

Texas Vendor Drug Program **Pharmacy Provider Procedure Manual**

Coordination of Benefits

May 2018

The Pharmacy Provider Procedure Manual (PPPM) is available online at txvendordrug.com/about/policy/manual.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Table of Contents

Table of Contents	i
1 Medicaid	2
1.1 With Other Insurance	2
1.1.1 Texas Pharmacy Third Party Insurance Call Center	3
1.2 Medicare	3
1.2.1 Medicare Part B	3
1.2.2 Medicare Part D	4
2 Children with Special Health Care Needs Services Program	7
2.1 With Medicaid	7
2.2 With Other Insurance	7
2.3 With Medicare Part B	7
2.4 With Medicare Part D	7
3 Kidney Health Care Program	7
3.1 With Other Insurance	7
3.2 With Medicare Part B	8
3.3 With Medicare Part D	8

1 Medicaid

It is common for people eligible for Medicaid to have one or more additional sources of coverage for health care services. Third Party Liability (TPL) refers to the legal obligation of third parties to pay part or all of the expenditures for medical assistance. By law, all other available third party resources must meet their legal obligation to pay claims before Medicaid pays for the care of a person eligible for Medicaid.

1.1 With Other Insurance

Pharmacy providers must bill all other third party payers when a person has coverage through another payer for prescription drugs, including non-prescription (over the counter) medications, some products used in symptomatic relief of cough and colds, and some prescription vitamins and mineral products. Refer to Section 1.2.2 below for more information regarding Medicaid coverage of wrap-around drugs for people who are dual eligible.

If other insurance exists in the VDP Pharmacy Claims System and Medicaid is billed as the primary insurer, then the claim will reject with NCPDP code 41 (“Submit Bill To Other Processor or Primary Payer”). The pharmacy will be provided with the third-party billing information needed for claims submission to the other payer. Refer to the [System Requirements](#) chapter of the PPPM for more information about COB program requirements.

If the pharmacy submits the claim to the primary payer and it is not paid, pharmacy staff should contact the primary payer and/or prescriber to address the rejection reason. If the claim is not payable by the other payer, Medicaid may pay the claim depending on the rejection reason (including expired coverage). Pharmacy staff should submit the claim to Medicaid and include the other payer’s rejection code in the “Other Payer Reject Code” field (472-6E).

Medicaid will continue to reject the claim until billing to all other known payers has been attempted. If the person is assessed a deductible or co-payment, the pharmacy should submit the claim to Medicaid (as secondary payer) and include the amount paid by the primary payer. The VDP Pharmacy Claims System will pay deductibles and co-payments, up to the amount Medicaid would have reimbursed, for eligible people and covered drugs.

The person should always walk out of the pharmacy with their prescribed medications and no out-of-pocket expense.

1.1.1 Texas Pharmacy Third Party Insurance Call Center

The Texas Pharmacy Third Party Insurance Call Center ensures the accuracy of third-party information used in the claims adjudication processes.

Pharmacy staff may contact the Call Center to confirm non-Medicare third party insurances for people eligible for fee-for-service Medicaid or report discrepancies found with other payers.

Pharmacy providers should attempt to bill the third-party payer in question before contacting the Call Center. Call center staff cannot process a request until the pharmacy has received a rejection from the third-party payer. Call center staff will verify insurance within 72 hours and provide updates to the VDP claim processor.

Refer to the “Third-party Recovery” section of the [Contact Information](#) chapter of the PPPM to verify other insurance through the Call Center.

1.2 Medicare

A person deemed dual-eligible has full Medicaid and is eligible for Medicare Part A and/or Part B. People that qualify for Medicare Part A and/or Part B are eligible for Medicare Part D (Medicare drug coverage).

1.2.1 Medicare Part B

Medicare Part B covers medical benefits, such as physician services, outpatient care, durable medical equipment, home health services, some outpatient "Part B" medications, some laboratory tests, and many preventive services.

People eligible for Medicaid who are also covered by Medicare Part B may have all or a portion of their co-insurance and deductible amounts paid by Medicaid. Test strips, lancets, and needle disposal systems are covered under the Medicare Part B durable medical equipment (DME) benefit, and Medicaid will pay the cost share of covered home health supplies after Medicare Part B provides a paid response.

Pharmacies must follow the coordination of benefits process when billing claims to Medicaid. The pharmacy must submit the claim to Medicare prior to submitting to Medicaid for payment consideration. Medicaid is the payer of last resort. This includes claims for Part B covered drugs for people with qualified Medicaid

beneficiary (QMB) benefits. Medicaid will reimburse up to the maximum payable Medicaid amount. If the amount paid by Medicare is greater than the maximum payable Medicaid amount, the claim will pay at zero dollars.

If Medicare Part B provides a paid response, the pharmacy should process the Medicaid claim to result in one of the following:

- The claim is paid with a \$0.00 paid amount; Medicaid will cover the cost share (co-insurance, copay, deductible) up to the Medicaid allowed amount.
- The claim is paid with an amount greater than \$0.00, but less than the Medicaid allowed amount for identified drugs covered by Medicaid; Medicaid may cover the cost share portion up to the Medicaid allowed amount. Pharmacies may not request payment directly from the Medicaid-eligible person.

1.2.2 Medicare Part D

Medicare Part D (Medicare Rx) is the Medicare prescription drug benefit, enacted as part of the Medicare Modernization Act of 2003. CMS states that people eligible for Medicare Part A or who are enrolled in Medicare Part B are also eligible for Medicare Part D.

Medicare Part D offers optional drug coverage to all Medicare-eligible people through private prescription drug plans (PDPs) or Medicare Health Maintenance Organizations (HMOs). Prescriptions reimbursable by Medicare Part D are not eligible for additional reimbursement through Medicaid.

Medicaid does not pay for Medicare Part D covered drugs and cannot be billed after payment is collected from Medicare Part D for dual-eligible people. Certain drugs can be excluded from coverage by the PDP. Each plan has their own formulary and the person must choose the plan that is best for their prescription drug needs. Part D sponsors are required to implement reject messaging that will allow pharmacies to identify claims for excluded Part D drugs that can be billed to the state.

Medicaid may choose to pay for some drugs excluded from Medicare Part D coverage. Texas Medicaid will pay for wrap-around drugs/products for dual eligible people after commercial insurance has been billed or if there is no commercial insurance on file. These drugs include non-prescription (over the counter medications), some products used in symptomatic relief of cough and colds, and some prescription vitamins and mineral products.

Medicaid will pay for a limited set of home health supply products. CMS states that medical supplies directly associated with delivering insulin to the body (including syringes and needles) are considered Medicare Part D covered. However, test strips, lancets, and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D. These items should be covered under the Medicare Part B DME benefit, and Medicaid will pay the cost share for covered home health supply products after Medicare Part B provides a paid response. If the person does not have Medicare Part B, Medicaid will pay for these items. Refer to the [Home Health Supplies](#) chapter of the PPPM for more information regarding coverage of home health supply products for people dually enrolled in Medicare and Medicaid.

Claims submitted to Medicaid with a Medicare Part D covered drug and/or product will reject to bill Medicare Part D and/or commercial insurance (if there is commercial insurance on file) if the person is eligible for Medicare Part D. If a pharmacy receives a rejection from Medicaid to bill the person's PDP, then the pharmacy should submit the claim to the person's PDP. If the person does not have plan information or says that they are not enrolled in a plan, then pharmacy staff should do one of the following:

- Call Medicare for PDP information.
- Utilize the Facilitated Enrollment process (see Section 1.2.2.2 below).
- Submit the claim to the Medicare Limited Income (LI) NET program if the person has never been enrolled in a Medicare PDP (see Section 1.2.2.3 below).

1.2.2.1 Opting out of Medicare Part D

People that are deemed dual-eligible are automatically enrolled in a Medicare PDP. Some people may choose to disenroll, or opt out, from their PDP, meaning the person has chosen to not participate in the Medicare Part D plan. Medicaid is not liable for the person's prescription drug coverage if the person opts out of enrolling in a Part D plan.

The VDP pharmacy claims system returns a message on paid claims for people that will soon become eligible for Medicare Part D. This message will be returned several months prior to the person's Medicare coverage effective date to alert the pharmacy that Medicare will become liable for prescription drug coverage. The message is returned in the "Additional Message Information" field (526-FQ) and read "Part D liable for this client's Rx's no later than XX/XX/XXXX".

Pharmacy staff should advise the person that Medicaid will no longer pay for prescriptions for Part D covered drugs as of the date returned in the message. The person must choose a Medicare Part D plan by that date in order for their prescription benefits to continue. After the date returned Medicaid will only be responsible for the Part D-excluded wrap-around drugs.

1.2.2.2 Facilitated Enrollment

Facilitated Enrollment is the process by which low-income subsidy (LIS) people are enrolled in a Part D plan. The point-of-sale facilitated enrollment process ensures that dual-eligible people who are not yet enrolled in a Medicare PDP are still able to obtain prescription drug coverage when evidence of Medicare and Medicaid eligibility is presented at the pharmacy. Pharmacy staff can submit an eligibility verification transaction to Relay Health to identify whether the person is already enrolled in a PDP. Refer to the "Medicare" section of the [Contact Information](#) chapter of the PPPM to learn about this program.

1.2.2.3 Limited Income NET Program

The Limited Income Newly Eligible Transition (LI-NET program) provides immediate and temporary Part D prescription drug coverage for low income Medicare people not already in a Medicare PDP. The LINET program covers all Part D covered drugs, and there are no network pharmacy restrictions during the time period covered by this program. Refer to the "Medicare" section of the [Contact Information](#) chapter of the PPPM to learn about this program.

1.2.2.4 Extra Help with Medicare Prescription Drug Plan Costs

People with limited incomes may qualify for extra help to pay for their prescription drug costs. The person will be charged the reduced copayment based on the level of Extra Help they receive. The program also covers prescriptions that eligible people may have filled within the last 30 days.

Refer to the "Medicare" section of the [Contact Information](#) chapter of the PPPM to learn about this program.

2 CSHCN Services Program

Refer to the [Introduction](#) chapter of the PPPM for more about the Children with Special Health Care Needs (CSHCN) Services Program pharmacy benefit.

2.1 With Medicaid

If a person is eligible for Medicaid and the service is covered by Medicaid then Medicaid will pay the claim through either VDP (for drugs) or through the Medicaid Comprehensive Care Program (for items not covered by VDP). Pharmacy providers that want to enroll in the Medicaid Comprehensive Care Program (CCP) should refer to the "Pharmacy Enrollment and Support" section of the [Contact Information](#) chapter of the PPPM.

2.2 With Other Insurance

People enrolled in the CSHCN Services Program may have coverage for prescription drugs through another primary payer. Pharmacy providers must bill the primary payer first and bill the CSHCN Services Program as secondary payer. The program will pay drug co-pays, deductibles, and co-insurances. The program does not qualify as a CMS-defined State Pharmaceutical Assistance Program (SPAP).

2.3 With Medicare Part B

CSHCN will pay the Medicare Part B co-insurance for people without supplemental drug coverage.

2.4 With Medicare Part D

CSHCN will coordinate benefits with Medicare Part D deductibles, co-insurance, and gap coverage.

3 KHC Program

Refer to the [Introduction](#) chapter of the PPPM for more about the Kidney Health Care (KHC) Program pharmacy benefit.

3.1 With Other Insurance

Pharmacy staff should report any private/group health insurance coverage to the KHC Program at 1-800-222-3986.

3.2 With Medicare Part B

KHC will pay the Part B co-insurance for immunosuppressant drugs on the KHC formulary for people without supplemental drug coverage.

3.3 With Medicare Part D

People eligible for both KHC and Medicare must apply for a stand-alone Medicare Part D plan. Medicare Part D will become the primary payer for prescription drugs, and KHC will become the secondary payer for the quantity covered by Medicare, up to a 90 day supply. When KHC is the secondary payer for claims coordinated with Medicare Part D, the person will have a zero copay. A copay is assessed when KHC is the sole payer for the claims. KHC does not coordinate with Medicare Advantage Plans.

KHC will coordinate benefits with Medicare Part D for deductibles, co-insurance, and gap coverage only for KHC formulary products. If the drug is a Part D included drug, but not covered by the person's Part D plan, it will not be covered by KHC. KHC will cover Medicare Part D wrap-around drugs that are on the KHC formulary.

KHC will only provide assistance with four (4) prescriptions per month. KHC will waive day supply limitations for Medicare Part D drugs when paying secondary claims. KHC may apply a co-payment for coordinated claims.

The KHC program is a State Pharmacy Assistance Program (SPAP), and any payments made by the program for Medicare-allowable drugs will count toward the person's out-of-pocket expenses.