PRIME THERAPEUTICS®

Prime Perspective

Pharmacy Newsletter from Prime Therapeutics LLC

Prime Perspective provides information and updates about Prime services

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INSIDE

From the auditor's desk 1

Medicare news/Medicaid news . .3

Florida news 5

HCSC news 5

Prime news 6

MAC list updates 6

How to reach Prime Therapeutics. 7

From the auditor's desk

Prescriptions transferred from a Pharmacy

Required documentation for transferred prescriptions

The New Year is just around the corner, and Pharmacies will experience many insurance changes, including Covered Persons switching plans, Pharmacies joining new networks and more. With these insurance changes, a Pharmacy may have a high number of requests to transfer prescriptions to and from their Pharmacy. A prescription transfer from another Pharmacy requires communication between the Pharmacies to provide necessary and relevant information from the original Prescribing Provider's prescription. The Pharmacy documents the information per applicable laws, which may differ depending on location.

Obtaining all necessary information and appropriately documenting it is important due to the Covered Person's safety, time efficiencies and audit precautions. Prescription requirements include patient information, date written, Prescribing Provider information, medication name and strength, quantity, directions, substitution documentation when specified, refills and prescription number. A transferred prescription should also have the date the prescription is transferred, the pharmacy information, the name and title of the staff members transferring the prescription, refills remaining and last fill date. Requirements for which staff can transfer a prescription differ depending on state laws. Ensuring these elements are appropriately documented for each transferred prescription will help to prevent audit findings.

Common auditor findings

Prime has reviewed transferred prescription errors discovered during audits. Recognizing these error trends may help the pharmacy staff take appropriate steps to prevent them. For instance, auditors have found prescriptions dispensed from a transfer that did not have any refills remaining. The Pharmacy should have contacted the Prescribing Provider for a new prescription but mistakenly used the information from the transfer as a prescription. Clear and consistent documentation could reduce the potential for filling the prescription.

Medications with cyclic dosing (e.g., 28 days on/28 days off, every 12 weeks, every 6 months) or that have packages that cannot be split may have plan benefit limitations on the days' supply (e.g., 30 days). Although processing of each individual claim has days' supply limits, the timing of the next fill is based on the duration the supply from the previous fill should last. When a transferred prescription is filled, it is important for the Pharmacy to verify they are filling it in accordance with the previous fill.

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For example, if a medication is injected once every 12 weeks but the benefit limit is 28 days, the Pharmacy should base the fill date on the previous fill date and directions rather than on the days' supply. To avoid similar dosing errors, the Pharmacy should verify if a loading dose or tapered dose is already complete when transferring a prescription so that the appropriate days' supply is submitted.

Another auditor finding that is more common with transferred prescriptions, although applicable to all prescriptions, is the use of override codes without proper documentation. This occurs more frequently with overrides associated with early refill messaging. An override should only be used when necessary, and the reason (e.g., lost medication, vacation supply) is required to be documented at the time of dispensing.

These audit findings are not all-inclusive of errors that could occur with transferring a prescription. The Pharmacy should follow applicable regulations based on their location to further reduce risks with transferring a prescription. Utilization of these common findings and appropriate actions to prevent them could reduce the risk of audit findings at the Pharmacy.

DAW billing codes

Reviewing appropriate use of dispense as written codes

Dispense as written (DAW) codes, also known as product selection codes (PSCs), are numeric values a Pharmacy submits on claims to indicate special circumstances. The Pharmacy must submit an accurate DAW code in accordance with National Council for Prescription Drug Programs (NCPDP) billing standards. DAW submissions may change the calculation of the claims adjudication depending upon the Benefit Plan. A Prime auditor may review the pharmacy documentation and the submitted claims to verify that the DAW codes have been submitted correctly on claims based on the pharmacy documentation provided.

The Pharmacy must dispense a generic drug whenever permitted and in accordance with applicable laws. However, there are instances when the Prescribing Provider may request brand-name products to be dispensed instead of generic equivalent drugs. These claims would utilize DAW-1, and the prescription order must contain DAW. If a telephone order is received, the pharmacist must manually write DAW on the prescription order.

Members may request brand-name products to be dispensed instead of generic products. At the time of dispensing, the Pharmacy must document or have a computer date and time stamp on the prescription to indicate the member requested a brand-name product. The Pharmacy would then submit the claim with a DAW-2. In the event the generic is not available to the market, the Pharmacy must document on the original hard copy and submit the claim with a DAW-8.

There have been reported instances of excessive use of the DAW-9 code. DAW-9 is generally only to be used when a plan's formulary requires the use of a brand despite a generic equivalent being permitted. This is an appropriate code for instances such as when the plan has the brand-name drug on the formulary instead of the generic (e.g., ADVAIR DISKUS®, Mitigare®, NuvaRing®, TRUVADA® and some brand albuterol inhalers). Drugs in which the plan requires the use of the brand will typically reject at Point of Sale (POS) with a message indicating that the brand-name product is on the formulary (e.g., reject for Wixela Inhub® may say "Advair Diskus is formulary, fluticasone-salmeterol in powder is non-formulary"). When the Pharmacy resubmits the claim for the formulary drug, a DAW-9 code should be entered in response to the system messaging. Pharmacies should not submit a DAW-9 code in other situations.

DAW codes with definition:

- DAW-0: No product selection indicated
- DAW-1: Substitution not allowed by prescriber
- DAW-2: Substitution allowed – patient requested brand-name product
- DAW-3: Substitution allowed – pharmacy request, product dispensed
- DAW-4: Substitution allowed – generic drug not in stock
- DAW-5: Substitution allowed – brand drug dispensed as generic
- DAW-6: Override – all-purpose override code used whenever an override is needed
- DAW-7: Substitution not allowed – brand drug mandated by law/regulation
- DAW-8: Substitution not allowed – generic not available in the marketplace
- DAW-9: Substitution allowed by prescriber, but plan requests brand

Note that acceptance of a specific DAW code on a claim is dependent on benefit plan design, and Pharmacies should follow system messaging.

continued

Approved or confirmed verbal changes and clarifications to the Prescribing Provider's prescription order must be documented on the original hard copy or electronically noted in the Pharmacy's online system prior to dispensing. The Pharmacy should not request changes to a prescription for the sole purpose of avoiding POS messaging.

Pharmacies are required to submit the appropriate DAW code for the claim. Inappropriate selection, whether intentional or unintentional, may result in remediation.

In summary:

- Incorrect use of DAW codes when submitting a claim can alter adjudication and/or payment.
- The Pharmacy is responsible for submitting the correct DAW in accordance with NCPDP billing standards and applicable laws. The Pharmacy is required to document DAW on the prescription.
- DAW-9 should be reserved for claims in which the Prescribing Provider has not indicated brand is necessary, but the plan requires use of the brand name product.
- Incorrect use of DAW codes can result in remediation actions by Prime.

Pharmacy audit information

For more information regarding pharmacy audits, including common billing errors, pharmacy audit appeals and pharmacy audit guidelines, please visit Prime's website: **https://www.primetherapeutics.com/resources/.**

Medicare news/Medicaid news

Medicare E1 Eligibility Query

An E1 Eligibility Query is a real-time transaction submitted by a Pharmacy to RelayHealth, the Transaction Facilitator contracted by CMS to house Medicare eligibility information and respond to transaction requests. It helps determine a Covered Person's Medicare Part D coverage and Payer order if the Covered Person has insurance through more than one Benefit Plan Sponsor.

Pharmacies generally submit E1 Queries when Covered Persons do not have their Medicare Part D Identification Card.

Additional information on E1 Transactions can be found at **https://medifacd.mckesson.com/e1/**.

Pharmacies should not submit an E1 Query for pharmaceutical manufacturer co-pay assistance coupon programs.

CMS standardized pharmacy notice

CMS requires all Medicare Part D Benefit Plan Sponsors to use a single uniform exceptions and appeals process with respect to the determination of prescription drug coverage for a Covered Person under the plan. Medicare Part D claims will be rejected when a claim cannot be covered under the Medicare Part D Benefit Plan at Point of Sale (POS).

Pharmacy claims will be rejected with the following POS reject code:

- NCPDP Reject Code 569

Pharmacies are required to provide a Covered Person with the CMS Notice of Medicare Prescription Drug Coverage and Your Rights to Covered Persons when they receive National Council for Prescription Drug Programs (NCPDP) reject code 569. The CMS Notice of Medicare Prescription Drug Coverage and Your Rights to Covered Persons are posted on Prime's website: **https://www.primetherapeutics.com/resources/**.

Home Infusion Pharmacies receiving the NCPDP reject code 569 must distribute the CMS notice to the Covered Person either electronically, by fax, in person or by first-class mail within 72 hours of receiving the claim rejection.

Long Term Care (LTC) Pharmacies receiving the NCPDP reject code 569 must contact the Prescribing Provider or LTC facility to resolve the rejected claim to ensure the Covered Person receives their needed medication or an appropriate substitute. If the Pharmacy must distribute the CMS notice, they must fax or deliver the notice to the Covered Person, the Covered Person's representative, Prescribing Provider or LTC facility within 72 hours of receiving the claim rejection.

A copy of the CMS Notice of Medicare Prescription Drug Coverage and Your Rights to Covered Persons has been included on Page 4 of this publication.

National Plan/Provider Enumeration System – updates

To ensure pharmacy directory accuracy, the National Plan/Provider Enumeration System (NPPES) now allows Pharmacies to certify their National Provider Identifier (NPI) data. Please submit any changes to your Pharmacy's demographic information, including Pharmacy name, address, specialty and telephone number, as soon as you are aware of these changes.

Enrollee's Name:_____(Optional)

Drug and Prescription Number:_____(Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

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CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Form CMS -10147 OMB Approval No. 0938-0975 (Expires: 02/28/2021)

Florida news

Florida Blue utilization management program

Utilization management (UM) program updates for the upcoming quarter, when available, will be posted at **https://www.primetherapeutics.com/resources/.**

HCSC news

Member drug safety programs – opioid management

Preventing overuse of prescription medications is important to improve patient care and reduce Fraud, Waste and Abuse. To help protect the health and safety of Medicare members, CMS provides guidance to Plan Sponsors that aims to help prevent the overuse of opioids. As a result, CMS will identify members who are overusing or potentially abusing opioid-containing products, with a goal to bring the use to a safe level.

Based on these guidelines, HCSC has created appropriate drug utilization management programs to help prevent overuse of these medications. These controls include a layered clinical program approach that integrates the use of utilization management, concurrent drug utilization review (cDUR) and retrospective drug utilization review to help identify and resolve potential drug therapy situations.

As part of the management of opioids, extreme overusers will be identified and targeted for case management. In these cases, a pharmacist will attempt to contact the prescriber(s) by both fax and phone to help determine medical necessity and facilitate the best possible outcome for the member. Other outcomes include Point of Sale (POS) edits, pharmacy lock-in and/or prescriber lock-in for the member.

Starting on January 1, 2022, HCSC will implement new safety edits at POS. These new safety edits include hard edit configuration and hard edit rationale.

Hard edit configuration includes the following:

- Cumulative MME daily dose threshold (in mg) – 200
- Number of prescribers included in the edit – 3
- Number of pharmacies included in the edit – 3

Hard edit configuration cannot be overridden at POS and will require a coverage determination.

These hard edit configuration updates will be implemented because CMS has noted the "concern is more focused on cases involving multiple prescribers who may not know about each other." The hard edit has been configured to address the concern over multiple prescribers without causing a large member impact. When a submitted claim causes the total opioid MME to exceed the maximum daily dose of 200 mg for at least one day, the system proceeds to calculate the number of unique pharmacies and unique prescribers that are present on the current opioid claims. If the cDUR edit identifies three or more unique pharmacies and three or more unique prescribers, the claim results with a cDUR alert returned to the Pharmacy. These alerts are in the form of a hard reject. Hard rejects will require the member or the member's representative to submit a Coverage Determination/Redetermination to assess the appropriateness of the medication in the rejecting claim. Persons performing Coverage Determinations/Redeterminations will assess a prescriber's supporting statement to determine the outcome of the Coverage Determination/Redetermination decision.

The 7-day opioid naïve edit and soft edit configuration from 2021 will continue.

The 7-day opioid naïve edit: The safety edit for opioid naïve patients is to not allow for therapy of an opioid agent beyond seven days for those without a prior opioid prescription within the past 90 days. To receive therapy beyond seven days when there is no prior opioid agent claim within the past 90 days, prior authorization is necessary. This is a soft edit that can be overridden at POS at the Pharmacy with specific PPS codes entered by the pharmacy team.

Soft edit configuration:

- Cumulative MME daily dose threshold (in mg) – 90
- Number of prescribers included in the edit – 2 (This is a recommended decrease from 3 in 2021.)
- Number of pharmacies included in the edit – 2 (This is a recommended decrease from 3 in 2021.)

Soft edit configuration can be overridden at POS with PPS codes.

Prime news

Vaccine coverage

As a reminder, the following Plan Sponsors use Prime's Commercial Vaccine Network:

- BCBS of Alabama
- BCBS of Illinois
- BCBS of Kansas
- BCBS of Minnesota
- BCBS of Montana
- BCBS of Nebraska
- BCBS of New Mexico
- BCBS of North Carolina
- BCBS of North Dakota
- BCBS of Oklahoma
- BCBS of Texas
- BCBS of Wyoming
- Boeing
- BridgeSpan Health Idaho
- BridgeSpan Health Oregon
- BridgeSpan Health Utah
- BridgeSpan Health Washington
- Capital Blue Cross
- Capital Health Plan
- Florida Blue
- Horizon BCBS of New Jersey
- Regence BlueCross BlueShield of Oregon
- Regence BlueCross BlueShield of Utah
- Regence BlueShield
- Truli for Health

Pharmacy licensure

Pharmacies with independent contracts must provide Prime with the following on an annual basis:

- Certificate of Insurance with proof of general and professional liability insurance

To update our records, please visit our website at: **https://pharmacy.primetherapeutics.com/en/resources/pharmacists/ac.html.**

Choose **Renewal of Pharmacy Certificate of Insurance** from the options and follow the instructions to upload and submit a PDF of your current or renewed Certificate of Insurance.

Provider Manual update

A new version of Prime's Provider Manual with an effective date of Jan. 1, 2022, is available for review on Prime's website at **https://www.primetherapeutics.com/resources/**. Please continue to use the April 2021 Provider Manual until Jan. 1, 2022.

MAC list updates

If a Pharmacy would like access to Prime's Maximum Allowable Cost (MAC) lists, weekly MAC changes, the sources used to determine MAC pricing and the appeals process, please refer to Prime's website for registration instructions. After network participation is verified, the Pharmacy will receive a secure username and password via email.

How to reach Prime Therapeutics

As a service to Pharmacies, Prime publishes the Prime Perspective to provide important information regarding claims processing. Prime values your opinion and participation in our network. If you have comments or questions, please contact us:

- By phone: Prime's Pharmacy Contact Center **800.821.4795** (24 hours a day, seven days a week)
- By email: **pharmacyops@primetherapeutics.com**
- By mail: 2900 Ames Crossing Road, Eagan, MN 55121

Where do I find formularies?

For commercial formularies, access either the Blue Cross Blue Shield plan website or **https://www.primetherapeutics.com/resources/.**

For Medicare Part D formularies, access **https://www.primetherapeutics.com/resources/.**

Keep your pharmacy information current

Prime uses the National Council for Prescription Drug Programs (NCPDP) database to obtain key pharmacy demographic information. To update your pharmacy information, go to **www.ncpdp.org** (Pharmacy Login located at top right).

Report Compliance, Privacy, or Fraud, Waste and Abuse concerns

Prime offers the following hotlines to report compliance, privacy, and Fraud, Waste and Abuse (FWA) concerns:

Compliance

Report suspected compliance concerns:

- Phone: **612.777.5523**
- Email: **compliance@primetherapeutics.com**

Privacy

Report privacy concerns or potential protected health information (PHI) disclosures to Prime:

- Privacy Hotline: **888.849.7840**
- Email: **privacy@primetherapeutics.com**

Fraud, Waste and Abuse

If you suspect Fraud, Waste or Abuse (FWA) by a Covered Person, Prescribing Provider, Pharmacy or anyone else, notify Prime:

- Phone: **800.731.3269**
- Email: **fraudtiphotline@primetherapeutics.com**

Anonymous reporting

Report a compliance concern or suspected Fraud, Waste or Abuse anonymously by contacting Prime's 24-hour anonymous compliance hotline:

- Phone: **800.474.8651**
- Email: **reports@lighthouse-services.com**
- Third-party vendor's website: **www.lighthouse-services.com/prime**

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