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CMS Process to Ensure Effective Transition to Medicare Part D

In spite of all best efforts to identify and auto-enroll dually eligible individuals prior to the effective date of their Medicare Part D eligibility, it is possible that some individuals may show up at pharmacies before they have been auto-enrolled. For this reason, the Centers for Medicare and Medicaid Services (CMS) have developed a process for a point-of-sale (POS) solution to ensure full dual eligible individuals experience no coverage gap. When beneficiaries present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, they can have the claim for their medication submitted to a single account for payment. The beneficiary can leave the pharmacy with a prescription, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

In order for this process to operate effectively, there must be a uniform and straightforward set of instructions that all pharmacists can follow no matter which prescription drug plan (PDP) networks they are in or where they are located in the country. This requires a single account administered by one payer. In addition, a national plan that offers a basic plan for a premium at or below the regional low-income premium subsidy amount in every PDP region will be able to both process the initial prescription (generally at in-network rates) and enroll the beneficiary within a matter of days, thus eliminating any gap in coverage. Therefore, CMS has contracted with Wellpoint, an approved national PDP, to manage a single national account for payment of prescription drug claims for the very limited number of dually eligible beneficiaries who have not yet been auto-enrolled into a Part D plan at the time they present a prescription to a pharmacy.

Details on the Four Step POS Facilitated Enrollment process are provided below:

1. Request the beneficiary's Medicare Part D Plan Identification (ID) card. Beneficiaries may have a plan enrollment "acknowledgement letter" that should contain the BIN, PCN, GROUP, and Member ID information. If the beneficiary has no proof of enrollment, their plan's billing information may be available through the new E1 query. If none of these sources of information are available and the beneficiary is dually eligible for Medicare and Medicaid, the POS Facilitated Enrollment Process will allow the beneficiary's prescription to be filled.
2. Submit an E1 transaction to the TrOOP Facilitator. This ensures that the beneficiary has not already been assigned to a PDP. If the E1 transaction returns a valid BIN/PCN indicating the beneficiary has been enrolled with a PDP or Medicare Advantage Prescription Drug Plan (MA-PD), the pharmacist may not submit the claim under the POS Facilitated Enrollment. (If the E1 returns a help desk phone number, this means that the beneficiary has been enrolled in a PDP but the billing data is still in process.)
3. Identify a "Dually Eligible" beneficiary. The first step is to request the beneficiary's Medicare and Medicaid identification cards. If the beneficiary cannot provide clear evidence of enrollment in both programs, the claim should **not** be processed under the POS Facilitated Enrollment process. Please see the options below that are available to verify a beneficiary's dual eligibility.

To verify Medicaid eligibility: Any of the following can be used to verify Medicaid eligibility:

- Medicaid ID card
- Recent history of Medicaid billing in the pharmacy patient profile
- Copy of current Medicaid award letter

In addition to these options to verify Medicaid eligibility, the North Carolina Automated Voice Response System (AVRS) is readily accessible twenty-four hours each day at 1-800-723-4337 except for 1:00 a.m.-5:00 a.m. on the first, second, fourth and fifth Sunday and 1:00 a.m.-7:00 a.m. on the third Sunday. Additional information on the N.C. AVRS is available at <http://www.dhhs.state.nc.us/dma/bulletin/AppendixAAug2005.pdf>.

To verify Medicare eligibility: Any of the following can be used to verify Medicare eligibility:

- Submit an expanded E1 query to determine A, B or AB eligibility
- Request to see a Medicare card
- Request to see a Medicare Summary Notice (MSN)
- Call the dedicated Medicare pharmacy eligibility line at 1-866-835-7595

4. **Bill the POS Contractor.** There is no need to call WellPoint to confirm enrollment as no enrollment preexists the claim submission. There are no edits for non-formulary, prior authorization or step therapy drugs. However, drugs excluded from Medicare or Part D coverage will not be paid for.

Make sure an E1 query has first been submitted to rule out evidence of enrollment in a Part D plan before billing Wellpoint. Enter the claim into the pharmacy claims system in accordance with the Wellpoint payer sheet. This payer sheet is available at: http://www.anthem.com/jsp/antiphona/apm/nav/ilink_pop_native.do?content_id=PW_A081085. It is important that the payer sheet is carefully reviewed so that claims are submitted in the required format. It is critical that both the Medicaid ID number and the Medicare ID number (HICN) are submitted to validate the beneficiary's "dual eligible" status. Submission of claims without both of these numbers will be considered invalid.

If there are problems with these submission requirements, another option is available until the pharmacy provider's software vendor can support these requirements. For systems that do not currently support two beneficiary numbers, the following alternative requirements may be used:

- BIN: 610575 (Anthem Prescription Management, LLC)
- PCN: CMSDUAL02 (instead of CMSDUAL01)
- Medicaid ID number in field 301 C1 Group ID (instead of the Patient ID 332-CY and Patient ID Qualifier 331-CX)
- Patient Segment Required fields are still required including date of birth, first and last name, full address, phone number and patient location code
- Medicare ID number in field 302-C2 Cardholder ID

Beneficiary Coverage:

The days supply is limited to fourteen days. This will allow for an appropriate opportunity for beneficiaries to be enrolled in a PDP.

For Further Assistance with the POS Facilitated Enrollment Process:

Pharmacy Help Desk: (800)-662-0210

Hours of Operation: Monday - Friday, 8:30 a.m.-12:00 a.m.

Saturday and Sunday, 9:00 a.m.-7:00 p.m.

Medicare Part D Prescription Drug Plans and Temporary First Fill Policies

Medicare Part D prescription drug plans are required to establish a transition process for Medicare/Medicaid full-benefit dual eligible enrollees who are transitioning from other prescription drug coverage. This transition process includes filling of a temporary one-time transition supply for a prescription drug that is not on the formulary of the Medicare Part D drug plan in which the beneficiary is enrolled. This accommodates the immediate need of the beneficiary and allows the beneficiary and the drug plan to work out with the prescriber an appropriate alternative medication or completion of an exception request to maintain coverage. Temporary first fill policies can vary from plan to plan based on the drug in question, the unique needs of an individual and an individual's setting (e.g., a long term care setting). The following information includes temporary first fill policies for Medicare Part D prescription drug plans available in North Carolina:

Organization	Formulary ID #	New Enrollee General Transition Day Supply (First Fill)	New Enrollee Long Term Care Transition Day Supply (First Fill)
SilverScript	619	30 days	90 days
Blue Cross Blue Shield of North Carolina	786	30 days	90-180 days
Blue Cross Blue Shield of North Carolina	787	30 days	90-180 days
SilverScript	897	30 days	90 days
Cigna Healthcare	1241	Utilization management clinical edits lifted during the 30 day transition period	Utilization management clinical edits lifted during the 90 day transition period
Pennsylvania Life Insurance Company	1446	60 days	60 days
RxAmerica	1479	30 days	30 days initially. Based on exceptions process outcome, may extend up to 90-180 days
RxAmerica	1644	30 days	30 days initially. Based on exceptions process outcome, may extend up to 90-180 days

Organization	Formulary ID #	New Enrollee General Transition Day Supply (First Fill)	New Enrollee Long Term Care Transition Day Supply (First Fill)
Humana, Inc.	1863	30 days	Up to 90 days
WellCare	2003	30 days	90 days
WellCare	2129	30 days	90 days
Unicare	2493	90 days	90 days
Unicare	2546	90 days	90 days
WellCare	2629	30 days	90 days
PacifiCare Life and Health Insurance Company	2654	30 days	30 days initially, but may be extended up to 90 days if stabilized on multiple non-formulary medications
PacifiCare Life and Health Insurance Company	2656	30 days	30 days initially, but may be extended up to 90 days if stabilized on multiple non-formulary medications
Aetna Medicare	2662	Up to 30 day supply for all Part D medications and for select drugs, 1 plan year	90-180 days for all Part D medications or 1 plan year coverage
Aetna Medicare	2681	Up to 30 day supply for all Part D medications and for select drugs, 1 plan year	90-180 days for all Part D medications or 1 plan year coverage
Coventry AdvantraRx	2759	30 days	Up to 90 days
Coventry AdvantraRx	2764	30 days	Up to 90 days
Coventry AdvantraRx	2766	30 days	Up to 90 days
Medco Health Solutions, Inc.	3164	30 days	Up to 90 days
Sterling Prescription Drug Plan	3245	30 days	90 days
United American Insurance Company	3296	30 days	90 days
MemberHealth	3422	30 days	90-180 days
United Healthcare	3440	30 days	Up to 90 days

Medicare Part D Conference Calls for Providers

The Centers for Medicare and Medicaid Services (CMS) host a weekly conference call for providers. The calls are scheduled for every Tuesday from 2:00 pm to 3:00 pm beginning January 3, 2006. These 60-minute conference calls enable discussions of issues and resolutions involving the Medicare Part D program. Providers are encouraged to use this time to ask questions and to describe problems so that CMS can continue to improve the Medicare Part D program.

To participate in this weekly conference call, dial the conference phone number **1-800-619-2457** and reference the password "**Part D**".

Denial on Medicaid Covered Excluded Drugs

Pharmacy providers receiving a denial on a Medicaid covered excluded drug for a Medicaid eligible recipient after the Medicare Part D prescription drug program begins on January 1, 2006 may contact the EDS pharmacy unit to check for coverage status of the drug at 919-851-8888 or 1-800-688-6696.

Family Planning Waiver Services

Effective October 1, 2005, the North Carolina Division of Medical Assistance (DMA) implemented a 5-year 1115 Medicaid demonstration waiver project for family planning services for the citizens of North Carolina. Eligible recipients are identified by a blue Medicaid card with the program class 'MAFD' and the following statement "**FAMILY PLANNING WAIVER: RECIPIENT ELIGIBLE FOR LIMITED FAMILY PLANNING SERVICES ONLY**". Recipients eligible to receive waiver services are not eligible for Medicaid under any other current program.

The Automated Voice Response System (AVRS) has been updated to identify recipients with the program class 'MAFD' as the Family Planning Waiver. As a result, the AVRS will not give the provider dental history, an optical confirmation number, or DME prior approval information for recipients covered by the waiver. Instead, the AVRS will state: "**This recipient is eligible for limited Family Planning Services only. Dental, DME, and optical services are not covered by the Family Planning Waiver Program.**"

For more information, refer to the January 2006 Special Bulletin, Family Planning Waiver "Be Smart" on DMA's web site at <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

Federal Mac List Changes

Effective February 18, 2006, the following changes will be made to the Medicaid Drug Federal Upper Limit:

FUL Price Decreases

<u>Generic Name</u>	<u>FUL Price</u>
Citalopram Hydrobromide	
10 mg, Tablet, Oral, 100	\$0.2963 B
20 mg, Tablet, Oral, 100	\$0.3090 B
40 mg, Tablet, Oral, 100	\$0.3224 B
Glyburide	
1.5 mg, Tablet, Oral, 100	\$0.1875 R
3 mg, Tablet, Oral, 100	\$0.2175 R

FUL Price Increases

<u>Generic Name</u>	<u>FUL Price</u>
Chlorpropamide	
100 mg, Tablet, Oral, 100	\$0.2325 B
250 mg, Tablet, Oral, 100	\$0.4917 B
Desipramine Hydrochloride	
25 mg, Tablet, Oral, 100	\$0.2835 B
Hydroxyzine Pamoate	
EQ 25 mg, Capsule, Oral, 100	\$0.1150 R
EQ 50 mg, Capsule, Oral, 100	\$0.1572 R

FUL Additions

<u>Generic Name</u>	<u>FUL Price</u>
Alclometasone Dipropionate	
0.05%, Cream, Topical, 45 gm	\$0.8283 B
0.05%, Ointment, Topical, 45 gm	\$0.8283 B
Gabapentin	
600 mg, Tablet, Oral, 100	\$2.4704 B
800 mg, Tablet, Oral, 100	\$2.9586 B
Glimepiride	
1 mg, Tablet, Oral, 100	\$0.1341 B
2 mg, Tablet, Oral, 100	\$0.2174 B
4 mg, Tablet, Oral, 100	\$0.4100 B
Glyburide	
1.25 mg, Tablet, Oral, 100	\$0.1244 R
2.5 mg, Tablet, Oral, 100	\$0.1893 R
5 mg, Tablet, Oral, 100	\$0.2831 R

FUL Additions (cont.)

<u>Generic Name</u>	<u>FUL Price</u>
Halobetasol Propionate 0.05%, Cream, Topical, 50 gm	\$1.4766 B
Isoniazid 100 mg, Tablet, Oral, 100	\$0.0561 B
Leflunomide 10 mg, Tablet, Oral, 30	\$2.5000 R
20 mg, Tablet, Oral, 30	\$2.5000 R
Metformin Hydrochloride 750 mg, Tablet, Oral, 100	\$1.1498 B
Mupirocin 2%, Ointment, Topical, 22 gm	\$1.8839 B
Tretinoin 0.025%, Cream, Topical, 45 gm	\$1.5693 B
Zidovudine 300 mg, Tablet, Oral, 60	\$3.6503 B

Changes in Drug Rebate Manufacturers**Additions**

The following labelers have entered into Drug Rebate Agreement and joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
10454	Solstice Neurosciences, Inc	01/01/2006
12162	Monte Sano Pharmaceuticals, Inc.	01/01/2006
68734	Critical therapeutics (CRTX)	01/01/2006

Reinstated Labeler

Ranbaxy Laboratories Inc. (Labeler code 10631) has signed a new rebate agreement with a mandatory coverage effective date of 10/01/2005. There is no optional coverage date for this reinstated labeler.

Checkwrite Schedule

January 06, 2006	February 07, 2006	March 07, 2006
January 10, 2006	February 14, 2006	March 14, 2006
January 18, 2006	February 23, 2006	March 21, 2006
January 26, 2006		March 30, 2006

Electronic Cut-Off Schedule

January 06, 2006	February 03, 2006	March 03, 2006
January 13, 2006	February 10, 2006	March 10, 2006
January 20, 2006	February 17, 2006	March 17, 2006
		March 24, 2006

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day prior to the electronic cut-off date to be include in the next checkwrite.



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