Texas Vendor Drug Program
Pharmacy Provider Procedure Manual

System Requirements

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1 Pharmacy Claims System

The Vendor Drug Program real-time point-of-sale claim system processes outpatient pharmacy claims, verifies state assistance program eligibility, and sends weekly payment file to the Texas Comptroller of Public Accounts to process payment.

- Outpatient pharmacy claims are processed for fee-for-service Medicaid, the Children with Special Health Care Needs (CSHCN) Services program, the Kidney Health Care (KHC) program, and Healthy Texas Women (HTW) program.

- The system performs over 100 separate edits, including validation of the submission format; pharmacy, prescriber, and product; identifying prior authorization requirements or other known insurances; and calculating reimbursement.

- The system responds with information regarding the person's eligibility, the program's allowed payable amount, applicable prospective drug utilization review messages, and applicable error codes and messages.

- The system allows pharmacy staff to query program eligibility, prescription benefits, and managed care enrollment status when applicable. Refer to the **Eligibility** chapter of this manual to learn more about real-time eligibility verification.

1.1 Maintenance

The system undergoes regularly scheduled weekly maintenance between 11 p.m. Saturdays and 1 a.m. Sundays (central time). Pharmacy claims submitted during this time will not be adjudicated. Expanded maintenance hours will be announced via the VDP website and email notification service.

2 Claim Format

The current telecommunications standard for pharmacy claim transactions is the National Council for Prescription Drug Programs (NCPDP) version D.Ø. Claim transactions submitted in any other version will reject.

Refer to the payer sheets for specific transaction, segment, and field requirements and, for the E1 transaction, detailed messaging returned in the "Additional Message

Information" field (526-FQ). Download the **VDP Pharmacy Provider Payer Sheets** from txvendordrug.com/about/manual/payer-sheets.

2.1 Transactions

The transaction codes referenced in Table 1 are defined according to the standards established by NCPDP. Ability to use these transaction codes will depend on the pharmacy's software. At a minimum all pharmacy software should have the capability to submit original claims (transaction code B1) and reversals (transaction code B2).

Table 1 - VDP Allowable Transactions

Code	Name	Support Requirements
B1	Billing	Required
B2	Reversal	Required
B3	Re-bill	Not Supported
C1	Controlled Substance Reporting	Not Supported
C2	Controlled Substance Reporting Reversal	Not Supported
C3	Controlled Substance Reporting Rebill	Not Supported
D1	Predetermination of Benefits	Not Supported
E1	Eligibility Verification	Supported
N1	Informational Reporting	N1 from pharmacies not supported
N2	Informational Reversal	N2 from pharmacies not supported
N3	Informational Re-bill	Not Supported
P1	Prior Authorization Request and Billing	Not Supported
P2	Prior Authorization Reversal	Not Supported
P3	Prior Authorization Inquiry	Not Supported

Code	Name	Support Requirements
P4	Prior Authorization Request Only	Not Supported
S1	Service Billing	Not Supported
S2	Service Reversal	Not Supported
S3	Service Rebill	Not Supported

Network switch companies offer a centralized telecommunication link between the pharmacy and VDP. All arrangements with switching companies should be handled directly by the pharmacy provider. VDP currently accepts transactions from the following switch companies:

- Change Healthcare (formerly Emdeon)
- QS/1 Data Systems
- Relay

2.1.1 Billing (B1)

This transaction captures and processes the claim in real time. On payable claims, the system notifies the pharmacy of the dollar amount allowed under the Medicaid reimbursement formula. If the claim is not payable, the system returns an NCPDP reject code. In some cases, a message is included in "Addition Message Information" (field 526-FQ).

B1 transactions submitted to VDP for people enrolled in Medicaid managed care or CHIP will reject with NCPDP code "AF" (“Patient Enrolled Under Managed Care") and identify the name of the MCO the person is enrolled with. Pharmacy staff should then refer to the **Pharmacy MCO Assistance Chart** for MCO-specific pharmacy claim billing values. Download the Pharmacy MCO Assistance Chart from the "Downloads" page at txvendordrug.com/resources/downloads.

2.1.2 Reversal (B2)

This transaction is used by the pharmacy to cancel a claim previously processed as paid. The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- "Service Provider ID" (2Ø1-B1)
- "Prescription/Service Reference Number" (4Ø2-D2)

- "Product/Service ID" (4Ø7-D7)
- "Date of Service" (4Ø1-D1)

2.1.3 Eligibility Verification (E1)

This transaction is used by the pharmacy to determine a person's program-specific eligibility, prescription benefits, and managed care enrollment status when applicable. Refer to the **Eligibility** chapter of this manual for information about the Pharmacy Eligibility Verification Portal, an alternate method of verification.

E1 transactions submitted to VDP for people enrolled in CHIP will reject with NCPDP code "AF" ("Patient Enrolled Under Managed Care") and identify the name of the MCO the person is enrolled with. Pharmacy staff should then refer to the **Pharmacy MCO Assistance Chart** for MCO-specific pharmacy claim billing values. Download the Pharmacy MCO Assistance Chart from the "Downloads" page at txvendordrug.com/resources/downloads.

2.2 Segments

Data in the NCPDP standard is grouped together in segments. Table 2 identifies current program segment requirements.

Table 2 - VDP Allowable Transaction Segments

NCPDP Segment	B1	B2	E1	Segment Support Requirements
Header	M	M	M	Required for all transactions.
Patient	R	N	R	Required for B1 and E1. Not used for B2.
Insurance	M	N	M	Required for B1 and E1. Not used for B2.
Claim	M	M	N	Required for B1 and B2. Not used for E1.
Pharmacy Provider	N	N	N	Not used.
Prescriber	R	N	N	Required for B1 only.
COB/Other Payments	O	N	N	Required for B1 when other payer exists.
Worker's Comp	N	N	N	Not Used.

NCPDP Segment	B1	B2	E1	Segment Support Requirements
DUR/PPS	O	O	N	Optional.
Pricing	M	N	N	Required for B1 only.
Coupon	N	N	N	Not Used.
Compound	O	N	N	Required for B1 when claim is for a compound.
Prior Authorization	N	N	N	Not Used.
Clinical	N	N	N	Not Used.
Additional Documentation	N	N	N	Not Used.
Facility	N	N	N	Not Used.
Narrative	N	N	N	Not Used.

Segment designations:

- M = Mandatory
- O = Optional
- N = Not Used
- R = Required
- RW = Required when

2.3 Data Elements

The system uses program-specific data elements for each transaction as outlined in Table 3. The pharmacy's software vendor must review the VDP Pharmacy Provider Payer Sheets before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the descriptions regarding data elements in the table below. The system will not process claims without all the required data elements for the transaction submitted. Required fields may or may not be used in the adjudication process for all transactions.

Table 3 - VDP Allowable Transaction Data Elements

Code	Description
M	Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø. These fields must be sent if the segment is required for the transaction.
R	Designated as REQUIRED for this program.
O	Designated as OPTIONAL in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø. It is necessary to send these fields in noted situations where they are conditional based on data content.
N	Designated as NOT USED in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø.
R	The "***R***" indicates the field is repeating.

3 Edits

Following an online claim transmission by a pharmacy, the system will return a response to indicate the outcome of processing. If the claim passes all edits, a "paid" response will be returned with VDP's allowed amount for the paid claim. A "rejected" response will be returned when a claim fails one or more edits. Pharmacy staff should consult with their software provider for a list of NCPDP standard reject codes.

3.1 Timely Filing Limits

While most claims are generally submitted at the time of dispensing, there may be mitigating reasons requiring a claim be submitted after being dispensed. The pharmacy's software should allow the transmission of claims with past service dates.

- The timely filing limit from the date of service is 90 days for all original claims.
- The timely filing limit from the date of service is 720 days for all reversals.
- Transmission of claims using the current date for a past service date is a violation of program policy and could result in an audit exception.

- The inability of a pharmacy's software to submit past service dates is not an acceptable reason for the submission of paper claims.

Claims exceeding the timely filing limit will reject with NCPDP code "81" (“Claim Too Old”). Claims for people certified with retroactive Medicaid eligibility will process online for 90 days after the certification date of retroactive eligibility regardless of the date of service.

4 Claim Submission

Pharmacy staff must submit correct information on all prescription claims, including National Provider Identification (NPI) numbers for pharmacy and prescriber, National Drug Code (NDC), drug quantity, and days supply. Inaccurate information runs the risk of an audit exception and causes erroneous data on reports. Non-compliant pharmacies may be referred to the Texas HHS Inspector General (IG). Table 4 contains identification numbers and values used for VDP claims processing.

Table 4 - VDP Program Requirements

Field	Description
NCPDP Processor ID (BIN)	61ØØ84
Processor Control Number (PCN)	• DRTXPROD o For Medicaid, CSHCN, and HTW (and CHIP*) • DRTXPRODKH o For KHC
Group Number	MEDICAID CHIP * KHC CSHCN
Cardholder ID	Program-specific Texas Cardholder ID Number
Provider ID	10-digit Pharmacy NPI
Prescriber ID	10-digit Prescriber NPI
Product Code	11-digit NDC

* See transaction-specific notes in Transactions, section 2.1 above.

4.1 Cardholder ID

The number entered in “Cardholder ID” (Field 3Ø2-C2), in combination with "Group ID" (Field 3Ø1-C1), identifies the program to which the claim is submitted for payment. For people eligible for more than one program the adjudication process will refer submitted claims to the appropriate payer based on the following hierarchy:

1. Medicaid
2. Kidney Health Care (KHC) program
3. Children with Special Health Care Needs (CSHCN) Services Program

For example, when a claim for a Medicaid/CSHCN dual-eligible person is submitted using the CSHCN cardholder number, and the claim is payable by Medicaid, the claim will reject with code “41" ("Submit Bill To Other Processor or Primary Payer"). One of the two messages in Table 5 will be returned.

Table 5 - VDP Medicaid/CSHCN Dual-Eligible Messages

Message	Meaning
Client has Medicaid ID. Resubmit using the Medicaid ID# nnnnnnnnn (ID Number)	This claim needs to be re-submitted using the Medicaid number provided.
Correct and Resubmit using Med #nnnnnnnnn	Additional errors on the claim must be corrected prior to Medicaid resubmission. These errors are considered correctable and “non-fatal” and apply to the referred program (in this example, Medicaid) and not to the submitted program (in this case, CSHCN).

4.2 Prescriber Provider Identifier

Claims for the payment of items and services ordered, referred or prescribed must be enrolled as a participating provider and contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred or prescribed the items or services will be denied. These requirements only impact programs for traditional Medicaid, CSHCN Services Program, and HTW Program. Out-of-network providers ordering, referring, or prescribing only for people enrolled in managed care are not subject to these requirements.

Pharmacies cannot substitute a missing prescriber NPI with the facility NPI or NPI of another provider who did not directly treat the person. This includes claims processed for a 72-hour emergency supply.

Table 6 - NCPDP Prescriber Provider Identifier Values

Field Name	Field Number	Values	Usage
Prescriber ID	411-DB	10 - digit Prescriber NPI	R
Prescriber ID Qualifier	466-EZ	Ø1 - National Provider Identifier	R
Prescriber Last Name	427-DR	Last Name	O

Prescribing physicians do not enroll with the VDP but demographic data about each prescriber is received from various state licensing agencies and loaded into the system for use in the claim adjudication process. The most current information loaded into the system is accessible through the **Prescriber Search** at txvendordrug.com/providers/prescriber-search. Pharmacy claims submitted to VDP without a valid NPI will reject. If the NPI is not on file with VDP then the prescriber's NPI can be found by accessing the Nation Plan & Provider Enumeration System (NPPES) NPI Registry at npiregistry.cms.hhs.gov.

4.3 Coordination of Benefits

The system receives daily pharmacy/drug insurance eligibility and insurer information verified by the Texas Medicaid third-party recovery vendor. The system then checks each pharmacy claim at point of sale for other insurance.

Table 7 - NCPDP Coordination of Benefits Values

Field Name	Field Number	Usage
Coordination of Benefits/Other Payments Count	337-4C	Required.
Other Payer Coverage Type	338-5C	Required.
Other Payer ID Qualifier	339-6C	Required if the Other Payer ID is submitted.
Other Payer ID	34Ø-7C	Required if the Other Payer ID Qualifier is submitted.
Other Payer Date	443-E8	Required.
Other Payer Amount Paid Count	341-HB	Required when submitting payment from Other Payer.
Other Payer Amount Paid Qualifier	342-HC	Required when submitting Other Payer Amount Paid Count.

Field Name	Field Number	Usage
Other Payer Amount Paid	431-DV	Required when submitting Other Payer Amount Paid Qualifier.
Other Payer Reject Count	471-5E	Required when not submitting Other Payer payment.
Other Payer Reject Code	472-6E	Required when submitting Other Payer Reject Count.
Benefit Stage Count	392-MU	Required when submitting Benefit Stage Qualifier.
Benefit Stage Qualifier	393-MV	Required for: • KHC claims when the person is dual eligible (KHC and Medicare Part D). • CSHCN claims when the person is dual eligible (CSHCN and Medicare Part D).
Benefit Stage Amount	393-MV	Required when submitting Benefit Stage Qualifier.

If Medicaid is billed as primary insurer, and other third-party insurance (other than Medicare) exists in the system, 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 claim submission to the other payer. The message will be returned in the “Additional Message Information” field (526-FQ) as follows: “Bill Other Payer (Payer ID:x, Policy No: x, Bin:x, PCN:x, Group:x, Cardholder ID:x)”.

Pharmacy staff should contact their software provider if the “Additional Message Information” field is not displayed.

Refer to the **Coordination of Benefits** chapter of this manual for more information on Medicaid, Medicare, and third-party insurances.

4.4 Multi-ingredient Compounds

The system accepts multi-ingredient compounds in the compound segment of the B1 transaction. Only one compound claim is allowed per transmission and cannot be included as part of a multiple claim transaction. All ingredients of each compound must be submitted, and the system will only reimburse for products on the program-specific formulary. The order of the ingredients does not matter. Pharmacy staff may submit up to 25 ingredients online using the fields in Table 8.

Table 8 - NCPDP Multi-ingredient Compounds Values

Field Name	Field Number	Usage
Compound Code	4Ø6-D6	Enter "2" (Compound).
Product/Service ID Qualifier	436-E1	Enter “ØØ”
Product/Service ID	4Ø7-D7	Enter "Ø"
Compound Type	996-G1	Required.
Compound Dosage Form Description Code	45Ø-EF	Required.
Compound Dispensing Unit Form Indicator	451-EG	Required.
Compound Ingredient Component Count	447-EC	Required.
Compound Product ID Qualifier	488-RE	Required.
Compound Product ID	489-TE	Required.
Compound Ingredient Quantity	448-ED	Required.

To receive payment for non-covered products pharmacy staff should use the fields outlined in Table 9.

Table 9 - NCPDP Submission Clarification Code

Field Name	Field Number	Usage
Submission Clarification Code Count	354-NX	Enter the number of repetitions (1-3) of "Submission Clarification Code"
Submission Clarification	42Ø-DK	Enter "8" (Process Claim for Approved Compound Ingredients)

Notes:

- Over the counter (OTC) products in compound claims for eligible people residing in a nursing home will be considered for payment only if a payable legend drug is included as part of the claims.
- Certain drugs are only payable when submitted as part of a multi-ingredient compounds claim. Pharmacy staff should use the VDP website Formulary Search at txvendordrug.com/formulary/formulary-search to find drugs with this limitation, or refer to the "Compound-only Products" section of the **Drug Policy** chapter of this manual.

- Compound claims submitted with home health supply products will reject.
- Vitamin/Mineral products as part of a compound claim will not be paid.
- Enter the gross amount due of the total compounded product in the "Gross Amount Due" (GAD) field (430-DU).

4.5 Medication Synchronization

Medication synchronization establishes processes for early refills to align the filling or refilling of multiple medications for a person with chronic illnesses. In accordance with the Texas Insurance Code (Chapter 1369, Subchapter J) the person, their prescribing physician, or the dispensing pharmacist may initiate the medication synchronization request.

4.5.1 Eligible Medications

A drug is eligible for medication synchronization if:

- It is listed in the Texas Drug Code Index (formulary) for Medicaid, CHIP, KHC or CSHCN Services Program
- It is used for treatment and management of chronic illnesses
- It is a formulation or dosage form able to be effectively dispensed in a medication synchronization protocol
- It must meet all prior authorization criteria applicable to the medication on the date the synchronization request is made, including clinical prior authorizations, non-preferred prior authorizations, and drug utilization review edits
- It must be within the same Generic Code Number (GCN) class as the previously dispensed prescription (the GCN class includes NDCs form different manufacturers with the same drug strength and formulation)

4.5.2 Medication Exceptions

A drug is not eligible for medication synchronization if it is one of the following:

- Schedule II controlled substance
- Schedule III controlled substance containing hydrocodone

4.5.3 Eligibility

Medications eligible for synchronization must be used to treat chronic illnesses. A chronic illness is defined as an illness or physical condition:

- Reasonably expected to continue for an uninterrupted period of at least three months, and
- Controlled, but not cured by medical treatment. This includes drugs used to treat mental health conditions and substance abuse.

4.5.4 Claims

4.5.4.1 VDP Processed

A synchronized claim will count as one of the three prescriptions Medicaid will pay if a person is limited. A fourth claim will reject with NCPDP error code 76 ("Plan limitations exceeded").

Pharmacy staff attest the medication is used to treat a chronic illness by submitting these values:

- “9Ø1” in the “Prior Authorization Number Submitted” field (462-EV)
- “Ø8” in the “Prior Authorization Type Code” field (461-EU)

Pharmacy staff may call the Pharmacy Benefits Access Help Desk at 1-800-435-4165 for assistance.

4.5.4.2 Medicaid Managed Care and CHIP

Each MCO has an HHSC-approved process for medication synchronization for people eligible for Medicaid or CHIP. In CHIP, cost sharing or copayment amounts will be prorated. Dispensing fees will not be prorated.

Pharmacy staff should contact the MCO medication synchronization requirements using the contact information on the **Pharmacy MCO Assistance Chart**. Download the Pharmacy MCO Assistance Chart from the "Downloads" page at txvendordrug.com/resources/downloads.

4.6 Dispensing Fees

Dispensing fees for synchronized refills claims will not be reduced or prorated.

5 E-prescribing

Electronic prescribing (e-prescribing, or eRx) allows a prescriber to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy. It also provides the ability to verify eligibility and formulary data for people, prior to and during the prescribing process, and view medication history for the previous 12-month period. This is enabled with the authorized exchange of data between the payer and the prescriber.

Full support of e-prescribing is available for Medicaid fee-for-service, CSHCN, KHC, and HTW claims (via SureScripts) and for Medicaid managed care pharmacy claims.

5.1 Brand Medically Necessary

If an e-prescription is received by a pharmacy with “dispense as written” (DAW) indicated but without the free text message ("Brand Medically Necessary") or additional note, pharmacy staff must contact the prescriber for a new prescription. Once the pharmacy receives the e-prescription with both data elements, the prescription may be transmitted with the values in Table 10.

Table 10 - Brand Medically Necessary Fields

Field Name	Field Number	Usage
Dispense as Written	4Ø8-D8	Enter "1" (Substitution Not Allowed by Prescriber)
Prescription Origin Code	419-DJ	Enter "3" (Electronic)

Failure of the pharmacy to produce electronic records indicating the proper DAW and “Brand Medically Necessary” in the free text message for the prescription will result in the claim subject to recoupment. All non-electronic “Brand Medically Prescriptions” (for controlled and non-controlled substances), must continue to comply with current policy and Texas State Board of Pharmacy rules.

6 Paper Claims

Paper claim submission is permissible for the following cases:

- Newborns when a Medicaid cardholder ID number has yet to be issued.
- Special circumstances as defined by HHSC (e.g. natural disasters).

The **Pharmacy Claims Billing Request** (HHSC Form 1319) is the only acceptable paper form. Download the form the "Downloads" page at txvendordrug.com/resources/downloads.

All other types of paper forms, and any form submitted for an unapproved reason, are not accepted and will be returned with no action taken. The reason for the claim submittal or adjustment must be stated on the face of the form before the claim will be processed, and forms must be signed and dated prior to submission. Forms are kept for five years after the end of the federal fiscal year in which the pharmacy sends the form.

Form fields should be completed using NCPDP standard values when applicable. Refer to the values in the NCPDP B1 Transaction Billing Request payer sheet.

The “Submission Explanation” field is required and identifies why the form is being submitted. Pharmacy staff must sign and date the form prior to submitting to VDP by mail. Refer to the mailing address in the "VDP Correspondence" section of the **Contact Information** chapter of this manual to submit the form.

The form is kept for five years after the end of the federal fiscal year in which the pharmacy provider submits the form.

Table 11 - VDP Pharmacy Claims Billing Request Instructions

Field	Usage
Submission Explanation	Enter the type of claim submittal or adjustment and reason must be stated in the explanation line before the claim will be processed by HHSC.
Date Submitted	Enter the date the form is being submitted to HHSC.
Pharmacy Name	Enter the name of pharmacy.
NPI	Enter the 10-digit National Provider Identifier number.
Vendor ID	Enter the 6-digit vendor ID number.
Pharmacy Phone	Enter the pharmacy phone number (plus area code).
Pharmacy Fax	Enter the pharmacy fax number (plus area code).
Cardholder ID	Enter person’s program-specific identification number. • If claim is for a newborn and no ID# is available, this field should be left blank. Do not enter the mother’s ID number.

Field	Usage
Date of Birth	Enter person's date of birth.
Gender	Enter using standard NCPDP values.
Date of Service	Enter the date the prescription was filled.
Date RX Written	Enter the date prescription was written.
Product ID	Enter 11-digit National Drug Code.
Quantity Dispensed	Enter the quantity dispensed expressed in metric decimal units.
Units	Enter using standard NCPDP values.
Days Supply	Enter estimated duration of the prescription supply in days. Refer to Maximum Days Supply By Program.
Quantity Prescribed	Enter quantity prescribed expressed in metric decimal units.
RX Number	Enter prescription/service reference number.
Prescription (Rx) Origin Code	Enter using standard NCPDP values.
Refill Authorization	Enter ØØ through 11.
Refill Number	Enter "ØØ" to identify original prescription. Enter value between "01" and "11" to identify refill.
Dispense as Written	Enter "1" to override the MAC when a physician wants a brand name dispensed and hand writes the phrase "Brand Necessary," "Brand Medically Necessary," "Brand Name Necessary," or "Brand Name Medically Necessary" across the face of the prescription.
Prescriber ID	Enter 10-digit Prescriber NPI.
Prior Authorization Type	Enter if prior authorization number submitted is transmitted. Follow VDP-accepted values.
Prior Authorization Number	Enter if prior authorization type code is transmitted. Follow VDP-accepted values.
Other Coverage Code	Required if Coordination of Benefits (COB) segment is submitted. Enter using standard NCPDP values.

Field	Usage
Usual and Customary Charge	Enter usual and customary cost (amount claimed for reimbursement).
Gross Amount Due	Enter gross amount due.
Patient Paid Amount Submitted	Not used.
Basis of Cost Determination	Enter using standard NCPDP values.
Submission Clarification Code Count	Enter using standard NCPDP values.
Submission Clarification Code	Enter using standard NCPDP values. Repeating field.
Coverage Type	Enter using standard NCPDP values.
Other Payer ID Qualifier	Enter using standard NCPDP values.
Other Payer ID	Enter ID assigned to other payer.
Other Payer Date	Enter payment or rejection date of the claim submitted to other payer.
Other Payer Amount Paid Qualifier	Enter code qualifying the Other Payer Amount Paid. Repeating field.
Other Payer Amount Paid	Amount of any payment known by the pharmacy from other sources. Repeating field.
Other Payer Reject Code	Enter using standard NCPDP values.
Amount Paid	HHSC use only.
Paid Date	HHSC use only.