Aetna Better Health
Pharmacy Provider Overview

April 2016
State of Texas Medicaid (STAR) and (CHIP) Program

Aetna Better Health
Pharmacy Provider Overview

Provider Network Services
CVS Caremark
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• Other participation requirements

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• Coordination of Benefits/payer sheet information
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• Prescription Origin Code
• Children’s Health Insurance Program (CHIP) Coverage for Contraceptives

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• Emergency 72-hour override
• Prior Authorization

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• Preferred Drug List
• DUR Conflict Codes and Messages
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Pharmacy Network Participation

Requirements
Pharmacy Participation in CVS Caremark (Caremark) Networks Serving Aetna Better Health Texas Members

Program became effective March 1, 2012

Aetna Better Health is the managed care organization that will provide prescription drug benefit to selected State of Texas Medicaid (STAR) and CHIP plan members

• Caremark will administer/process claims on behalf of Aetna Better Health
• By participating in Caremark’s national pharmacy networks, you automatically participate in the pharmacy network
• Aetna Better Health will be using for its state of Texas Medicaid (STAR) and CHIP program members
• Caremark’s national network is CareValue3
Pharmacy Participation in CVS Caremark (Caremark) Networks

Updates to contact information must be sent in writing, within 10 business days to Caremark by either: (1) fax to 480-661-3054; or (2) mail to:

Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

And to HHSC’s administrative services contracts at:
Texas Health and Human Services Commission
Medicaid/CHIP Contract Management (H-330)
4900 North Lamar Blvd.
Austin, TX 78751
Phone: 1-800-435-4165 Fax: 512-730-745266
Web address: http://www.txvendordrug.com/providers/contracts.shtml
Other Pharmacy Participation Requirements

• Even though your pharmacy participates in Caremark’s national networks, your pharmacy also must meet the following requirements in order to serve Texas Medicaid (STAR) and CHIP members:

• Your pharmacy must be in good standing with the Texas Health and Human Services Commission’s Office of Inspector General (OIG)

• Your pharmacy must participate in the Texas Vendor Drug Program (VDP)

• If you currently do not participate in the VDP and would like to apply for participation, please visit the website http://www.txvendordrug.com/providers/contracts.shtml to receive instructions on the pharmacy application process
Aetna Better Health’s Service Areas

Bexar County Service Area
Tarrant County Service Area
STAR Service Areas

Aetna Better Health

Bexar

Aetna Better Health

Tarrant
Claims Submission Information

Claims Submission Requirements for Primary Claims
Claims Submission Requirements for Medical Claims
Cancellation of Product Orders
Coordination of Benefits
Prescriber NPI
Prescription Origin Code
Children’s Health Insurance Program (CHIP) Coverage for Contraceptives
Eligibility
Claim Submission Requirements for Primary Claims

- RXBIN 610591
- RXPCN ADV
- RXGRP RX8801

- Other member-level required elements for claims submission:
  - Member ID number
  - Member date of birth

- Please ask the member to see their ID card
Claims Submission Requirements for Medical Claims

Electronic Claims Submission: Emdeon – Use Payer ID 38692

– If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054
  • If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.
– If your electronic billing vendor can convert to 38692, but doesn’t submit directly to Emdeon, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

Paper claims Submission:

Aetna Medicaid and CHIP Services
Attention: Claims Department
P.O. Box 60938
Phoenix, AZ 85026

CMS-1500 Claim Forms: Providers must use the revised CMS-1500 (version 08/05) claim form to file or re-file claims. Please refer to the Aetna Medical Provider Manual for additional information regarding the HHSC Managed Care Organization paper claim filing requirements. The provider manual can be found on the ABH website at [http://www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas).
Cancellation of Product Orders

• If a Network Provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, the Provider is required to reduce, cancel, or stop delivery at the Member’s or the Member’s authorized representative’s written or oral request. The Provider must maintain records documenting the request.

• If a Network Provider offers delivery services, those services are optional, not mandatory.
Coordination of Benefits

- Online coordination of benefits (COB) is supported
- COB segment is required
- The following information is required when submitting secondary claims:

<table>
<thead>
<tr>
<th>Claim</th>
<th>RXBIN</th>
<th>RXPCN</th>
<th>Comments</th>
<th>Other Coverage Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>610519</td>
<td>ADV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>013089</td>
<td>COMSEGADV</td>
<td>OPAP Billing</td>
<td>Ø2, Ø3, Ø4</td>
</tr>
</tbody>
</table>

- COB Payer sheets with additional details are located at [www.caremark.com/pharminfo](http://www.caremark.com/pharminfo) (under downloadable forms and information)

- Remember, Medicaid (STAR) and CHIP is a “payer of last resort” which means other forms of insurance coverage (e.g., Medicare Part B or D, commercial insurance, etc.) should be submitted before state of Texas Medicaid (STAR) and CHIP programs

- Prescriptions reimbursable by Medicare Part D (Medicare Rx) are not eligible for additional reimbursement through Medicaid (STAR) and CHIP

- State of Texas Medicaid (STAR) and CHIP plan members should leave the pharmacy with their prescribed medications and no out-of-pocket expense*

  *Unless the plan member qualifies for a level of coverage with required copayments
Other Required Claim Elements – Prescriber NPI

• Prescriber NPI

• For all claims, including controlled substance prescriptions, provider must use the prescriber’s valid and active NPI

• Provider must maintain the DEA number on the original hard copy for all controlled substances prescriptions in accordance with State and Federal laws

• Nurse Practitioners and Physician Assistants must use the NPI of the supervising physician

• Claims submitted without an appropriate, valid, NPI will be rejected
Other Required Claim Elements – Prescription Origin Code

• Providers should use the Prescription Origin Code when submitting claims; Original fill Claims submitted without one of the values below will be rejected

• The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:

  1 = Written
  2 = Telephone
  3 = Electronic
  4 = Facsimile
  5 = Pharmacy

• The Fill Number should be placed in the 403-D3 field, and the following values should be used:

  Ø = Original dispensing
  1 to 99 = Refill number
Children’s Health Insurance Program (CHIP) Coverage for Contraceptives

- Children’s Health Insurance Program (CHIP) Coverage for Contraceptives: Family planning drugs prescribed for contraception are not covered by the Children’s Health Insurance Program (CHIP). Claims submitted for family planning drugs will reject with the following or similar message:

  • REJECT 70: << NDC Not Covered >>

- Prior Authorization

  • If applicable, the pharmacy may indicate that the prescription was written for a non-contraceptive diagnosis. Pharmacies should submit the following Prior Authorization values:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Explanation</th>
<th>Pharmacy Should Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 461-EU</td>
<td>Prior Authorization Type Code</td>
<td>2</td>
</tr>
</tbody>
</table>
| Field 462-EV | Prior Authorization Number Submitted | • 31 - Dysmenorrhea  
  • 32 - Acne Treatment  
  • 33 - Miscellaneous, other than contraception |

- Please note: Submitted claims information must be accurate and complete. Recorded diagnosis (on prescription hard copy or maintained in the pharmacy’s computer system) must be maintained in accordance with the Provider Manual and applicable law.
Eligibility

Eligibility inquiries

• Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format and all claims and remittance transactions in the 837/835 HIPAA-compliant format

• Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format

• Check the plan specific contact list for more further resources

Newborns

• A newborn needs an ID to process claims. If one is not provided, you must call or e-mail the Eligibility verification group at http://www.aetnabetterhealth.com/texas to obtain one.

Eligibility contact numbers:

1-800-248-7767 Bexar Medicaid  1-800-306-8612 Tarrant Medicaid
1-866-818-0950 Bexar CHIP     1-800-245-5380 Tarrant CHIP

Eligibility verification website: www.txvendordrug.com/claims/eligibility-verification.shtml
Benefit Plan Design

Copayments
Emergency 72-hour Override
Prior Authorization
Copayments and Prescription Maximums Per Month

For Texas Medicaid (STAR) program
- There are no prescription drug copayments
- There is no maximum number of prescriptions
- May receive up to a 34-day supply

For Texas CHIP program*:
- The following copayments are dependent upon the level of benefit:
  - Generic $0  Brand $3
  - Generic $0  Brand $5
  - Generic $10  Brand $35
- CHIP members may receive up to a 90-day-supply of a drug.
- Pharmacies cannot deny a CHIP member’s prescription, even if a member cannot pay their copay.

*CHIP Perinates and Chip Perinate newborns do not pay these copays, nor do CHIP members who have met their annual limit.
Emergency 72-hour override

- Federal and Texas law require providers to dispense a 72-hour emergency supply of a prescribed drug when the medication is needed without delay and prior authorization is not available.

- Applies to nonpreferred drugs on the Preferred Drug List and any drug that is affected by a clinical PA needing prescriber’s prior approval.

- The pharmacy should submit an emergency 72-hour prescription when warranted; this procedure should not be used for routine and continuous overrides.

- This process is subject to audit.

- For further details on the 72 hour emergency supply requests, please use this link to the State VDP website: [http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf](http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf)
Emergency 72-hour override (continued)

If the pharmacy receives a reject for “Prior Authorization Required”, and prescriber or their designee is not available, the pharmacy should submit the following information in order to provide the member with an emergency 72-hour supply:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Explanation</th>
<th>Pharmacy Should Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 461-EU</td>
<td>Prior Authorization Type Code</td>
<td>8</td>
</tr>
<tr>
<td>Field 462-EV</td>
<td>Prior Authorization Number Submitted</td>
<td>801</td>
</tr>
<tr>
<td>Field 405-D5</td>
<td>Days Supply</td>
<td>3</td>
</tr>
<tr>
<td>Field 442-E7</td>
<td>Quantity Dispensed</td>
<td>Dependent on package size*</td>
</tr>
</tbody>
</table>

*Nonbreakable package sizes should be dispensed in the smallest package size available (see Provider Manual for details)
Prior Authorization

When a claim rejects with reject code 75:

<< Prescriber should call 855-656-0363 or Fax 866-255-7534 or RPh should submit 72 hr emergency Rx if Dr is not available>>

– Please call or fax the prescriber with the above information so the prescriber can initiate a prior authorization

• Please include any supporting medical records that will assist with the review of the prior authorization request. For all requests allow 24 hours to complete the authorization process

• Pharmacist should submit 72 hour Emergency Rx if prescriber not available

• Pharmacies are allowed to fill an emergency 72-hour supply without delay if the PA is not available

If the PA is:

• Approved, Caremark will enter the PA and fax the prescriber with the outcome

• Denied, Caremark will deny the PA and fax the prescriber with the outcome
Clinical Formulary

Formulary Information & Preferred Drug List
Limited Home Health Supplies (LHHS)
Durable Medical Supplies
Comprehensive Care Program (CCP)
Tamper-proof Prescription Pads
E-prescribing
DUR Conflict Codes and Messages
Formulary & Preferred Drug List

• The Texas Drug Code Formulary covers more than 32,000 line items of drugs including single source and multisource (generic) products
  • Some benefit drug exclusions may apply by plan (e.g. CHIP – Oral contraceptives)

• The Vendor Drug Program only reimburses pharmacy providers for outpatient prescription drugs

• Preferred Drug List
  • Preferred drugs will be available without prior authorization unless a clinical prior authorization is required
  • Nonpreferred drugs will require PDL prior authorization
  • Only the prescribing physician or one of their staff representatives can request a prior authorization
  • The Preferred Drug List (PDL) is located at http://www.txvendordrug.com/pdl/ or Epocrates drug information system at https://online.epocrates.com/home

• Partial Fills
  • Partial fill processing is not permitted for Medicaid and CHIP claims
Limited Home Health Supplies (LHHS)

- The Vendor Drug Program (VDP) started covering Limited Home Health Supplies (LHHS) through the outpatient pharmacy benefit for Medicaid members as of November 12, 2012. This formulary also applied to CHIP members beginning March 7, 2014.

- To provide LHHS to CHIP and Medicaid members enrolled with Aetna Better Health of Texas, pharmacies must be contracted with the VDP and with Caremark, our pharmacy benefit manager (PBM). Enrollment as a Durable Medical Equipment (DME) provider is not required. Providers already enrolled as a Medicaid/CHIP DME provider must submit a claim for LHHS through the pharmacy benefit by way of the pharmacy claim system; these items will not be processed under the medical benefit.

- In addition, Aetna Better Health of Texas will have certain LHHS products designated as preferred. Aetna’s preferred diabetic test strips are the TrueTest and the TrueMetrix blood glucose test strips. Aetna Better Health of Texas has teamed up with the company that makes the True Result and the True Metrix blood glucose monitor, which will be provided to the member free of charge when submitted as a pharmacy claim.
Limited Home Health Supplies (LHHS) continued

LHHS Items:

- Insulin Syringes (1 cc or less)
- Insulin Needles
- Blood Glucose Test Strips (for home blood glucose monitor)
- Blood Glucose Test Strips with Disposable Monitor
- Blood Glucose Monitor (Talking)
- Lancets
- Spring-Powered Device for Lancet
- Aerosol Holding Chamber (for use with metered dose inhaler)
- Oral Electrolyte Replacement Fluid
- Hypertonic Saline Solution 7%

See [www.txvendordrug.com](http://www.txvendordrug.com) for the full list of LHHS covered products.

Please keep the following in mind when submitting a LHHS claim:

- A Title XIX form is not required for LHHS dispensed through a pharmacy. A prescription (faxed, written, or electronic) is required.
- Claims must be submitted in accordance with the most current NCPDP pharmacy billing standard.
- Nurses and Physician Assistants may not prescribe DME products for CHIP or Medicaid members.
Durable Medical Equipment and Supplies

- Pharmacies are encouraged to provide full array of Durable Medical Equipment (DME) and medical supplies – such as nebulizers or ostomy supplies – to Medicaid STAR; STAR+Plus and CHIP plan members

- To participate as a DME provider, pharmacies must enroll with the MCO as a DME medical provider and satisfy all the requirements of the Texas Medicaid and CHIP Vendor Drug Program

- DME claims (including CCP* claims) will be processed under the medical claim benefit – the pharmacy will need to submit a standard CMS 1500 claim to the MCO

* refer to next slide for more information on CCP
Comprehensive Care Program (CCP)

- The Medicaid Comprehensive Care Program (CCP) can cover medically necessary drugs and supplies that are not available through Vendor Drug for clients from birth through 20 years of age.

- Pharmacies must be enrolled as a CCP provider to provide these services.

- Pharmacies that want to enroll in the CCP program should complete an application at tmhp.com. For assistance contact the TMHP Contact Center at 1-800-925-9126, or e-mail TMHP Provider Relations to request assistance from the local TMHP provider relations representative in your area.

- Pharmacies must also contract with the MCO to participate in the MCO’s network.

- Pharmacies not enrolled with CCP should direct the client to a CCP provider or to the MCO for assistance in locating a CCP provider.

- Authorizations for CCP services are handled by the MCO, not Caremark.

- CCP claims will be processed under the medical claim benefit and the pharmacy will need to submit a standard CMS 1500 claim to the MCO.
Tamper-proof Prescription Pads

• Prescribing practitioners are required to use tamper-resistant prescription paper when writing a prescription for any drug for Medicaid (STAR) recipients

• This requirement applies to all written Medicaid (STAR) prescriptions submitted for payment

• The regulation does not apply to prescription orders transmitted to a pharmacy via telephone, fax, or electronically

• The tamper-resistant requirement is only mandatory for prescriptions written for Medicaid (STAR) clients, it is not a requirement for the CHIP program
E-prescribing

• Providers engaged in E-prescribing must do so in accordance with all applicable State and Federal laws

• Providers are encouraged to utilize E-prescribing practices, the benefits of which include the correct identification of covered, preferred drugs and the subsequent reduction in the need to work with the prescriber to find alternatives

E-prescribing with “brand medically necessary” requirements:

• If the pharmacy receives an e-prescription requiring “dispense as written” by the prescriber, there must be a “Brand Medically Necessary” indication in the Notes to Pharmacy field” (usually a free-form text field); although, some systems may use a separate field to choose a reason why the prescription is DAW

• If an e-prescription is received by a pharmacy with DAW indicated but without the free text message or additional note, the pharmacist must contact the prescriber for a new prescription

• Pharmacy should enter “1” in “Dispense as Written” (Field 4Ø8-D8)

• Pharmacy should enter “3” in “Prescription Origin Code” (Field 419-DJ)

• Failure of the pharmacy to produce electronic records that indicate the proper DAW and “Brand Medically Necessary” in the free text message for the prescription will result in the claim subject to recoupment
• All DUR messages appear in the claim response and pharmacies must view all screens necessary to receive the message detail, and act upon all such messages subject to the professional judgment of the provider.

• Caremark, in accordance with current NCPDP standards, returns up to 9 DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to 9 DUR messages on the same claim.

• Following are some of the most commonly used DUR conflict codes and messages with corresponding descriptions separated into categories as recommended by NCPDP:

<table>
<thead>
<tr>
<th>DUR Conflict Codes and Messages</th>
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</tr>
</thead>
<tbody>
<tr>
<td>High Dose (HD)</td>
<td>Excessive Utilization - Early Refill (ER)</td>
</tr>
<tr>
<td>Drug-Drug Interaction (DD)</td>
<td>Therapeutic Duplication (TD)</td>
</tr>
<tr>
<td>Drug-Age Precaution (PA)</td>
<td>Drug-Pregnancy Alert (PG)</td>
</tr>
<tr>
<td></td>
<td>Under Utilization – Late Refill (LR)</td>
</tr>
<tr>
<td></td>
<td>Ingredient Duplication (ID)</td>
</tr>
<tr>
<td></td>
<td>Drug-Disease Precaution (DC)</td>
</tr>
</tbody>
</table>
Pharmacy Payment and Contact Information

Pharmacy Payment
Provider Complaint/Appeal Process
MAC Pricing
Contact Information
Pharmacy Payment

- Pharmacies will receive payment for Aetna Better Health claims adjudicating as paid on a weekly basis from Caremark in accordance with prompt pay regulations.

- Pharmacies will continue to receive their remittance advice (paper) or 835 file (electronic) as they normally do from Caremark.

- Aetna Better Health claims will appear with an RXBIN code that differentiates claims from all other claims appearing in the paper/electronic data.

- From time to time, Caremark may adjust paid claims to correct errors, or offset for discrepant claims or other charges for noncompliance and audit-related costs.

- In accordance with Texas Insurance Code 843.339, a pharmacy claim submitted electronically will be paid by Caremark through electronic funds transfer no later than the 18th day after the date on which the claim was affirmatively adjudicated. A pharmacy claim not submitted electronically will be paid by Caremark no later than the 21st day after the date on which the claim was affirmatively adjudicated.
Provider Complaint/Appeal Process

Issues regarding the handling of a complaint should be reported to Aetna Better Health.

Aetna Better Health
Attention: Member Advocate
P.O. Box 569150
Dallas, TX 75356-9150

Any Medicaid issues not resolved to the provider’s satisfaction by Caremark or Aetna Better Health can be submitted to the state.

Texas Health and Human Services Commission Provider Complaints
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708
HPM_complaints@hhsc.state.tx.us
Provider Complaint/Appeal Process

• CHIP provider complaints should be submitted to TDI, rather than HHSC. The address is:
  Texas Department of Insurance
  Consumer Protection (111-1A)
  P.O. Box 149104
  Austin, TX 78714-9104
  or call toll free 1-800-252-3439

• Audit resolution – Appeals Process
  • Provider must submit an appeal to Caremark no later than the 120th day after the date Provider provides health care services.
MAC PRICING
MAC (MAXIMUM ALLOWABLE COST)

Background

• Caremark’s analytical process to establish a maximum allowable cost (MAC) is at a product level for generics and multi-source brand products. The analytical process involves a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by CMS, and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis, if not more often, and are based on marketplace trends and dynamics, and price fluctuations. MAC pricing is not applied to any preferred brand name drugs.

Web Portal MAC Price Access

• With respect to Pharmacy Services provided to Texas Medicaid and CHIP enrollees, Caremark has provided Texas Medicaid and CHIP pharmacies with the following process for pharmacies to access MAC prices.
  – Pharmacy Portal Texas MAC Price Look Up: https://rxservices.cvscaremark.com

MAC Challenge Process

• Network pharmacy providers may submit a MAC challenge and Caremark shall respond to the provider within fifteen (15) days after the challenge is made.
• Chain and affiliation (PSAO) pharmacies should submit MAC paid claim appeals through their respective Chain or PSAO headquarters, which will then submit appropriate data to Caremark.
• Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) should submit MAC paid claim appeals through the Pharmacy Help Desk.
# Contact Information

<table>
<thead>
<tr>
<th>Reason</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caremark Pharmacy Help Desk (Point of service/adjudication issues)</td>
<td>Call 1-877-874-3317</td>
<td><a href="www.caremark.com/pharminfo">www.caremark.com/pharminfo</a></td>
</tr>
<tr>
<td>Texas Vendor Drug Program (for pharmacies only)</td>
<td>Call 1-800-435-4165 Fax 1-512-730-7466</td>
<td><a href="www.txvendordrug.com">www.txvendordrug.com</a></td>
</tr>
</tbody>
</table>