



PROVIDER BULLETIN

No. 06-06

February 1, 2006

TO: All Pharmacies Participating in Nebraska Medicaid

FROM: Mary Steiner, Administrator
Medicaid Division

BY: Barbara Mart, R.P.
Pharmacy Consultant

RE: Eliminating Medicaid Coverage of Drugs for Sexual or Erectile Dysfunction;
Medicare Part D

1. Eliminating Coverage of Drugs for Sexual or Erectile Dysfunction

Effective January 1, 2006, Nebraska Medicaid eliminated coverage of drugs used to treat sexual or erectile dysfunction, unless such drugs are also used to treat conditions other than sexual or erectile dysfunction and those uses have been approved by the Food and Drug Administration. The Centers for Medicare and Medicaid Services notified state Medicaid agencies of this required change via State Medicaid Director letter dated December 29, 2005. Therefore, all coverage for these drugs for sexual or erectile dysfunction, even if previously approved by Nebraska Medicaid, has ended. These drugs will continue to require prior authorization, even when used for approved diagnoses other than erectile or sexual dysfunction.

2. Part D Copays for Dual Eligibles

Medicare/Medicaid dual eligibles (Duals) have a unique copay structure which is much different than the general Medicare copay structure. The following information applies to Duals who are enrolled in 1 of the 14 plans available to NE duals as identified in Provider Bulletin No. 05-35. Duals with income between 100 to 135% of Federal Poverty Level (FPL) have copays of \$2.00 for preferred drugs and \$5.00 for non-preferred. Duals with income below 100% FPL have copays of \$1.00 for preferred drugs and \$3.00 for non-preferred drugs. Duals who have been in a long term care (LTC) facility for at least one full month have no copay. Duals who move into a nursing facility or nursing facility residents newly eligible as duals have no Part D copay beginning on the first of the month following the change. Copays during the transition month are patient responsibility.

If the Part D plan responds with copays higher than stated above, it is likely that either the Plan does not have the patient designated as dual eligible or does not have correct living arrangement.

3. Billing Copays for Dual Eligibles

NE Medicaid has agreed to cover copays for certain Duals, as noted in Provider Bulletin No. 05-35. Duals with living arrangement other than nursing facility and exempt from NE Medicaid copay are also eligible for state coverage of Medicare copays. Copay status can be determined by checking the monthly eligibility document or calling the NMES line at (800) 642-6092. NE Medicaid will not cover copays for duals residing in a nursing facility since they should not have copays; the living arrangement will have to be corrected with the Part D plan.

NE Medicaid processes Part D copays using Other Coverage Code (OCC) 8, according to the process recommended by NCPDP. Copay only claims are slightly different from typical coordination of benefit (COB) claims so pharmacies may have to work with software vendors for proper setup. An updated Payor Sheet was posted on the ACS website December 14, 2005, and can be found at: www.acspbmhipaa.com. Select "Payer Sheet" from the Go To pull down menu, scroll down to Nebraska and select B1-B3 Billing-Rebilling. Fields have been added and changes made to existing fields as noted in the chart below.

Field	Name	Status	Comment
443-E8	Other Payer Date	Change	Required with all OCC Codes
431-DV	Other Payer Amount Paid	Change	Must be 0 or blank with OCC 8
478-H7	Other Amount Claimed Submitted Count	New	Required when billing Medicare D copay
479-H8	Other Amount Claimed Submitted Qualifier	New	Value=99; Required when billing Medicare D copay
480-H9	Other Amount Claimed Submitted	New	Value=copay amount from Medicare D plan
430-DU	Gross Amount Due	Change	For Medicare D claims, must contain copay from Part D plan; must match amount in field 480-H9

4. Determining Medicare Part D Plan Enrollment

Different methods to determine Medicare Part D Enrollment:

- A. Use the E-1 transaction.
- B. The Medicare Pharmacy Help Line number is 866-835-7595. When pharmacies call, they should provide their NCPDP number and as much as possible of the following patient specific information to the Call Service Representative (CSR): HIC number, date of birth, name, zip code, Part A or Part B effective date and gender. The CSR will then identify the drug plan name to the caller.

Note that there is an educational video available on the use of the transaction at the following website:

<http://new.cms.hhs.gov/PrescriptionDrugCovGenIn/>

5. Low Income Subsidy Cost Sharing

If plans are aware that a beneficiary is subsidy eligible but do not know the exact subsidy level, they have been directed by CMS to default the enrollee to a \$2-\$5 benefit package. If they have no information indicating that the beneficiary is subsidy eligible, they may default the enrollee to the base non-subsidized benefit package; however-

Even with these defaults in place, plan service representatives who answer pharmacists' calls should be trained and prepared to assist pharmacists with overriding default benefit packages in the event that an enrollee presents at the pharmacy with evidence of dual eligibility or an SSA subsidy determination.

6. Exceptions Process

Drug coverage varies between Part D plans. Coverable Part D drugs may not be on the plan's formulary or may require trial and failure on a formulary product. In these cases, plans are required to have an exceptions process to allow the patient or patient's representative to request coverage. It is likely that the prescriber will have to become involved in this process. Plans are required to provide a response within 72 hours. If the prescriber feels that the patient's life, health or ability to regain maximum function is in jeopardy, they may request an expedited review. Plans must respond to an expedited review within 24 hours. A form titled "Request for Prescription Information or Change" is included for use in making exceptions requests. This is offered as a tool; specific requirements may vary from plan to plan. Plans are required to provide transition supplies of existing therapies when patients moves from Medicaid to Medicare coverage or when the plan discontinues coverage of the product.

7. Date of Birth Discrepancy

Medicare has a date of birth for some dual eligibles that is different than the date of birth in the Nebraska Health and Human Services System. Therefore, in order to get claims for copay or other services billed and paid correctly, the date of birth for Medicare must be used when billing Medicare and the Medicaid date of birth must be used for Medicaid. An algorithm to get these resolved will be developed in the near future.

8. POS Facilitated Enrollment

Despite best effort on the part of Medicare to auto-enroll all Duals who did not select a Part D plan, some individuals have not yet been enrolled. CMS has created a process to allow pharmacies to identify, enroll and bill for prescriptions for these individuals. A copy of this process, entitled "POS Facilitated Enrollment," is included with this bulletin. Additional information on this process is available at www.anthemprescription.com.

9. Waiving Medicare Part D Copayments

As clarification to information provided in the HHSS Provider Bulletin dated December 15, 2005, pharmacies may, for low income subsidy recipients only, waive the cost sharing in non-routine fashion after ascertaining that there is a financial need. However, pharmacies cannot, in any way, advertise provision of the waiver or cost sharing reduction.

10. Part D Plan Over-the-Counter Drug Coverage

Part D plans can include coverage of over-the-counter products (OTC) in step therapy protocols since they provide cost savings when compared to legend counterparts. The Centers for Medicare and Medicaid Services will allow Medicare plans the options to provide this alternative. These drugs must be furnished at no cost to the beneficiary.

11. Pharmacy Contracting Information is available at the following website:

<http://www.cms.hhs.gov/pharmacy/>

The file is titled "Pharmacy Contracting Contact List."

12. Coverage of Supplies Associated with IV Home Infusion

NE Medicaid has learned that Part D reimbursement for IV drugs administered by home infusion does not include supplies associated with such administration. Since these supplies may be covered under Part B, they should first be billed to the Part B carrier. If Medicare Part B denies, the claim will not crossover and therefore will have to be billed to NE Medicaid as a supply claim. A copy of the Medicare EOB showing the reason for denial must be attached to the claim. Supplies for maintenance of catheters for IV infusion (e.g., heparin flushes) are covered under Part B and should crossover to Medicaid for payment of coinsurance or deductibles.

If you have questions about this, please call Barbara Mart at 402-471-9301 or barbara.mart@hss.ne.gov, or Gary Cheloha at 402-471-0800 or gary.cheloha@hss.ne.gov.

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Attachments