Important Provider Notice: Information Regarding 2014 Medicare Part D Plan Claims Processing

Dear Pharmacy Provider:

This notice is provided as a general reference regarding new processing requirements and program changes for the Part D benefit for 2014. It also seeks to reinforce already established practices. While Catamaran seeks to include as much as possible in these notices, it is important to always refer to the online claims system response at Point of Sale:

**NPI/Prescriber Identifier:** As a reminder, pharmacies are required to process prescription claims using the prescriber’s National Provider Identifier (NPI). Prescribers need to be identified by an individual (Type I) NPI. If a Type I NPI is not used to identify the prescriber, the claim will reject. To assist pharmacies in complying with this requirement, if a non-NPI identifier such as a DEA is submitted the claims processing system will attempt to match that identifier with a Type I NPI. If the submitted prescriber identifier is inactive or invalid, the claim will reject with the NCPDP reject code 56 or 619. If your pharmacy can document that the NPI is correct and active, please resubmit the claim with the Submission Clarification Code (SCC) of 42- *(Prescriber ID Submitted has been validated, is active).* Every attempt should be made to obtain a correct prescriber identifier without impacting a beneficiary’s access to drugs. Claims submitted with SCC 42 will undergo post adjudication review by Catamaran. Claims for which a prescriber identifier is not found to be valid in a national database source may result in notifications or warnings, or require claims corrections or reversals. It is required that all network pharmacy providers utilize and maintain internal processes for the validation of prescriber information for NPI active status and DEA confirmation of the schedule levels when applicable to a dispensed product along with appropriate confirmation of the prescriber’s prescriptive authority for the medication being dispensed.

**DEA/Prescriber Identifier for Scheduled II Controlled Substances:** Scheduled II Controlled Substances require a validated DEA number. Once you submit a valid NPI, Catamaran will attempt to cross walk the submitted NPI to the DEA number on file.
As DEA numbers can be for an individual or a hospital/institute we will verify the prescriber’s DEA license category is valid, and appropriate for the drug being prescribed, especially for narcotic prescriptions. For example, prescribers with a 2N or 3N DEA license cannot prescribe narcotics. If you receive a reject and believe the prescriber’s DEA schedule is appropriate for the drug prescribed, you may resubmit the claim using one of the following NCPDP SCCs in field 420-DK.

<table>
<thead>
<tr>
<th>SCC Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>For prescriber ID submitted, associated prescriber DEA Renewed, or In Progress, DEA Authorized Prescriptive Right</td>
</tr>
<tr>
<td>44</td>
<td>For prescriber ID submitted, associated prescriber DEA recently licensed or re-activated</td>
</tr>
<tr>
<td>45</td>
<td>For prescriber ID submitted, associated DEA is a valid Hospital DEA with Suffix</td>
</tr>
<tr>
<td>46</td>
<td>For prescriber ID submitted, and associated prescriber DEA, the DEA has authorized prescriptive right for this drug DEA Class</td>
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Similar to claims submitted with an SCC of 42, claims submitted with SCC 45 will undergo post adjudication review by Catamaran. Claims for which a prescriber identifier is not found to be valid in a national database source may result in notifications or warnings, or require claims corrections or reversals. It is recommended that all network pharmacy providers utilize and maintain validation of prescriber information for NPI validation and DEA confirmation of the schedule levels.

**Compounds** must be submitted using NCPDP D.0 Multi-Ingredient –compound fields. In order to ensure accurate payment please submit compounds correctly using NCPDP fields as required. Compounds containing Part B products are not covered by Part D. Compounds that contain Part D excluded ingredients must be submitted with the proper submission clarification code (SCC).

**Daily Cost Share:**
For any Part D Rx written for solid oral dosage forms for less than one month supply (30/31 days), the beneficiary co-pay will be calculated by taking the daily copayment multiplied by days supply. The final copay is always rounded down to nearest dollar/cents depending on Plan Sponsor set up. Pharmacies must submit an accurate day supply based on quantity dispensed or the claim will not adjudicate appropriately.

Exceptions that will not use the daily cost share include antibiotics or drugs which are dispensed in their original containers as indicated in the Food and Drug Administration
New NCPDP Submission Clarification Code values for this scenario are as follows:
• 47: Shortened Days Supply Fill - only used to request an override to refill limits when dispensing a shortened days-supply.
• 48: Fill Subsequent to a Shortened Days Supply Fill - only used to request an override to refill limits when a fill subsequent to a shortened days’ supply is being dispensed.

Required submission of the Pharmacy Service Type Code & required submission of the Patient Residence Code:
Beginning in 2014, CMS is requiring valid Patient Residence and Pharmacy Service Type values. Therefore, claims with a missing or invalid code will reject at point-of-sale.

Pharmacies must include a valid Patient Residence code on all Part D claims transactions; however if the patient residence is unknown, these pharmacies may default to a Patient Residence of 01 (Home). CMS expects that LTC pharmacies, home infusion pharmacies and specialty pharmacies, since they deliver to the patient residence, know the patient residence code.

Valid Pharmacy Service Type codes currently include the following values:
  1- Community/Retail Pharmacy Services;
  2- Compounding Pharmacy Services;
  3- Home Infusion Therapy Provider Services;
  4- Institutional Pharmacy Services;
  5- Long Term Care Pharmacy Services;
  6- Mail Order Pharmacy Services;
  7- Managed Care Organization Pharmacy Services;
  8- Specialty Care Pharmacy Services; and
  99- Other

Valid Patient Residence codes at this time include:
  0- Not specified, other patient residence not identified below;
  1- Retail; Home Infusion;
  3- Nursing Facility;
  4- Assisted Living Facility;
  6- Group Home;
  9- LTC: Intermediate Care Facility/Mentally Retarded; and
  11- Hospice

(FDA) Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance (for example, steroid dose packs).
**Accurate submission of applicable LTC Patient Residence Coding**
Catamaran requires that you submit the proper Patient Residence Code for all claims as processing references this code in several validation processes. It is critical that the LTC Patient Residence Code is appropriately submitted with the claim transaction.

**Auto-Ship Refill Program - Patient consent on new or refill Rx before dispensing**
By January 1, 2014, to help control fraud, waste, and abuse and ensure that Medicare beneficiaries only receive new prescriptions and refills that are requested, Part D regulation requires all pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery.

This is an auditable and recoverable scenario; please take the necessary steps to ensure your pharmacy is compliant with this regulation. Pharmacy must be able to demonstrate the process and documentation to support a patient request was validated on each prescription fill.

**Illegal Refills Schedule II Controlled Substances:**
As a reminder refills of Schedule II’s are not allowed under federal law. Partial fills of Schedule II controlled substances are permissible under Federal law only when certain circumstances are present. A partial fill is when a pharmacist does not dispense all doses of the prescribed medication at one time. Please ensure all partial or refills of CII medications have clear documentation in accordance with the law for purposes of audit.

**Partial Filling of Schedule II Prescriptions: Terminally Ill or Long Term Care Facility Patients**
A prescription for a schedule II controlled substance written for a patient in a Long Term Care Facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness, may be filled in partial quantities to include individual dosage units. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist must contact the practitioner prior to partially filling the prescription. Both the pharmacist and the prescribing practitioner have a corresponding responsibility to assure that the controlled substance is for a terminally ill patient.

The pharmacist must record on the prescription whether the patient is "terminally ill" or an "LTCF patient." A prescription that is partially filled and does not contain the notation "terminally ill" or "LTCF patient" must be deemed to have been filled in violation of the CSA. For each partial filling, the dispensing pharmacist must record on the back of the prescription (or on another appropriate record, uniformly maintained, and readily retrievable) the date of the partial filling, quantity dispensed, remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist. The total quantity of schedule II controlled substances dispensed in all partial fillings must not exceed the total quantity prescribed. Schedule II prescriptions for patients in an LTCF or terminally ill patients are valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of medication.

**Retail Patients**
A prescription for a schedule II controlled substance written for a patient in a retail setting should be filled in accordance with any state or federal guidelines. In the event that the pharmacist is unable to fill the entire amount and the remaining balance is dispensed within 72 hours, we would require the same documentation as stated below (i.e. quantity dispensed and date dispensed) on the face of the prescription.

**Part B vs. D Prior Authorizations:**
To avoid delay in therapy for B vs. D claim rejections, please contact the Pharmacy Help desk or direct the member or prescriber to contact their Plan Sponsor, to begin the Prior Authorization review process. All B vs. D determinations must be made within 72 hours to meet regulatory compliance and prevent delay in patient care.

**ESRD– New PAs required for commonly used drug classes**
Claims for medications directly associated with an End Stage Renal Disease (ESRD) diagnosis for patients on dialysis are covered under a bundled Part B payment to the dialysis facility of the patient and should not be submitted under Part D.

Beneficiary-level PA requirements will be placed on seven categories of prescription drugs, including: Antiemetic, Anti-infectives, Antipruritic, Anxiolytic, Excess fluid management, Fluid and electrolyte management including volume expanders, and pain management drugs to assist pharmacies in identification of medications which may have been inappropriately submitted to the Part D benefit.

Claim will reject and will return the following reject codes:
- A4 – This Product May Be Covered Under the Medicare B Bundled Payment to the ESRD Dialysis Facility
- 75 – Prior Authorization Required
- 569 - Provide Notice: Medicare Prescription Drug Coverage and Your Rights

Refer to additional Custom Messaging for additional details.

ESRD PA requirements also apply to transition fills to allow the B vs. D determination to be made prospectively.

**Hospice:**
If it is known that a member is in Hospice, or if there is a claim rejection notating Hospice coverage, it is the pharmacies responsibility to bill medications related to the terminal illness or for palliative care in accordance with the hospice care. Please submit to appropriate payer as Part D Coverage is not covered.

**Transition Supply:**
If a transition claim rejects, and member has not received a 30 d/s or a 31 d/s (for LTC members) please contact the Pharmacy Help Desk for day supply verification to prevent disruption of therapy.

Pharmacies must submit an accurate day supply based on quantity dispensed or claim will not adjudicate appropriately.

**Barbiturate drugs – Expanded diagnoses now covered under Part D benefit**
Currently there is a restriction on barbiturate coverage under Part D that limits coverage for epilepsy, cancer, and chronic mental health disorder indications only. Beginning January 1, 2014, barbiturates that meet the definition of a Part D drug under §1860D-2(e) will be covered under Part D for any medically accepted indication (as defined in 1927(k)(6)).

**Home Infusion:**
Plan Sponsors have option to cover home infusion products as a bundled service under Part C. If Plan Sponsor has this set up in place, the following applies:
- Impacts all members
- If filled by a Home Infusion Pharmacy, pay under Part D
- If filled by a Non-Home Infusion Pharmacy, reject and message pharmacy “Covered under Part C HI bundled billing”

**High Risk Medications:** Certain medications cause an increased risk in elderly population. PA’s have been added for members over the age of 65. Follow custom messaging on the claim response to begin coverage determination process.

**LTC Emergency (ER) Fills and Level of Care (LOC) Changes:**
Catamaran can identify LOC changes based on a change in Patient Residence Code to automatically allow for processing of these claims. ER fills are not automatically processed.

If a claim for one of these scenarios rejects, please contact the Pharmacy Help Desk for an override to prevent disruption of therapy.

**Enhancement of the NCPDP TelComm: Use of Quantity Prescribed (460-ET)**
The original industry requested implementation timeframe for Quantity Prescribed was January 1, 2014. THIS IS NOW ON HOLD PENDING REGULATORY APPROVAL PROCESSES.
All entities should put on hold the implementation of Quantity Prescribed changes pending the regulatory process outcome.
**General Guidance:**

Please ensure that your pharmacy:

- Provides the required written appeals notice (CMS 10147) to the Part D member when prompted by the online transaction response.
- Provides a transition fill, as required when prompted by the online transaction response. The purpose of a transition fill is to ensure there is no disruption in therapy.
- Routinely screens all new employees against both the OIG and GSA exclusion lists and again monthly. In addition you must remove all employees, contractors or any party involved in the delivery of the drug benefit from administering the Medicare Part D prescription drug benefit if found on this listing.
- Completes the required annual Fraud, Waste and Abuse and Compliance training and ensures that all new employees, contractors or any party involved in the delivery of the drug benefit complete this training within ninety (90) days of hire.

If you suspect potential Fraud, Waste or Abuse (FWA) is occurring please contact the Plan Sponsor for the claims transaction or Catamaran at 1-888-625-5685 or email us at [SIU@catamaranrx.com](mailto:SIU@catamaranrx.com).

Should you have any further questions, please call the Catamaran helpdesk at: 1-800-880-1188.

Thank you,

Catamaran Provider Relations