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Mission Statement of the Vendor Drug Program

- To provide statewide access to covered outpatient drugs in an efficient and cost-effective manner.
- To provide quality pharmaceutical care for individuals enrolled in:
  - Medicaid (managed care and fee-for-service)
  - Children’s Health Insurance Program (CHIP)
  - Children with Special Health Care Needs (CSHCN) Services Program
  - Kidney Health Care (KHC) program
  - Healthy Texas Women (HTW) program
- To effectively manage the drug manufacturer rebate programs to maximize rebate revenue.

Revision History

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<tr>
<th>Date</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>02/01/2015</td>
<td>Update to chapter:</td>
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<tr>
<td></td>
<td>• Health Resources and Services Administration</td>
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<tr>
<td>09/01/2015</td>
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<td>• Pharmacy Audits</td>
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<td>04/01/2016</td>
<td>Update to chapters:</td>
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<td>• Contact Information</td>
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<td>• Pharmacy Provider Enrollment</td>
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<tr>
<td>07/01/2016</td>
<td>Revisions to the following chapters (located at TxVendorDrug.com/about/policy/):</td>
</tr>
<tr>
<td></td>
<td>• Provider Enrollment &amp; Maintenance</td>
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<td>• System Requirements</td>
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<td>• Client Eligibility</td>
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<td>• Drug Pricing &amp; Reimbursement</td>
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<td></td>
<td>• Pharmacy Audits</td>
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<tr>
<td></td>
<td>• Drug Rebates</td>
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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) provides, among other things, strong protection for personal health information. It gives individuals certain rights concerning their health information, sets boundaries on how it is used, establishes formal safeguards, and holds violators accountable. The HIPAA Privacy regulations went into effect on April 14, 2003.

Personal health information includes any health information whether verbal, written, or electronic, that is created, received, or maintained by Xerox on behalf of VDP. It relates to the past, present, and future physical or mental health of any individual.

Protected Health Information (PHI) is available to you on a daily basis. You use it when you carry out your assigned tasks. PHI is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. Claims data, prior authorization information, and attachments such as medical records and consent forms, are all PHI.

Never release any Protected Health Information to anyone who does not have a need to know that information. If you are asked about the PHI of an individual and you do not feel the person asking has a need to know, immediately refer the individual to your supervisor, who will forward the request to the proper person. Questions about PHI should be directed toward your management.
1. Introduction
The Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for individuals eligible for:
- Medicaid
- the Children’s Health Insurance Program (CHIP)
- the Children with Special Health Care Needs (CSHCN) Services program
- the Kidney Health Care (KHC) program
- the Healthy Texas Women (HTW) program

Outpatient prescription drug claims processed by VDP are for individuals eligible for fee-for-service Medicaid and the CSHCN, KHC, and HTW programs. Pharmacy providers submit claims electronically in the current NCPDP telecommunications standard for pharmacy claims transactions.

2. Contact Information

2.1. Vendor Drug Program

<table>
<thead>
<tr>
<th>Issue</th>
<th>Media</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>General correspondence with the Vendor Drug Program</td>
<td>Mailing Address</td>
<td>Vendor Drug Program (MC-2250) Texas Health and Human Services Commission 4900 North Lamar Blvd. Austin, TX 78751</td>
</tr>
<tr>
<td>Pharmacy Benefits Access Help Desk: • Outpatient pharmacy claims processing assistance for fee-for-service Medicaid, CSHCN, HTW, and KHC programs. • To expedite your call, please be ready to give your 10-digit National Provider Identifier (NPI) number and the appropriate cardholder ID number(s).</td>
<td>Phone</td>
<td>1-800-435-4165 Monday-Friday, 8:30 a.m. to 5:15 p.m. (central)</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>512-730-7483 (Central office) 512-491-1958 (Help Desk only) 512-491-1959 (Help Desk only)</td>
</tr>
<tr>
<td></td>
<td>Website</td>
<td>TxVendorDrug.com TxVendorDrug.com/about/contact/</td>
</tr>
</tbody>
</table>

2.2. Pharmacy Provider Enrollment/Maintenance

<table>
<thead>
<tr>
<th>Pharmacy Provider Enrollment/Maintenance</th>
<th>Mailing Address</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>General correspondence and inquiry • Pharmacy enrollment application and documents</td>
<td>Mailing address</td>
<td>Contract Compliance and Support (H-330) Texas Health and Human Services Commission 4900 North Lamar Blvd. Austin, TX 78751</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td>1-800-435-4165 Monday-Friday, 8:30 a.m. to 5:15 p.m. (central)</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>512-730-7466</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td><a href="mailto:MCDPharmacyContractManage@hhsc.state.tx.us">MCDPharmacyContractManage@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td></td>
<td>Website</td>
<td>TxVendorDrug.com/providers/ TxVendorDrug.com/about/contact/pharmacy-enrollment.shtml</td>
</tr>
</tbody>
</table>
2.3. Texas Prior Authorization Call Center
To obtain prior authorization for non-preferred drugs and clinical criteria failures for individuals enrolled in fee-for-service Medicaid, prescribing providers or their representatives should call the Texas Prior Authorization Hotline at 1-877-PA-TEXAS (1-877-728-3927). The hotline is available Monday through Friday, 7:30 a.m. to 6:30 p.m. (CST). Pharmacists cannot obtain prior authorization for medications. If the individual arrives at the pharmacy without a prior authorization for a non-preferred drug, the pharmacist should alert the doctor’s office and ask the doctor to get the prior authorization. Pharmacies should not contact VDP to verify the prior authorization rejection (error code 75 and message, “Prescriber call PA Texas…”).

2.4. Texas Third Party Call Center

<table>
<thead>
<tr>
<th>Issue</th>
<th>Media</th>
<th>Contact</th>
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</thead>
<tbody>
<tr>
<td>Verification of any non-Medicare third-party liability insurance for fee-for-service Medicaid clients.</td>
<td>Phone</td>
<td>1-866-389-5594  Monday-Friday, 7:30 a.m. to 6:30 p.m. (central)</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-866-389-6342</td>
</tr>
</tbody>
</table>

2.5. Waste, Abuse, and Fraud
The HHSC Inspector General (IG) investigates waste, abuse, and fraud in all Health and Human Services agencies in the State of Texas. To report waste, abuse or fraud please call 800-436-6184 or visit the IG website at https://oig.hhsc.texas.gov/.

2.6. Medicare

<table>
<thead>
<tr>
<th>Issue</th>
<th>Media</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of Medicare Part D plan information.</td>
<td>Phone</td>
<td>1-800-MEDICARE (800-633-4227)</td>
</tr>
<tr>
<td>Facilitated Enrollment</td>
<td>Website</td>
<td>Medicare Eligibility Verification Transaction <a href="http://medifacd.relayhealth.com/e1">http://medifacd.relayhealth.com/e1</a></td>
</tr>
<tr>
<td>Limited Income NET</td>
<td>Phone</td>
<td>1-800-783-1307</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-877-210-5592</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td><a href="mailto:MedicareLINET@cms.hhs.gov">MedicareLINET@cms.hhs.gov</a></td>
</tr>
<tr>
<td></td>
<td>Website</td>
<td><a href="https://www.humana.com/pharmacy/pharmacists/linet">https://www.humana.com/pharmacy/pharmacists/linet</a></td>
</tr>
<tr>
<td>Extra Help with Medicare Prescription Drug Plan Costs</td>
<td>Phone</td>
<td>Contact your local Social Security office US Social Security Administration: 1-800-772-1213</td>
</tr>
<tr>
<td></td>
<td>Website</td>
<td><a href="https://www.ssa.gov/medicare/prescriptionhelp/">https://www.ssa.gov/medicare/prescriptionhelp/</a></td>
</tr>
</tbody>
</table>

2.7. Contact Information for Clients
    Medicaid Client Hotline: 1-800-252-8263
    CHIP Call Center: 1-877-543-7669 or 1-800-647-6558
    CSHCN Services Program: 1-800-252-8023
    KHC Program: 1-800-222-3986
    STAR Health Member Services: 1-866-912-6283
2.8. Website
The VDP website (TxVendorDrug.com) is an important resource for all pharmacy staff. Our online tools are lost to providers if they cannot properly access our website through their store’s intranet sites. We encourage all corporate offices to provide the proper education on how to access and utilize our website so that pharmacists and other pharmacy staff may take full advantage of the services provided.

Specific links:
- Manuals, Policies, and Rules: TxVendorDrug.com/about/policy/
- VDP contacts: TxVendorDrug.com/about/contact/
- News and updates: TxVendorDrug.com/news/
- Formulary lookup: TxVendorDrug.com/formulary/
- Preferred Drug List (PDL): TxVendorDrug.com/formulary/preferred-drugs.shtml
- Pharmacy/Prescriber Lookup: TxVendorDrug.com/providers/
- Managed care resources: TxVendorDrug.com/managed-care/
- Drug Utilization Review Board: TxVendorDrug.com/advisory/
- Texas Medicaid: http://www.hhsc.state.tx.us/Medicaid/
- HHSC: http://www.hhsc.state.tx.us/

2.9. Newsletter
The Rx Update is a quarterly publication that communicates with the pharmacy community about changes in program procedures or policy, updates to the formulary and Medicaid Preferred Drug List (PDL), continuing education initiatives, and claim submission reminders. To review the current and past few issues, visit TxVendorDrug.com/news/newsletter.shtml.

2.10. Email Subscription Service
The HHSC Email Notification Service is used to send notices to subscribers on behalf of the Medicaid/CHIP Division and VDP. Notices are sent when new content such as the Medicaid Preferred Drug List (PDL) and clinical prior authorization edits is published to the VDP. Notices are also sent when VDP has important news to share with providers. To sign-up for this free service visit TxVendorDrug.com/news/email-notification.shtml.
3. Pharmacy Provider Enrollment
Refer to the Pharmacy & Prescriber Provider Enrollment & Maintenance chapter of this procedure manual at TxVendorDrug.com/about/policy/.

4. Managed Care Resources
Most Medicaid and all Children’s Health Insurance Program (CHIP) prescription drug benefits are delivered through managed care. HHSC contracts with managed care organizations (MCO) and pays the MCO a monthly amount to coordinate health services for the Medicaid or CHIP members enrolled in their health plan. The health plans contract directly with pharmacy providers to create provider networks their members can use.

There are three Medicaid managed care programs in Texas: STAR, STAR+PLUS, and STAR Health. The type of Medicaid coverage a person gets depends on where the person lives and what kind of health issues the person has.

Pharmacy resources for Medicaid managed care are online at TxVendorDrug.com/managed-care/.

Pharmacy Enrollment
- Pharmacy providers must be contracted with VDP before participating in any Medicaid managed care network.
- Each MCO contracts with a pharmacy benefits manager (PBM) to process prescription claims. The PBM contracts with individual pharmacies.
- Each MCO must allow any contracted pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO’s network.
- Each MCO develops its own participating pharmacy network for delivery of services.
- The Pharmacy Enrollment Chart identifies how pharmacy providers with questions pertaining to a new, pending, or existing contract can contact each health plan and pharmacy benefits manager (PBM).
- The MCO Service Area Chart provides a breakout of which health plans serve each service delivery areas (SDA).

Formulary and Clinical Prior Authorization Criteria
- Each MCO is required by state law to adhere to the VDP Medicaid and CHIP formularies and the Medicaid Preferred Drug List (PDL).
- The MCO cannot establish a drug as non-preferred.
- The MCO cannot establish clinical prior authorization criteria on a drug without approval by HHSC.
- Certain clinical prior authorization criteria must be performed for individuals enrolled in Medicaid managed care. Health plans may implement any other of the approved criteria but no more. Please verify with each plan to identify which criteria apply.
5. System Requirements
Refer to the System Requirements chapter of this procedure manual at TxVendorDrug.com/about/policy/.

6. Client Identification Numbers
Refer to the Client Eligibility chapter of this procedure manual at TxVendorDrug.com/about/policy/.

7. Coordination of Benefits
Refer to the Coordination of Benefits chapter of this procedure manual at TxVendorDrug.com/about/policy/.
Refer to VDP Pharmacy Provider Payer Sheets at TxVendorDrug.com/about/policy/ for specific field requirements.

8. Program Operations

8.1. Prescriber Identification Numbers
Pharmacies enrolled in VDP are be required to submit claims using the individual national provider identification number (NPI) of the prescribing provider or the supervising prescriber where applicable.

For prescriptions written by physician assistants (PA), advance practice registered nurses (APRN), or prescribing pharmacists (PH), that do not have a NPI, the supervising prescriber’s NPI will be accepted. These providers have the prescribing authority as allowed by their respective state boards.

If claims reject with any of the following NCPDP codes:

- 9V – Prescriber ID Qualifier Submitted Not Covered
- 71 – Prescriber ID Qualifier is Not Covered
- 56 – Non-Matched Prescriber ID

Verify the correct prescriber NPI is submitted in "Prescriber ID" (Field 411-DB) and “Ø1” in "Prescriber ID Qualifier" (Field 466-EZ). Other prescriber identifiers or qualifier values will no longer be supported and will cause the claim to reject.

It is essential that the correct prescriber identification be submitted on all prescription claims. Providing accurate information allows VDP to follow-up with prescribers about their prescribing practices, when needed. Inaccurate information runs the risk of an audit exception and causes erroneous data on reports.

8.2. Dispensing Limits

8.2.1. Days Supply
The “Days Supply” (Field 4Ø5-D5) is one of the key fields in Drug Use Review (DUR) edits as well as the early refill edit. The incorrect day supply can result in inaccurate DUR alerts and can cause claims to reject for early refill. Please use the correct method of determination of the day supply (quantity divided by total dosage units per day).

The maximum day supply for each program is as follows:

- Medicaid per Rx maximum = 185 days
- KHC per Rx maximum = 34 days
- CSHCN per Rx maximum = 185 days
8.2.2. Quantity
Pharmacies must bill VDP for the amount actually dispensed at the point of sale in the “Quantity Dispensed” field (Field 442-E7). VDP cannot override quantities that are more than the prescriber designated on the prescription. Providers must dispense the quantity prescribed or ordered by the prescriber except as limited by the policies and procedures described in the Pharmacy Provider Handbook. Where actual quantity dispensed deviates from the prescribed quantity, the provider must bill for the amount actually dispensed.

Many National Drug Code (NDC) numbers are packaged in a size that is not a whole number. When entering a claim for a drug that is packaged in a metric decimal sized package (i.e. 1Ø.2; 2.5; 6.8; etc.), be sure to include the decimals on your claims and do not round up. For example, if you dispense one 1Ø.2 gm inhaler, you should be entering “1Ø.2” in the "Quantity Dispensed" field. The same goes for inhalers where the package quantity is 12.9 gm for 1 inhaler. When dispensing ophthalmic drops be sure to include the decimal quantity and do not round up.

Many of these issues are resolved by having the pharmacy update their drug file with the rounded/whole number units on the "Package Size" and the true decimal units on the "Metric Decimal Size" fields. The majority of these products that are affected by this error are ear drops, eye drops/ointments, inhalers, and injectables. Please verify the units that are being submitted are accurate for the claim and product being submitted. If the pharmacy cannot correct the drug file and is continuing to have issues with billing invalid units, then the pharmacy must follow up with their software vendor for further assistance with the issue.

Incorrect quantities may prompt drug manufacturers to dispute the claim and result in rebate auditors reviewing the claim level data.

8.2.3. Dispensing Limitations
- **Anorexies**
  Weight management diagnoses will be denied. Prior Approval required for age 21 years and over.
- **Anti-Fungal**
  Anti-Fungal limitation is 180 day supply per calendar year. Days Supply limitation will deny with NCPDP Error Code 76 and message: “Days Supply Limited per Year by Program.”
- **Biosynthetic Growth Hormone**
  Prior Approval and documentation of appropriate diagnosis required.
- **Enzymes and other specialty drugs**
  VDP reimburses the following products: Tyvaso Kit, Naglazyme, Fabrazyme, Ceprotin, Cerezyme, Adagen, Myozyme, Elaprase, Sucraido, Cinryze and Aldurazyme. Also, Zelboraf, Teduglutide, Korlym, Juxtapid, Kynamro, require in-house prior approval. Approvals are valid for a maximum of one year.
- **Erectile Dysfunction drugs**
  Erectile Dysfunction drugs are no longer covered effective January 1, 2006.
- **Family Planning**
  Claims for family planning drugs for a non-contraceptive diagnosis should be submitted on-line with an acceptable value contained in “Prior Authorization Type Code” (461-EU) and “Prior Authorization Number Submitted” (462-EV).
- **Migraine**
  Migraine medications are limited to specific quantities per calendar month for each drug. Limitation denies for NCPDP Error Code 76 with message: “Exceeds Max Product Quantity/Month – MI”.

VDP Pharmacy Provider Procedure Manual

Effective: July 1, 2016
• **Pediculosis treatment**
  Doctors can write one prescription for the beneficiary in an amount that would cover the whole family if a child is diagnosed with lice or scabies.

• **Prenatal Vitamins**
  Prenatal Vitamins Limitation is for females under the age of 50 only:
  - Age limitation denies for NCPDP Error Code 6Ø with message: “Product Not Covered for Patient Age – PN”.
  - Gender limitation denies for NCPDP Error Code 61 with message: “Product Not Covered for Patient Gender – PN”.

• **Pulmozyme, Tobramycin (Tobi), and Cayston**
  Prior approval with documentation of appropriate diagnosis required for CSHCN only.

• **Stadol**
  Stadol limitation is 10 ml per calendar month (4 bottles). Limitation denies for NCPDP Error Code 76 with message: “Exceeds Max Product Quantity/Month – ST”.

• **Synagis**
  Synagis® is a prescription medication that is used to help prevent a serious lung disease caused by respiratory syncytial virus (RSV) in infants and children at high risk for severe lung disease from RSV. The start and end of each RSV season is based on the individual's county of residence. RSV appears earlier in some counties and remains active later in other counties. HHSC uses RSV statistics from prior years plus regular virology reports to determine the each year's start and end dates for each region. HHSC reserves the right to extend or end the season after subsequent review of RSV levels in each region.

  Please refer to the VDP website at [TxVendorDrug.com/pa/rsv/](http://TxVendorDrug.com/pa/rsv/) for the dates of each season, participating pharmacies, and the Medicaid and CSHCN Services Program prior authorization forms.

• **Xenical**
  Obesity management diagnoses will be denied. Prior Approval and documentation of hyperlipidemia required.

  Appropriate prior authorization forms, when required, are available at [TxVendorDrug.com/dur/prior-approval.shtml](http://TxVendorDrug.com/dur/prior-approval.shtml).

### 8.2.4. Prescription Limits
The Medicaid drug benefit is limited to 3 prescriptions per month with the exception of:

- Children under the age of 21.
- Individuals enrolled in managed care.
- Individuals enrolled in eligibility waiver.
- Family planning drugs.
- Diabetic supplies.
- Smoking cessation products.
- Home health supplies.

KHC-eligible individuals are limited to 4 prescriptions per month.
CHIP- and CSHCN-eligible individuals have unlimited prescriptions.
8.2.5. Refills
Refills may only be submitted when requested by the individual. Providers must not bill Medicaid unless the individual has requested the refill – this includes pharmacies that use automated refill systems/programs.

- DEA = Ø  Original + 11 refills within 365 days from original Date Rx Written
- DEA = 2  No refills
- DEA = 3, 4, 5  Original + 5 refills within 185 days from original Date Rx Written

8.2.6. Partial Fills
No partial fill processing is allowed.

8.2.7. Dollar Limit
Claims are limited to $9,999.99. For claims $10,000.00 and greater, pharmacy providers should contact the VDP Pharmacy Benefits Access Help Desk.

8.3. Mandatory Generic Requirements
Multi-source brand drugs will pay but will be subject to Texas Federal/State Maximum Allowable Cost (MAC) Pricing. Preferred Brand drugs will not be subject to MAC pricing and do not require DAW “1” overrides.

Submit “1” in the “Dispense as Written” (DAW) field (4Ø8-D8) to override MAC pricing 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. DAW "1" will reimburse at normal calculated cost including comparison to Usual & Customary, and Gross Amount Due.

8.4. Drug Coverage
Separate formularies are maintained for Medicaid, CHIP, CSHCN, KHC, and HTW. Managed care organizations are required to adhere to the Medicaid and CHIP formularies. The Formulary Lookup is available online at TxVendorDrug.com.

NCPDP format requires 11 digits in the NDC field. Texas Medicaid requires the standard 5-4-2 format, meaning 5 digits in the labeler code, 4 digits in the product code, and 2 digits in the package size. A leading zero is placed in the labeler code, product code, or package size code to make the NDC conform to the 5-4-2 format.

Excluded:
- DESI drugs that are classified as 5 or 6 are not covered.

8.4.1. Unit of Measure
Quantity for milliliters and grams must be divisible by package size. Some products (such as Risperdal Consta, Humira, Enbrel, Lovenox, Neupogen, Pegasys, and Procrit) may have varying units depending on the NDC number. Pharmacies should be aware of the correct billing units for these medications to alleviate billing discrepancies and eventual audits.

- EA = Each
- GM = Grams
- ML = Milliliters
8.4.2. Over the Counter (OTC)
Formulary OTC drugs are covered for Medicaid, KHC and CSHCN.
OTC drugs are not covered for clients in a Nursing Facility
Insulin and diabetic supplies are the only OTC items covered for CHIP clients.

8.4.3. Compound Ingredients
Certain drugs are only covered in compounds. Please refer to the VDP Formulary Lookup at TxVendorDrug.com to determine if drugs have this limitation.

8.4.4. Premium Preferred Generic (PPG)
Providers are reimbursed an additional $0.50 incentive fee for dispensing Premium Preferred Generic (PPG) drugs for Medicaid clients. Please refer to the VDP Formulary Lookup at TxVendorDrug.com to identify PPG drugs. The PPG is returned in the pharmacy paid claim response, "Incentive Amount Paid" field (521-FL).

8.4.5. HIV Drugs
CSHCN eligible individuals are allowed 60 days of drug coverage with prior authorization. Pharmacies must contact CSHCN at 1-800-222-3986 for approval.

8.4.6. Insulin and syringes
Medicaid
VDP pays for insulin syringes only when the syringes are for insulin use. If insulin syringes are prescribed for other injectable drugs then they should be billed through the Texas Medicaid & Healthcare Partnership (TMHP). Only the Insulin counts toward a limited client’s three prescriptions limit, not the syringes. For insulin claims, it is acceptable to submit a day supply based on stability rather than the actual dose.

CSHCN / KHC
Prescriptions for syringes and home health supplies will count toward the KHC and CSHCN prescription limit.

8.4.7. Prescription Splitting
HHSC policy requires that the same drug in the same strength be dispensed no more than once per month, per client. An exception to this policy is only for medications that may be considered too unstable to be dispensed as a one-month supply.

8.5. Client Payment Information
There are no prescription drug co-payments for Medicaid- or CSHCN-eligible individuals.

Contact KHC (800-222-3986) for current copay information. The co-pay amount due is returned in the pharmacy paid claim response, "Patient Pay Amount" (Field 505-F5).

8.6. Long Term Care (LTC)
Non-legend drugs, with the exception of insulin, are not covered for nursing facility clients.

8.7. Hospice
Medicaid eligible individuals in hospice in a nursing facility have unlimited prescriptions.

8.8. Spend-down
Medicaid claims will reject if date of service of the claim matches spend-down begin date. Pharmacies should contact VDP to determine if the claim is used to meet spend-down.
8.9. Compounds
Refer to the **System Requirements** chapter of this procedure manual at [TxVendorDrug.com/about/policy/](http://TxVendorDrug.com/about/policy/).

9. Home Health Supplies
Refer to the **Home Health Supplies** chapter of this procedure manual at [TxVendorDrug.com/about/policy/](http://TxVendorDrug.com/about/policy/).

10. Vitamins and Minerals
Texas Administrative Code (TAC) 1 TAC §354.1831 (b) reinforces and sets parameters for the addition of vitamins and minerals to the VDP formulary and reimburse VDP-enrolled pharmacies for this Medicaid Children Services Comprehensive Care Program (CCP) benefit. VDP-enrolled pharmacies are allowed to provide some vitamin and minerals to clients twenty years of age and younger and enrolled in Medicaid fee-for-service (FFS) and the Children with Special Health Care Needs (CSHCN) Services Program,

10.1.1. Pharmacy Participation
Medicaid Fee-For-Service (FFS) and Children with Special Health Care Needs (CSHCN):
To provide vitamin and mineral products to clients in FFS and the CSHCN pharmacies must be contracted with VDP. Enrollment as a durable medical equipment (DME) or Comprehensive Care Program (CCP) pharmacy provider is not required. Pharmacies already enrolled as a Medicaid DME or CCP pharmacy provider have the choice to submit a claim for vitamin and mineral products to clients twenty years of age and younger either the Texas Medicaid Healthcare Partnership (TMHP) or the VDP.

10.1.2. Covered Products, Reimbursement Rates, and Policy Guidelines for Medicaid FFS and CSHCN
These vitamin and mineral products prescribed or ordered by a physician to treat various conditions are a benefit of Texas Medicaid through CCP for clients who are 20 years of age and younger and classified as a Title XIX (Medicaid) home health benefit as Durable Medical Equipment or Medical Supplies. Pharmacies will not be paid a dispensing fee, incentive, or delivery fee for providing these vitamin and mineral products and reimbursed at (AWP-10.5%) - 8%. Vitamin and mineral products may be indicated for treatment of certain conditions, according to medical policy.

10.1.3. Claim Submission for Medicaid FFS and CSHCN
Please keep the following in mind when submitting a vitamin and mineral product claim:
- Claims must be submitted in accordance with the most current NCPDP pharmacy billing standard.
- Claims must include the specific NDC for each product.
- Claims will be limited to a thirty day supply.*
- Prescriptions will be valid for 6 months from date written.
- Claims are limited to clients twenty years of age or younger (through entire month of 21st birthday)
- Pharmacies must submit a “Prior Authorization Type Code” and “Prior Authorization Number Submitted” to acknowledge that the prescribed products are for a medically accepted indication according to the posted vitamin and mineral policy. The claims will reject with NCPDP reject code EU/5219 and EV/5220 if claim is not submitted with the following:
  - “8” in “Prior Authorization Type Code” (Field 461-EU) and
  - “826” in “Prior Authorization Number Submitted” (Field 463-EV)
- Vitamin and mineral products are not covered in a compound claim.**
- These vitamin and minerals will be a benefit for dual eligible clients (Medicaid/ KHC) or (Medicaid/ CSHCN) twenty years of age and younger.
*For liquid formulations in excess of a 30-day supply, please contact VDP Pharmacy Benefits Access.  
**Vitamin and mineral compound claims may be considered for coverage through Medicaid Children Services Comprehensive Care Program (CCP). For assistance please contact 1-888-701-1713.

**Additional Important Information:**
- Vitamin and mineral claims do not count towards the clients three prescription limit in FFS because clients twenty years of age or younger receive unlimited number of prescriptions per month.
- Vitamin and mineral claims will continue to be a benefit for clients enrolled in KHC and for count towards the clients four prescription limit per month.
- A refill of a prescription for vitamins and minerals may not be dispensed until 100% of the day supply has been used. For example, if a 30-day supply of vitamins or minerals is dispensed, the client is not eligible for another 30-day supply until the 31st day after the last refill of vitamins and minerals was dispensed.
- Medicaid DME providers who are not VDP-enrolled pharmacies should continue to bill for vitamin and mineral products to TMHP (for their patients in FFS); in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM) at [http://www.tmhp.com/HTMLmanuals/TMPPM/Current/toc.html](http://www.tmhp.com/HTMLmanuals/TMPPM/Current/toc.html). VDP-enrolled pharmacies that are also Pharmacy CCP providers will have the choice to submit a claim for vitamin and mineral products to either TMHP or VDP.
- Claims may be subject to post payment reviews to ensure claims from DME providers and pharmacies do not result in HHSC making a duplicate payment for the same client / vitamin and mineral and validate prescribed products are appropriate for the client’s medical indication as acknowledged on claim by dispensing pharmacy.
- A Title XIX form is not required for vitamin and mineral products dispensed through a pharmacy. A prescription (faxed, written, or electronic) is required with the following information:
  - Client’s name
  - Description of vitamin or mineral to be provided.
  - Quantity to dispense (quantity per day or month)
- For pharmacies that require a client signature when a filled prescription is picked up, a client signature should also be required when picking up vitamin and mineral products. (The DME Certification and Receipt Form is not required.)

*To help expedite processing, prescribing providers are encouraged to include diagnosis on prescription*

**10.1.4. Medicaid Managed Care**
To provide vitamin and mineral products to individuals under 21 years of age and enrolled in a Medicaid managed care organization (MCO), pharmacies must be contracted with the VDP and with the MCO’s pharmacy benefit manager (PBM). Pharmacies are required to work with the MCO or PBM in their service area to determine the billing requirements, reimbursements rates, and additional coverage limitations for these products. Medicaid MCOs have the ability to designate these vitamin and mineral products as preferred. Please contact the appropriate MCO or PBM ([TxVendorDrug.com/managed-care/](http://TxVendorDrug.com/managed-care/)) for specific requirements related to vitamin and mineral products.

**11. Drug Utilization Review**
Refer to the **Drug Utilization Review** chapter of this procedure manual at [TxVendorDrug.com/about/policy/](http://TxVendorDrug.com/about/policy/).
12. Prior Authorization

12.1. Preferred Drug List
VDP maintains a preferred drug list (PDL) comprised of various therapeutic classes. Prescriptions written for preferred drugs will be available without prior authorization, while non-preferred drugs will require prior authorization. This will involve the prescriber or one of his/her designated agents calling the Texas Prior Authorization Call Center to obtain approval before the drug can be dispensed. More information about the PDL is online at TxVendorDrug.com/formulary/preferred-drugs.shtml.

A 72-hour emergency supply should be dispensed any time a prior authorization is not available and a prescription must be filled for any medication or medical condition (see Section 6.5.6.).

12.2. Clinical Prior Authorization
Clinical prior authorizations check an individual's Medicaid medical and drug claims histories to determine whether the information on file indicates that the individual's medical condition matches the criteria for dispensing the requested drug without need of additional prior authorization. The edits are based on evidence-based clinical criteria and nationally recognized peer-reviewed information. A listing of clinical prior authorization criteria is online at TxVendorDrug.com.

A 72-hour emergency supply should be dispensed any time a clinical prior authorization is not available and a prescription must be filled for any medication or medical condition (see Section 6.5.6.).

12.3. 72-Hour Emergency Override
A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the Preferred Drug list and any drug that is affected by a clinical PA edit and would need the prescriber prior approval.

The 72-hour emergency supply should be dispensed any time a prior authorization is not available and a prescription must be filled, for any medication or medical condition. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription.

This procedure should not be used for routine and continuous overrides. A 72-hour emergency prescription will be paid in full, and it does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month (there is no prescription limit for children under 21 or clients enrolled in a managed care plan). For a 72-hr emergency prescription, pharmacies should submit the following information:

- “8” in “Prior Authorization Type Code” (Field 461-EU).
- “8Ø1” in “Prior Authorization Number Submitted” (Field 462-EV).
- “3” in “Days Supply” (Field 4Ø5-D5, in the Claim segment of the billing transaction).
- The quantity submitted in “Quantity Dispensed” (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.

These instructions are available at TxVendorDrug.com for downloading and displaying in your pharmacy for reference. Please reproduce this information for staff education.
13. Drug Pricing & Reimbursement
Refer to the Drug Pricing & Reimbursement chapter of this procedure manual at TxVendorDrug.com/about/policy/.

14. Pharmacy Provider Payment
All payable claims submitted electronically online or via paper form will be processed and paid weekly. The weekly payment cycle begins at 12:00:00 a.m. on Friday and ends at 11:59:59 p.m. the following Thursday. Pharmacy payments are generally issued to providers’ financial institutions Monday night, and are posted to providers’ accounts according to their financial institution's schedule (usually within 72 hours). Federal and State holidays may impact payment date. Payments for KHC and/or CSHCN claims will follow the same schedule as Medicaid, but will appear on separate payment remittance advices (RA). A separate warrant or direct deposit will be made for each program area (Medicaid, KHC, and CSHCN).

Pharmacies receive both a weekly payment register in the Portable Document Format (PDF) and the standard ASC X12N 835 Health Care Payment/Advice. These files are accessible through Xerox-Pharmacy’s secure Pharmacy Move-It website. To register for access to the Move-It website and to learn more about other payment issues, please visit http://www.txvendordrug.com/.

The ASC X12N 835 Health Care Payment/Advice is available in the HIPAA 5010 compliant layout. Pharmacies can use their 11-digit Texas Identification Number (TIN) to access the State Comptroller's website (https://fmx.cpa.state.tx.us/fin/payment/index.php) to obtain their State-to-Vendor payment information. Refer to the website's "Instructions for Accessing Payment Information" section to learn about your 11-digit TIN. Pharmacies should use agency code 529 (for HHSC) to search for Medicaid payments, or agency code 537 (for DSHS) to search for CSHCN and KHC payments.

14.1. Provider Payment Algorithms
14.1.1. Usual and Customary (UAC) (Field 426-DQ)
Texas Medicaid uses this field to capture the amount requested for reimbursement. The usual and customary price is the price most frequently charged to the general public.

14.1.2. Gross Amount Due (GAD) (Field 43Ø-DU)
The Gross Amount Due Field should be used to reflect a pharmacy's Usual & Customary price less discount or special price. It should also be used by pharmacy providers such as Government institutions.

14.1.3. Large Dollar Amount
For claims $10,000.00 and over, contact VDP Pharmacy Benefits Access.

14.1.4. Basis of Cost Determination (Field 423-DN)
Accepted values:
- ØØ = Default
- Ø1 = AWP (Average Wholesale Price)
- Ø3 = Direct
- Ø8 = 34ØB / Disproportionate Share Pricing/Public Health Service
- Ø9 = Other (submit to indicate warehouse). Claims for drugs purchased from a Central Purchasing Entity or a Warehouse must be submitted using the value of "Ø9".
Submitted values of “ØØ” and “Ø8” or submitting a blank field will default to Direct. Other values will reject with code DN (“M/I Basis Of Cost Determination”).

14.1.5. Submission Clarification Code (Field 42Ø-DK)
Pharmacies eligible to participate in the 340B Drug Pricing Program must identify all outpatient pharmacy claims filled with 340B stock for 340B-eligible individuals (refer to the Health Resources and Services Administration chapter of this procedure manual for more information).

Accepted values:
- 2Ø = 34ØB / Disproportionate Share Pricing/Public Health Service

14.2. VDP Payment File Portal
The VDP Payment File Portal (PFP) is browser-based portal to obtain pharmacy remittance advice files. All VDP-enrolled pharmacy providers are eligible to create a free account. Pharmacy staff must complete the Remittance Advice Authorization Form to register. Pharmacies that have an agreement with a third party entity to access payment information to reconcile RA files must also complete the form. Changes, terminations and addition of providers for third party entities must be reported by submitting an updated form. The PFP is accessible only through the Microsoft® Internet Explorer® browser.
Form: TxVendorDrug.com/providers/downloads/electronic_ra_authorization.pdf

14.3. Refunds
Claims that are billed incorrectly, resulting in the provider owing VDP a refund, should be adjusted or recouped within 90 days of the original date of service. If it is necessary to issue a refund to VDP, the pharmacy provider should first attempt to reverse the claim themselves or contact VDP Pharmacy Benefits Access to determine if the claim(s) can be adjusted electronically. Pharmacies have 720 days from the date of service to reverse the claim online. VDP can reverse claim(s) online through the current triennium (current fiscal year plus two previous fiscal years).

Claims that are outside the current triennium cannot be adjusted electronically and must be refunded to HHSC by check or money order. A cover letter including individual claim-level detail is required with the refund. The pharmacy's six-digit VDP contract ID number must be displayed on both the documentation and the check/money order to expedite the refund.

Regular Mail:          Overnight Mail:          
HHSC                 HHSC              
Attn: ARTS, BH-1470  Attn: ARTS, BH-1470  
P. O. Box 149055     4900 N. Lamar Blvd.  
Austin, Texas 78714  Austin, Texas 78751  

Please do not send refund checks to Xerox-Pharmacy as they are the claims processor for VDP, not the fiscal agent.

15. Health Resources and Services Administration
Refer to the Health Resources and Services Administration chapter of this procedure manual at TxVendorDrug.com/about/policy/.
16. Pharmacy Audits
Refer to the Pharmacy Audits chapter of this procedure manual at TxVendorDrug.com/about/policy/.

17. Drug Rebates
Refer to the Drug Rebates chapter of this procedure manual at TxVendorDrug.com/about/policy/.

18. Pharmacy Resources
18.1. Free Continuing Education Credits
HHSC offers free computer-based training courses to enhance your ability to provide pharmacy services to Medicaid eligible children in Texas. In addition, pharmacists and pharmacy technicians can earn Category One Continuing Medical Education (CME) credit. The courses are accredited by the Accreditation Council of Pharmacy Education (ACPE). More than 40 CME courses are offered at TxHealthSteps.com.

18.2. Rules and statute
Links to federal and state rules and regulations impacting VDP are available on our website:

- Texas Administrative Code (TAC)
  - TxVendorDrug.com/about/policy/texas-administrative-code.shtml
- Texas Government Code
  - TxVendorDrug.com/about/policy/texas-government-code.shtml
- United States Code of Federal Regulations (CFR)
  - TxVendorDrug.com/about/policy/us-code-federal-regulations.shtml