# OFFICE OF VERMONT HEALTH ACCESS

# PROVIDER ADVISORY

## SPECIAL LEGISLATIVE ISSUE

## ▶ PROVIDER REIMBURSEMENT RATE REDUCTIONS

Effective for July 2009 dates of service, **Medicaid rates paid to some provider groups will decrease by 2%** per the State Fiscal Year 2010 Budget Act passed by the Legislature. For pharmacies this will result in the reimbursement based on Average Wholesale Price (AWP) being reduced by 14.2% (from 11.9%) as of July 15, 2009. For other providers, rates will be reduced as of July 1, 2009 though some provider types or billing codes are **exempt** from this decrease due to federal or state mandated reimbursement rates. These include:

- Nursing Homes
- Hospitals
- Physicians Evaluation & Management (E&M) codes– rates will be maintained at the Medicare 2006 rate for E&M codes
- Hospice
- FQHC/RHC
- Dental

  *A $2 million rate increase planned for SFY '10 in the Dental Dozen Initiative will not be implemented.*

For affected non-pharmacy providers, the 2% reduction will be captured as the last step in claims processing. The total amount paid will be reduced by 2% with an explanation of reduction statement, "this payment has the reduced amount from the OVHA posted fee schedule of 2%" which will appear on the Remittance Advice (RA). The on-line fee schedule will include the same disclaimer.

## ▶ LIMITED ADULT CHIROPRACTIC SERVICES REINSTATED

Effective as of a July 15, 2009 date of service, **reimbursement for adult chiropractic services is reinstated for procedure codes 98940, 98941 and 98942** per the State Fiscal Year 2010 Budget Act. These chiropractic manipulative treatment codes include a pre-manipulation patient assessment. The following benefit limits will apply:

- Coverage for all beneficiaries is limited to 10 visits per beneficiary per calendar year. For more visits, the chiropractor must submit a prior authorization (PA) request, accompanied by sufficient documentation to support exceptional or unusual circumstances. This may include full clinical data, x-rays, progress notes, or other documentation.
- Chiropractic services will not be subject to a referral from a primary care provider.

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## PROVIDER MANUALS

There will be a Banner Page covering changes to the provider manuals at the top of the Remittance Advice (RA) on a monthly basis. In the case where there are no updates, the RA will reflect 'NONE' for that month.

Provider Manuals can be accessed at: http://www.vtmedicaid.com/Downloads/manuals.html

- Chiropractic services for children under the age of 12 will continue to require prior authorization (PA) and related documentation.

## ▶CO-PAYS IN VHAP, VPHARM AND VERMONT·RX

Effective July 15, 2009, the **VHAP, VScript, and VPharm plans will be modified to include a prescription drug copayment** per the State Fiscal Year 2010 Budget Act. The following identifies the copayments that beneficiaries will be responsible for in each program.

| Population affected | Prescriptions costing $29.99 or less | Prescriptions costing $30.00 or more |
|---|---|---|
| VHAP beneficiaries at or above 100% of the federal poverty guideline | $1.00 Co-pay | $2.00 Co-pay |
| VPharm beneficiaries | | |
| VHAP-Pharmacy, VScript, and VScript Expanded beneficiaries | | |

*A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the copayment. However, the beneficiary will still owe the pharmacy any co-pay that is not paid. The pharmacy may tell the beneficiary that any later prescriptions may not be filled if the beneficiary does not pay what is owed.*

## ▶ 90-DAY PRESCRIPTIONS FOR MAINTENANCE DRUGS

Each time a drug is dispensed, a dispensing fee is paid to the pharmacy. Medicaid policy currently allows for the dispensing of maintenance medications in 90-day supplies but few prescriptions are written in this manner. The result is that more dispensing fees are paid than are medically necessary.

Effective July 15, 2009, **when OVHA is the primary payer, pharmacies will be <u>required</u> to dispense designated classes of maintenance drugs in 90-day supplies after the first fill** per the State Fiscal Year 2010 Budget Act. This limit will not apply to the first fill to allow prescribers the opportunity to test for therapeutic effectiveness and patient tolerance. It will not apply to changes in dosage, as those are considered new scripts. After the first fill, prescriptions written for select maintenance drugs must be rewritten for a minimum of 90 days for the drug to be covered.
Please be aware that:

- The full list of classes of drugs affected by this change will be posted on the OVHA's website at http://ovha.vermont.gov/for-providers.
- Examples of selected drug classes include: contraceptives, hormonal therapies, anti-diabetics (excluding insulin and other injectables), thyroid hormones, bisphosphonates, antihypertensives, lipid lowering drugs, drugs for asthma and COPD, PPIs and glaucoma medications.
- Certain drugs have maximum quantity limits other than described here. See OVHA's Clinical Criteria document at http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria.


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*For beneficiaries with other primary insurance including Medicare Part D, this rule does not apply.*

## ▶ VPHARM PILOT PROGRAM: STATINS AND PROTON PUMP INHIBITORS

Effective July 15, 2009, **OVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select generic and/or OTC statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs)** per the State Fiscal Year 2010 Budget Act.

- Statins – all dosage strengths of simvastatin, lovastatin and pravastatin.
- PPIs – omeprazole RX 10 mg and 20 mg and Prilosec OTC 20 mg.
- Most of the drugs covered under this program do not require prior authorization (PA) from the Part D Plans. However, if a beneficiary has obtained a PA from his/her Part D Plan, the drug continues to be covered by VPharm. Research suggests that the only affected drug is Lipitor for those enrolled in First Health Part D Premier Plan and First Health Part D Secure Plan. Prescribers and pharmacists identifying other branded statins or PPIs covered by Medicare Part D plans with prior authorization should notify Stacy Baker: (802) 879-5912.

## ▶ DISPENSING FEES

**Out-of-State Pharmacies:** Effective July 1, 2009, dispensing fees paid to out-of-state pharmacies shall be reduced to $2.50 per script, per the State Fiscal Year 2010 Budget Act.

## ▶ OTHER NON-LEGISLATIVE CHANGES: BULK POWDERS USED IN COMPOUNDING

Effective July 15, 2009, **bulk powders/chemicals/products used in prescription compounding will no longer be covered by the pharmacy programs administered by OVHA.** CMS has clarified that bulk products are not considered covered outpatient drugs because they are not prescription drug products approved under section 505, 505(j), or 507 of the Federal Food Drug and Cosmetic Act. Please be aware that when prescribing compound drug products to your patients, pharmacies will be required to utilize other non-bulk, FDA-approved products for the claim to be covered (for example, tablets or capsules). Bulk powders used to compound products for the prevention of pre-term labor will continue to be covered after Prior Authorization when no commercial alternative exists.

## BANNER PAGE

The Banner Page included with your Remittance Advice (RA) is your resource for the most up-to-date billing, policy and operational information.

Be sure to read the Banner Page, paying close attention to any date specific and implementation information.

Recent Banner Page topics were pertinent to:

- Codes Deleted as of January 1, 2009
- Electronic Funds Transfer Form
- PCP Recipient Listing
- Clarification for Vision
- Lumbar Injections
- HCPCS A4534
- Ventricular Assist Devices
- Casting Supplies
- CPT Category III Procedure Codes
- Adaptive Weighted Eating Devices

And more…

The "Banner Archives" can be accessed at: http://www.vtmedicaid.com/Information/whatsnew.html

Office of Vermont Health Access (OVHA)
www.ovha.vermont.gov

Electronic Data Systems (EDS)
www.vtmedicaid.com

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