Addendum to Provider Manual: Texas Managed Care Medicaid & CHIP

For Managed Care Organization: Wellpoint Texas

PROGRAMS SERVING:

- Texas Medicaid (STAR)
- Texas Medicaid (STAR+PLUS)
- Children's Health Insurance Program (CHIP)
- Texas Medicaid (STAR Kids)

SERVICE AREAS COVERED:

STAR: Dallas, Harris, Tarrant, Jefferson, Bexar, Lubbock, MRSA Central, MRSA Northeast, MRSA West

STAR+PLUS: Jefferson, Lubbock, Nueces, MRSA West

CHIP: Dallas, Harris, Tarrant, Jefferson, Bexar

STAR Kids: Dallas, El Paso, Harris, Lubbock, MRSA West

Contact/Information Source:

Caremark Pharmacy Help Desk Number: **1-833-252-0329**

Caremark Pharmacy Help Desk (and Payer Sheets) Website: http://www.caremark.com/pharminfo

Eligibility Verification Number: **1-833-731-2162**

Eligibility Verification Website: https://www.provider.wellpoint.com/texas-provider/member-eligibility-and-pharmacy

Prior Authorization Number: 1-833-731-2162

- Prior Authorization Fax: **1-844-474-3341**

Eligibility Verification Website: https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-6-eligibility/pharmacy-verification-eligibility/real-time-eligibility-verification

Texas Vendor Drug Program (VPD) Number: **1-800-435-4165**
(for pharmacy use only – please do not give this number to Medicaid or CHIP clients)

Texas Vendor Drug Program (VPD) Website: http://www.txvendordrug.com

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I. Introduction

This is an Addendum to your current Caremark Provider Manual and outlines your provider responsibilities when providing Pharmacy Services to qualified State of Texas Medicaid/CHIP program ("Texas Medicaid") recipients ("Eligible Person"), through Wellpoint Texas, Inc. ("Wellpoint"), a managed care organization in the Medicaid Program and CHIP Program, administered by the Texas Health and Human Services Commission. You must be a contracted pharmacy provider in Caremark's pharmacy network and participate in the Texas Vendor Drug Program in order to provide outpatient pharmaceutical services to Texas Medicaid Eligible Persons. Capitalized terms used in this Addendum shall have the same meaning as in the **Glossary of Terms** in the Provider Manual, except as otherwise defined herein.

Contact Information: CVS Caremark Pharmacy Help Desk: 1-833-252-0329

Vendor Drug Program (MC-2250):
Texas Health and Human Services
4900 North Lamar Blvd.,
Austin, TX 78751

Web address: http://www.txvendordrug.com/providers/contracts.shtml
Phone: 1-800-435-4165
Fax: 512-730-7483 (Central office) or 512-491-1958 (Help Desk only)

Role of Pharmacy:
The role of the pharmacy is to provide covered services to eligible members according to the terms and conditions of the current Provider Manual and all appropriate Addendum and Pharmacy Communications which may be issued from time to time.

II. Covered Services

Member Prescriptions:
Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 34-day supply at a retail pharmacy and a 34-day supply from a mail pharmacy. CHIP members may receive up to a 90-day-supply of a drug.

III. Quality Management

Please refer to your Caremark Provider Manual, but more specifically, section **Credentialing and Quality Management** which states as follows:

Quality Management
Provider must comply with credentialing and quality management initiatives required by Caremark, and Provider must provide Caremark with documentation and other information that may be needed in connection with such initiatives including, but not limited to, disclosure of information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 CFR Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 CFR Part 420, Subpart C).

Caremark has the right to reasonably determine in its sole discretion whether or not Provider meets and maintains the appropriate credentialing and quality management standards to serve as a Provider for Caremark and its Plan Sponsors.

We also refer you to the **Clinical Programs, Services and Related Messages** section of the Provider Manual for utilization management programs.

IV. Provider Responsibilities

a. Availability: N/A

b. Updates to Contact Information: Providers must send changes of their contact information in writing, within 10 business days of any changes in the documentation and other information provided to Caremark in connection with enrolling as a Provider and in any credentialing or quality management initiatives. Such information, includes but is not limited to, changes in name, address, telephone number, fax number, services, group affiliation or ownership, and must be sent 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
4900 North Lamar Blvd.
Austin, TX 78751
Phone: 1-800-435-4165 Fax: 512-730-7483 (Central office) or 512-491-1958 (Help Desk only)

Web address: http://www.txvendordrug.com/providers/contracts.shtml

c. Network Provider: You must be a contracted pharmacy provider in Caremark's pharmacy network and participate in the Texas Vendor Drug Program in order to provide outpatient pharmaceutical services to Texas Medicaid Eligible Persons. Members have the right to obtain medications from any network pharmacy that meets all participation criteria.

d. Eligibility Verification and Authorizations for Service: Please refer to your Caremark Provider Manual, sections **Verification of Eligible Persons** and **Identification Cards** which states as follows:

Verification of Eligible Persons
Provider will not be paid for providing Pharmacy Services related to Covered Items to an Eligible Person whose eligibility was incorrectly submitted.

Wellpoint will provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims system. If an identification card is unavailable at the point of service, reasonable attempts/efforts should be made to obtain the necessary information for claim submission. Provider will not be paid for providing Pharmacy Services related to Covered Items to an Eligible Person whose eligibility was not correctly submitted.

Identification Cards
In most cases, the identification card will be produced in the NCPDP format and will contain the Eligible Person's identification number, the RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

RXBIN 020107
RXPCN CS
RXGRP WKEA

Verification of Electronic Eligibility: Provider may submit an NCPDP E1 Transaction to verify eligibility electronically.

Newborns
A newborn needs an ID to process claims. If one is not provided or available, you must contact the Eligibility verification team to obtain one. Eligibility contact details are published on the front cover of this addendum.

e. Pharmacy Records Standards: Please refer to your Caremark Provider Manual section **Records Maintenance** which states as follows:

Documentation
Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons in accordance with industry standards in a readily obtainable location for a minimum of ten (10) years or such period as required by applicable Law. Such documents and records may include, but are not limited to, original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; Prescriber information; and patient profiles. Refer to the **Professional Audits** of the Provider Manual for more detail on documentation requirements. Provider must maintain and secure records in accordance with HIPAA requirements, including disposing of any records containing Protected Health Information (PHI) in a secure manner in accordance with guidelines issued by the Secretary of Health and Human Services for rendering such records unusable, unreadable or indecipherable to unauthorized individuals.

f. Formulary and Preferred Drug List Adherence: Please refer to your Caremark Provider Manual, section **Formularies**. Please also refer to the Texas Health and Human Services Commission's website link http://www.txvendordrug.com/formulary/preferred-drugs.shtml for the most up to date Preferred Drug List (Texas Drug non-PA PDL Search and PDL/PA Status Search) and for the Texas Drug Code Formulary (https://www.txvendordrug.com/formulary/formulary-search). The Texas Medicaid preferred drug list is also available on the Epocrates drug information system. (https://online.epocrates.com/home). Please refer to the Clinical PA Assistance Chart located at https://www.txvendordrug.com/formulary/prior-authorization for drugs that require Clinical Prior Authorization.

g. General: Provider shall coordinate with the Prescriber as necessary in performing Provider's Pharmacy Services, and ensure that Eligible Persons receive all medications for which they are eligible. This includes filling all prescriptions under all plans Eligible Persons has prescription benefit coverage under (including public and private sources of coverage).

h. Coordination of Benefits: Please refer to your Caremark Provider Manual, section **Coordination of Benefits**, which states as follows:

Coordination of Benefits (COB)
Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any coordination of benefits requirements and must engage in appropriate coordination of benefits activities to the extent required by Caremark, or applicable by Law.

Plans may indicate if an Eligible Person's eligibility is "supplemental" and Provider may receive the following or similar reject:
Reject 41 <<Submit bill to other processor or primary payer>>

Upon receipt of the reject:

- Ask member if they have other prescription coverage
- Use the information provided in the chart below to submit the claim
- The OPAP field (Other Payer Amount Paid) should be populated
- Use Other Coverage Codes 02, 03, 04

Medicaid is a "payer of last resort", which means other forms of insurance coverage (e.g., Medicare Part B or Part D, commercial insurance, etc.) should be submitted before state of Texas STAR, STAR+PLUS or CHIP program.

Also, please update the member profile with COB information.

Scenario	If the Primary is…	If the Secondary is…	RXBIN	RXPCN	RXGRP
Scenario #1	**Texas Medicaid/CHIP**	N/A	020107	CS	WKEA
Scenario #2	Medicare Part D Plan	**Texas Medicaid**	020107	IRXCOBOPAP	WKEA
Scenario #3	Commercial Insurance Plan/Medicare Part B Plan	**Texas Medicaid**	020107	IRXCOMOPAP	WKEA

Provider must not hold Eligible Persons, who are dual eligible for both Medicare and Medicaid, liable for Medicare Part A and B cost sharing when Medicaid is responsible for paying such amounts; Provider must accept Caremark's payment as payment in full or bill the appropriate state Medicaid agency.

For complete information on COB, please refer to the payer specification sheet located at www.caremark.com.

i. **Fraud, Waste and Abuse:** The HHSC Office of Inspector General (OIG) investigates waste, abuse, and fraud in all Health and Human Services agencies in the State of Texas. To report waste, abuse or fraud please call 1-800-436-6184 or visit the HHSC OIG website at https://oig.hhsc.state.tx.us/.

Federal law requires all providers and other entities that receive or make annual Medicaid payments of $5 million or more to educate their employees, contractors, and agents about fraud and false claims laws and the whistleblower protections available under those laws.

V. Provider Complaint/Appeal Process to Caremark

Please refer to your Caremark Provider Manual, sections **Disputed Claims** and **Claims Adjustment**, for all payment disputes. Also, the **On-Site and Investigational Audit Resolution – Appeals Process** section of the Provider Manual contains information defining the appeals processes for Caremark audits conducted of Providers. Complaints regarding any issue other than payment disputes or audits can be submitted in writing or orally to the Caremark Help Desk. A complaint will be resolved within 30 days. Please refer to the **Pharmacy Help Desk** section in the Caremark Provider Manual or the Pharmacy Help Desk for assistance and guidance. Issues regarding the handling of a complaint should be reported to Wellpoint.

Appeals Team
Wellpoint
2505 N Hwy 360, Ste. 300
Grand Prairie, TX 75050
Phone: 833-731-2160

Any Medicaid issues not resolved to the provider's satisfaction by Caremark or Wellpoint can be submitted to the state.

Texas Health and Human Services Commission
Provider Complaints
Health Plan Management (H-320)
Texas Health and Human Services
4900 North Lamar Blvd.
Austin, TX 78751
Email: hpm_complaints@hhsc.state.tx.us

CHIP provider complaints should be submitted to TDI, rather than HHSC. The address is:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091
Phone: 1-800-252-3439 Fax: 512-490-1007
Online: www.tdi.texas.gov

VI. Encounter Data, Billing and Claims Administration

Please refer to your Caremark Provider Manual, section **Claims Submission**.

a. Cost Sharing Schedule:

There are no prescription drug copayments for Medicaid STAR, STAR Kids and STAR+PLUS programs.

There are three levels of relevant copayments for CHIP programs, depending on the member's level of benefit:

- Generic $0 / Brand $3
- Generic $0 / Brand $5
- Generic $10 / Brand $35

b. Emergency Services Claims: A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs that require a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the Prescriber cannot be reached or is unable to request a PA, Provider should submit an emergency 72-hour prescription. This procedure should not be used for routine and continuous overrides.

Provider can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g. an albuterol inhaler, as a 72-hour emergency supply, but should use the smallest available package size.

c. Billing Members: Please refer to your Caremark Provider Manual section **Limitation on Collection** which states as follows:

Limitation on Collection
Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including nonpayment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For Claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

According to the Texas Medicaid rules and regulations, it is unlawful for a pharmacy provider to withhold medication dispensation to a CHIP member who cannot afford required copayments. For auditing and legal purposes, the pharmacy provider is required to notate and document the balance due upon medication dispensation.

d. Time Limit for Submission of Claims: In accordance with Texas Insurance code 843.337, Provider must submit a claim to Caremark no later than the 95th day after the date Provider provides health care services.

e. Claims Payment: 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.

f. Compounded Medications: Please refer to your Caremark Provider Manual section **Compounded Medications** for unique claims submission requirements.

g. Claims Questions/Appeals: Please refer to your Caremark Provider Manual, sections **Disputed Claims** and **Claims Adjustment**. The **On-Site and Investigational Audit Resolution – Appeals Process** section of the Provider Manual contains information about the appeals processes for Caremark audits conducted on Providers. Provider must submit an appeal to Caremark no later than the 120th day after the date Provider provides health care services. For MAC paid claim appeals, Provider may appeal the MAC price paid by Caremark at a product level. Refer to the **Maximum Allowable Cost (MAC)** section of the Provider Manual.

h. List of Covered Drugs and Preferred Drugs: Please refer to the Texas Health and Human Services Commission's website link http://www.txvendordrug.com/formulary/preferred-drugs.shtml for the Preferred Drug List. This information is also available via the Epocrates drug information system at https://online.epocrates.com/home. The Medicaid Program also covers certain over-the-counter drugs if they are on the approved drugs list. Like other drugs, over-the-counter drugs must have a prescription written by the member's physician. Check the list of covered drugs (https://www.txvendordrug.com/formulary/formulary-search). Please refer to the Clinical PA Assistance Chart located at https://www.txvendordrug.com/formulary/prior-authorization for drugs that require Clinical Prior Authorization.

i. Process for Prior Authorization: Please refer to your Caremark Provider Manual, section **Prior Authorization** which states as follows:

Prior Authorization
For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber needs to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

If a medication is designated for prior authorization, the claim may reject with a message such as:

Prior Authorization Required
MD Call 1-833-731-2162
Fax 1-844-474-3341

The claims system response typically also provides the correct contact information in the subsequent message.

If the Prescriber feels the drug is medically necessary, he or she will need to call the number listed in the messaging

to initiate coverage in order to avoid jeopardizing the health or safety of the Member.

To obtain a prior authorization form you can call **1-833-731-2162** or fax **1-844-474-3341**.

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Caremark requires that its Network Pharmacy pharmacist make good faith efforts to contact the Prescriber to inform on prior authorization messaging.

Prior Authorization Process:

- 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 non-preferred 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 override when warranted; this procedure should not be used for routine and continuous overrides
- If the pharmacy receives a reject for "Prior Authorization Required", and the prescriber is not available, the pharmacy should submit the following information in order to provide the member with an emergency 72-hour supply:

Field Number	Field Explanation	Pharmacy Should Submit
Field 461-EU	Prior Authorization Type Code	8
Field 462-EV	Prior Authorization Number Submitted	801
Field 405-D5	Days' Supply	3
Field 442-E7	Quantity Dispensed	Dependent on package size*

***Non-breakable package sizes should be dispensed in the smallest package size available.**

j. 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 75: << Prior Authorization Required >>
Contraception not covered; other uses

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:

Please review "Double space"Field Number	Field Explanation	Pharmacy Should Submit
Field 461-EU	Prior Authorization Type Code	2
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.

k. Transaction Fees - Amendments to 2016 Caremark Provider Manual: Effective September 1, 2015, pursuant to Tex.Ins.Code § 1369.402, and to the extent applicable under the law, Caremark shall not directly or indirectly charge or hold Provider responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including (1) the adjudication of a pharmacy benefit claim; (2) the processing or transmission of a pharmacy benefit claim; (3) the development or management of a claim processing or adjudication network; or (4) participation in a claim processing or adjudication.

VII. Reporting 340B Claims

The State of Texas Health and Human Services Commission (HHSC) requires managed care organizations (MCOs) to provide network pharmacies with information on reporting 340B claims (i.e., claims for drugs acquired through the 340B

Drug Pricing Program as administered by the Health Resources and Services Administration). Providers must submit an indicator when utilizing medications filled with 340B acquired drugs. This indicator will allow the State of Texas to exclude claims filled with 340B acquired drugs from their Medicaid rebate invoicing.

Effective April 1, 2014, the Texas Health and Human Services Commission (HHSC) amends 1 T.A.C. § 355.8548, which concerns certain Medicaid fee-for-service (FFS) pharmacy provider types who are enrolled in the federal drug pricing discount program, to discontinue the methodology that requires covered entities to submit the actual acquisition cost and instead utilize a reimbursement methodology based upon the drug ingredient costs for pharmacies enrolled in the section 340B drug-pricing program.

Effective August 15, 2014, the Texas Health and Human Services Commission (HHSC) amends Uniformed Managed Care Manual (UMCM) Chapter 2.2, which concerns certain Texas Medicaid/CHIP Vendor Drug Program provider types who are enrolled in the federal drug pricing discount program, to implement the pricing methodology approved by HHSC. ACTION: Accordingly, and effective December 1, 2014, claims filled with 340B drugs for Texas Medicaid/CHIP enrollees will be reimbursed based on the revised 340B methodology described below, if the claim is appropriately submitted by the pharmacy.

When submitting claims filled with drugs acquired through the 340B program, the lower of logic reimbursement formula as detailed in Section 4.3 or Schedule A of the Caremark Provider Agreement, whichever is applicable, shall apply.

The following value must be used in the NCPDP Payer Field to identify drugs acquired at 340B pricing. Providers must use this field to indicate claims for which dispensed drugs were acquired at 340B pricing. Please start working with your software vendors immediately, if needed, to populate this field. Claims are subject to audit.

Field No.	NCPDP Field Name	Value		Comments
420-DK	Submission Clarification Code	20 = 340B	RW	20 = Required when designating the product being billed was purchased pursuant to rights as a 34ØB /Disproportionate Share Pricing/Public Health Service item.

Any claims submitted without the 340B Submission Clarification Code value of ‘20’ indicates that the claim is a non-340B drug. Thank you in advance for your attention to this important change. If there are any questions regarding this change, please contact Caremark Retail Services at **1-866-488-4708.**