim-see section above on Long-Term Care Nursing Home Claims)
- Diabetic supplies
- Vaccines
- Members enrolled in Recipient Aid Category Codes BG & BH (Breast and Cervical Cancer Treatment).
- Smoking cessation products

When Healthy Vermonter coverage applies, the beneficiary must pay the full allowed amount.

Medications that are covered by Medicaid cannot be denied for a Medicaid beneficiary who is unable to make their copayment. Health care administrative rules 6.100-hcar-cost-sharing-adopted-rule-.pdf (vermont.gov) state following at 6.100.2:

> (b) Copayments are a portion of the Medicaid rate and are deducted from the Medicaid payment for each service that is subject to cost sharing, regardless of whether the provider has collected the payment or waived the cost sharing.
> (c) If a beneficiary is unable to pay the copayment, providers shall not deny medical services.

(d) A beneficiary's inability to pay does not eliminate his or her liability for the copayment amount. Providers may bill a beneficiary for unpaid copayments.

Therefore, 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, and the pharmacy can continue to request payment. There is no rule stating that a pharmacy needs to "waive" a co-pay.

Counseling and Delivery Signature Requirements

Documentation of Offer to Counsel
As a component of Prospective DUR, federal law 42 CFR § 456.705(c) requires pharmacies that participate in Vermont Medicaid to offer patient counseling to each participant upon dispensing each prescription.

The Vermont Board of Pharmacy requires that all pharmacists offer counseling for all patients. Administrative Rules of the Board of Pharmacy, § 10.31.
Accordingly, pharmacies that participate in Vermont Medicaid must keep a signature log to verify that each participant accepted or refused an offer of counseling. The pharmacy must document each participant's signature in a uniform manner, including (at minimum):

(a) The participant's name
(b) The signature of the participant, or their representative
(c) The date the participant received the prescription
(d) Whether the participant accepted or refused an offer of counseling.

Either the participant or their representative must sign the signature log for each prescription they receive, unless the participant is inpatient at a hospital or other institution where other licensed health care professionals are authorized to administer the drug(s). An electronic signature is acceptable. The pharmacy must retain the signature log for 5 years from the date the pharmacy dispensed the prescription. Participants may not waive the signature requirement. Pharmacies cannot comply with this requirement by merely recording that a participant's signature is "on file."

If a pharmacy fails to record whether a participant accepted or refused an offer of counseling, this indicates that the participant did not receive an offer of counseling. This may subject the pharmacy to sanctions, such as having the funds for the prescriptions recouped. Pharmacies must document the offer to counsel regardless of whether the patient is picking up a prescription in person or the pharmacy is shipping or delivering the prescription. If a pharmacy is shipping or delivering a prescription, the pharmacy must document the offer to counsel prior to shipping or delivering the prescription.

Documentation of Proof of Delivery
Pharmacies that participate in Vermont Medicaid must verify that each participant has received the prescription that the pharmacy dispensed and must keep appropriate documentation that each

person has received their prescription.
If a participant or their representative picks up a prescription in person, the pharmacy may rely on the signature log required to document the offer to counsel to prove that the participant or their representative received the prescription that the pharmacy dispensed. If a pharmacy delivers an item directly to a participant, the pharmacy must be able to furnish proof of delivery. The proof of delivery must include:

(a) The participant's name
(b) A detailed description of the item delivered
(c) Either:
    (1) A signature from the participant or the participant's representative; or
    (2) A delivery service tracking slip with the participant's name or a reference to the participant's packages, the delivery service package identification number, and the delivery address.

Pharmacies serving LTC facilities, nursing facilities, ICF/IID, and PRTF must retain a signed delivery manifest, indicating proof of delivery, of each medication/supply to that facility. These delivery manifests must be signed by both pharmacy and facility staff to document the delivery process. This delivery manifest serves as verification that the LTC facility, nursing facility, ICF/IID, and PRTF received the dispensed prescription from the pharmacy.

All providers must make copies of their delivery logs or delivery manifests available on request from the Department. If a provider cannot make a delivery log or delivery manifest available, or the delivery log or delivery manifest fails to include appropriate signatures, this indicates that the participants or receiving facilities did not receive the items prescribed. Providers who cannot produce complete delivery logs or delivery manifests available may be subject to sanctions, including recoupment of claims.

Coordination of Benefits (COB)

Claim segment and field requirements are detailed in the Consolidated Payer Specification Sheet that can be found in the section of this manual entitled "Payer Specifications and General Information and Guidance."

DVHA is the payer of last resort. How DVHA pays secondary pharmacy claims is dependent on if the Member's primary pharmacy insurance is Medicare Part D.

Members <u>Not Enrolled</u> in a Medicare Part D Plan

Medicaid Members with Primary Drug Coverage that is not Medicare Part D:
For Medicaid Members with primary health insurance but without a Medicare Part D plan (including those with creditable coverage): The payment of covered outpatient drugs, including over-the-counter drugs, billed to DVHA on a secondary basis and dispensed by an enrolled pharmacy, will be reimbursed at the lower of the following pricing methodologies, less the payment from the Member's primary payer and the Member's Medicaid copayment.

a. The National Drug Average Acquisition Cost (NADAC) + Professional Dispensing Fee;
b. The Wholesale Acquisition Cost (WAC) + 0% + Professional Dispensing Fee;
c. The State Maximum Allowable Cost (SMAC) + Professional Dispensing Fee;
d. The Federal Upper Limit (FUL) + PDF
e. AWP-19% + Professional Dispensing Fee;
f. Submitted Ingredient Cost + Professional Dispensing Fee;
g. The provider's Usual and Customary (U&C) charges; or
h. The Gross Amount Due (GAD)

Members <u>Enrolled in Both</u> a Medicare Part D Plan AND a Creditable Coverage Plan

For Members with both creditable coverage and a Medicare Part D Plan, DVHA processes secondary claims based on these business rules and not those outlined below in "Members Enrolled in a Medicare Part D Plan."

Members Enrolled in a Medicare Part D Plan (no Creditable Coverage).

VT applies COB 2 option for VPharm Plans (Plan IDs VTD01, VTD02, VTD03, VTD04, VTD05) Coordination of Benefits with Part D plans. The following provides information on submitting COB claims. Claim segment and field requirements are detailed in VT Payer Sheet located http://www.changehealthcare.com/legacy/solutions/pharmacy/payer-documents.	
VTPARTD (COB 2 Processing Policy)	
The following OCC codes are not appropriate for claims billed to VPharm on a secondary	
OCC/Description	**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.	
The following codes are appropriate for claims being billed to Vpharm on a secondary basis	
OCC/Description	**Vermont Coverage Secondary to Alternate Insurance**
3 = Other coverage exists, claim rejected by primary insurance	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). OCC=3 does not apply to Medicare Part B.
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. Benefit Stage Fields not required for Part B drugs.

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

Vermont Medicaid is the payer of last resort after other insurers. Claim segment and field requirements are detailed in the VT Payer Sheet.

CMS Excluded Drugs, OTC Drugs, Diabetic Supplies

For Dual Eligible and VPharm Members, DVHA pays in full for drugs that PDP's do not cover, such as prescription cough and cold preparations and over-the-counter (OTC) drugs. In addition, DVHA reimburses for diabetic supplies not covered by PDPs (example, lancets and test strips). For Dual Eligible Members without Medicare Part B: DVHA provides drug coverage for Part B drugs.

Member Benefit:	**Process Control #**	**Other Coverage Code:**	**Additional Information:**
Dual Eligible (Medicaid /Medicare eligible with MAPD/PDP)	VTPOP	OCC3	Reject code from MAPD/PDP required
Creditable Coverage (Medicaid / Medicare eligible but no MAPD/PDP)	VTPOP	OCC3	Reject code from primary insurance required
VPharm (Medicare eligible with MAPD/PDP)	VTPARTD	OCC3	Reject code from MAPD/PDP required

Medicare Part B, C and D – Coordination of Benefits Overview

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 Change Healthcare.

Examples of 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 Change Healthcare Pharmacy Help Desk 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.

Submission of Part B Secondary Claims (Member has Part B)

Member Benefit	Processor Control #	Other Coverage Code	Additional Information

Dual Eligible (Medicaid/Medicare eligible with MAPD/PDP)	VTPOP	OCC2, OCC4	
Creditable Coverage (Medicaid/Medicare eligible but no MAPD/PDP)	VTPOP	OCC2, OCC4	
VPharm (Medicare eligible with MAPD/PDP)	VTPARTD	OCC8	No benefit stage qualifier needed

Medicare Prescription Drug Plan (Part C or Part D)

Effective January 1, 2006, Vermont Medicaid members who were also eligible for Medicare were enrolled in a PDP for primary coverage, with only a secondary benefit provided by Vermont programs.

Depending on a member's eligibility and the drug that you are dispensing, this benefit varies. See the "Pharmacy Plan Designs – 2018" section of this manual for the most current information.

Medicare/Medicaid Eligible without a Part D Plan – Facilitated Enrollment

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 eligible," who are not enrolled in a Medicare 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 2011 - Current Limited Income Newly Eligible Transition (LI NET) Program:

BIN: 015599
PCN: 05440000
ID Number: Medicare Beneficiary Identifier (MBI)
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.

Medicare 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 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 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 DVHA/Change Healthcare®. DVHA will closely monitor this process.

Payer Specifications and 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.

Please refer to the most current Payer Specifications document at: https://www.changehealthcare.com/support/customer-resources/state-payer-sheets. The Payer Specifications include details on claims submissions, host information, claims processing messages, submission clarifications, DUR information, DUR service codes, and COB messages.

Provider Reimbursement Schedule

The payment and Remittance Advice schedule is weekly.