



Questions and Answers for POS Facilitated Enrollment Administered by WellPoint, Inc.

The Point of Sale (POS)-Facilitated Enrollment program is being administered by WellPoint, Inc. Claims will be processed under BIN 610575 for Anthem Prescription Management.

The following is a list of commonly asked questions related to POS Facilitated Enrollment. This list includes new questions as well as previous questions so that you may have a full list as a reference guide.

As most of you are now aware, the POS Facilitated Enrollment program was implemented to ensure dual eligible members, waiting to be enrolled with a prescription drug program (PDP), have access to their prescription drugs while the enrollment process is being completed.

Submission Guidelines

Retail pharmacies can help to insure the success of the POS Facilitated Enrollment Program by adhering to the following:

- Utilize the E1 transaction when a potential dual-eligible member presents a claim to the pharmacy. This transaction will help identify those members who are already enrolled in a PDP.
- When submitting a claim to Anthem Prescription for members not yet enrolled, the integrity of the data submitted is key to successful adjudication and subsequent reconciliation of the claim:
 - Cardholder ID (302-C2) must contain the beneficiary's Medicare ID number. This can be found on the red, white and blue Medicare card for traditional Medicare beneficiaries or the corresponding card from the Railroad Retirement Board (RRB). The Medicare ID number can be no less than 7 bytes and no greater than 12 bytes in length.
 - Patient ID (332-CY) must contain the Medicaid ID. This field is a variable-length field depending on the specifications of the state Medicaid program, but will not exceed 14 bytes in length.
 - Patient ID Qualifier (331-CX) must equal '99' to properly identify the information in the Patient ID field.

Frequently Asked Questions

Question: How can pharmacies verify Medicaid eligibility to minimize the pharmacy's risk?

Answer: In addition to existing state resources, such as IVR systems, pharmacies can use the following as verification of Medicaid eligibility:

- Medicaid ID card; or
- Recent history of Medicaid billing in the pharmacy patient profile; or
- Copy of current Medicaid award letter

Question: Do pharmacies have to submit claims to Medicaid and receive a denial before proceeding with the POS Facilitated Enrollment program?

Answer: No. Pharmacies need only confirm reasonable evidence of Medicaid eligibility.



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Question: How can pharmacies verify Medicare eligibility?

Answer: The pharmacist can check for either Part D enrollment or eligibility for Medicare Parts A & B by submitting an E1 query to the TrOOP facilitator. Other (offline) ways to check for A/B Medicare eligibility are:

- Request to see a Medicare card; or
- Request to see a Medicare Summary Notice (MSN); or
- Call the dedicated Medicare pharmacy eligibility line at 1-866-835-7595, available Mon.-Fri. 8 AM-8PM EST; or
- Call 1-800-MEDICARE (available 24/7)

Please note that the dedicated pharmacy eligibility line is set up to address questions concerning beneficiary Medicare eligibility or enrollment in Part D plans, not other pharmacy issues. Questions concerning the E1 process should be directed to the TrOOP Facilitation Help Desk at NDCHealth at 1-800-388-2316.

Question: Which beneficiary identifiers will pharmacies have to submit to WellPoint in the billing transaction?

Answer: Pharmacies will have to submit the beneficiary's Medicare ID number (known as the HICN), as well as the Medicaid ID number. Both numbers are critical to rapid verification of dual eligibility and should be available from all the valid sources of Medicaid or Medicare eligibility verification.

If pharmacy systems do not currently support the entry of more than one ID number into the B1 record, we ask that efforts be made as soon as possible to do so since this will allow the eligibility verification process to be more fully automated and expedited. In the meantime, if a pharmacy's data entry systems do not currently support the Patient ID field and patient ID qualifier [332-CY or 331-CX], we ask that the pharmacy support one of the following two workarounds until they can:

1. Have the pharmacist enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment **and** bill a separate payer account: BIN: 610575; PCN: CMSDUAL02; or
2. Have the pharmacist enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment **and** include the Patient ID Qualifier field [331-CX] **and** program the pharmacy system to map the Group ID field to the Patient ID field in the creation of the B1 transaction.

Question: We blocked refills and still have not opened this up. Is there any way to identify the volume of enrollments that are taking greater than 14 days? Is there any way to match same customer, same NDC, and different RX?

Answer: As long as the claim is submitted with the same RX number it will allow a refill for the same drug for a 30 day supply. We have also loaded prior authorizations for those members who initially received a 14-day supply. The prior auth provides another 14 day supply at a zero copay for refills of the same core-9 NDC.



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Question: If we allow refills, will you reject the refill if the person is enrolled in a Part D?

Answer: Yes, if the temporary ID has been terminated it will reject the refill. We will not terminate the temporary ID in this case until we have confirmed that other coverage exists.

Question: When will the 30 day supply will be implemented?

Answer: The 14 day supply has been increased to a 30 day supply effective January 17, 2006.

Question: I have instructed our pharmacists to submit the Medicare ID number (red white blue) in the patient ID field. In the group field I have told our staff to submit the Medicaid ID. We are leaving the person code field blank. Is this correct?

Answer: A person code should not be submitted.

Question: What happens to the claim, which was already adjudicated, when there is a situation ? in which the pharmacy forgot to put the Medicaid ID number in the group number field?

Answer: If the pharmacy is using option 2 for the submission of the claim by inputting the Medicaid ID in the group number field, we require both the HCIN number and the Medicaid number in order to determine dual eligibility with CMS. Without those two fields we are not able to determine whether or not the individual should be enrolled.

Question: What happens to the claim, which was already adjudicated, when the pharmacy puts in a Social Security number instead of Medicare ID number in the patient ID field? (I am just trying to envision all scenarios that may be going on in retail pharmacy and will pharmacies still be reimbursed)? (Not patient ID field, it is the card id field)

Answer: CMS is attempting to verify dual eligibility with the Social Security number; however this may or may not be successful. Either way, the pharmacies will still receive payment for these claims.

Question: Why doesn't Wellpoint/Anthem edit the Medicare/Medicaid ID number?

Answer: Effective February 2, 2006, Anthem will implement a hard edit on the Medicare ID to be implemented by the Switch Company NDC Health. We are currently exploring the feasibility of implementing additional hard edits on the Medicaid number, however no timelines have been established.

Question: The POS WellPoint process does not edit for days supply. Is there a possibility you can apply days supply parameters to those claims?

Answer: Yes, we do have day supply edits in place. The day supply has been increased to 30 days.



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Question: If we have beneficiaries that still return no plan matching data in the E1 after the second 14 days and require another supply of medication, how should pharmacies handle this?

Answer: In these cases, claims should continue to be processed through the POS Facilitated Enrollment program.

Question: According to CMS, if after the first fill the E1 transaction continues to return no coverage and the member is indeed dual eligible, then they should begin billing UNICARE. But when they bill UNICARE the claim is rejecting? Is eligibility being loaded?

Answer: If after the first fill the E1 transaction continues to return no coverage, and the pharmacy has re-verified dual eligibility, then the POS payer will allow another fill.

Question: What is the maximum length of fill payable by WellPoint?

Answer: WellPoint has decided to allow up to a 30 day fill in order to limit risk to pharmacies and the times an individual needs to return to the pharmacy to get a refill. Pharmacies may elect to fill less than a 30 days supply.

Drug Coverage

Question: Are excluded Part D drugs covered during the "transition" period?

Answer: Drugs that are not on the formulary will be covered. The drugs that are a statutory exclusions will still be excluded.

Question: Please clarify procedure for day supply of eye drops, creams, ointments, inhalers, etc. Typically 14 days is not an accurate day's supply.

Answer: We have increased the day supply to 30 days for retail pharmacies.

Member Coverage

Question: Will the representatives at 1-800-Medicare be able to validate that a member has a dual eligible status?

Answer: CMS has asked that pharmacies call 1-866-835-7595 to verify Medicare eligibility. However, this line will not be able to verify dual status at this time, although work is progressing to provide this information in the future.

Question: If the pharmacy has to reverse the claim and bill another payer what should be done about the difference in member copay?

Answer: If the pharmacist has appropriately verified dual eligibility, then there will generally not be differences in copays since the copay levels for dual eligibles are fixed by statute and cannot vary by plan.



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Question: If a member turns out to be eligible for the \$2/\$5 cost sharing subsidy level instead of the \$1/\$3 level, will WellPoint adjust future claims to recoup the balance owed instead of requiring reversal and rebilling of claims through the pharmacy?

Answer: WellPoint will not reverse claims just to adjust the copay level. Once the person is enrolled into the appropriate UNICARE plan, future claims will be processed at the higher appropriate copays.

Question: If a member goes to two pharmacies in the same day, will the claim pay?

Answer: Yes, claims will continue to pay. However, we are asking pharmacies to verify eligibility via the E1 transaction and proper identification from the member as listed above.

Question: What end date are we going to apply to POS Facilitated Enrollment members once the claim goes through?

Answer: The member will be eligible for POS Facilitated Enrollment until WellPoint has received confirmation on the final DE status of the member.

Question: In the event an enrollment is denied due to previous enrollment in another Part D plan, will it be possible for WellPoint to know who the other payer is when contacting the pharmacy about a reversal?

Answer: In many cases, yes. In the situation in which the individual is actually already enrolled in another Part D plan, WellPoint will contact the pharmacy to reverse the claim and make best efforts to inform the pharmacy of the appropriate plan to bill. The Enrollment Contractor will provide WellPoint with the CMS contract number for any such Part D plans, and WellPoint will use a crosswalk table provided by CMS to provide "4Rx" data on these plans to the pharmacy to facilitate re-billing. CMS has already provided WellPoint with a table for all of the plans eligible for the dual eligible auto-enrollees, and will provide data on additional plans as they become available through the CMS enrollment process

Reporting

Question: Have the "reversal resubmission" reports been generated? Can we receive a copy for our chain?

Answer: We are still working on a payor to payor solution.

Question: How many beneficiaries have been submitted through the process, how many have been facilitated into a plan, and how many have been identified to be in another plan? Can we get a store/chain detail report on this?

Answer: We are working on developing reports to share with pharmacy chains that can be used to identify individual stores that are not submitting appropriate information to WellPoint.



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Adjustment of Paid Claims

Question: Will WellPoint consider billing ineligible individuals for ineligible claims instead of a claim reversal to the pharmacy?

Answer: WellPoint, like the pharmacies, understandably wants to avoid billing ineligible individuals because these are likely to be low-income individuals. We expect that proper verification of Medicare/Medicaid eligibility by the pharmacist will greatly reduce the likelihood that ineligibles will enter the POS process.

Question: Is there any way that WellPoint can bill the other Payer rather than require the pharmacy to reverse and resubmit the claim?

Answer: This option is being explored. In the meantime it is critical that pharmacists follow the process for verifying dual eligibility prior to submitting the POS claim.

Question: How will stores be notified of the correct payer to bill?

Answer: Refer to the Medicare Part D POS Facilitated Enrollment Payer Sheet located at <http://www.anthemprescription.com> Please work with your software vendor on appropriate setup to ensure accurate claims submission

Question: Will pharmacies have to re-bill from WellPoint to UNICARE once the individual has been enrolled in the appropriate regional UNICARE plan?

Answer: No. However, after enrollment, the next claim will need to be submitted to UNICARE under WellPoint Pharmacy Management BIN 610053.

Question: In the event that that a pharmacy submits a claim in error, how will the amount paid in error be recovered? How will the pharmacy be contacted?

Answer: Pharmacies will be notified of all claims that need to be reversed. Pharmacies are encouraged to establish a single point of contact for handling POS claims to ensure a smooth claims processing/billing process between the pharmacy and WellPoint. WellPoint will contact the pharmacy by telephone or fax (as arranged) and one of the following situations will occur:

- Individual is Medicaid-eligible only: WellPoint contacts the pharmacy to reverse the claim to the pharmacy and the pharmacy bills the appropriate State Agency. We expect this to be a rare outcome given that the pharmacist will have verified Medicare, and thus, dual eligibility using one of the several methods available.
- Individual is a dual-eligible but already enrolled in another plan: WellPoint contacts the pharmacy to reverse the claim and informs the pharmacy of the appropriate plan to bill. The pharmacy bills the appropriate plan.
- Individual is Medicare-eligible only: The Enrollment Contractor will notify the individual that they are not eligible for Facilitated Enrollment, but are eligible for Part D and must enroll in a Part D plan to obtain drug coverage. WellPoint contacts the pharmacy to reverse the claim, but will not know if or where they may have enrolled. The pharmacy can submit an E1 query to identify the payer for future claims, but will have to collect from



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the individual on the current claim. We expect this to be a rare outcome given that the pharmacist will have verified Medicaid, and thus, dual eligibility using one of the several methods available.

Question: What happens with claims submitted with invalid data (birth date, first name, last name, Medicare ID number, Medicaid ID number) and dual eligible status cannot be verified?

Answer: WellPoint will contact the pharmacy or designated single point of contact for follow-up.

CMS Policy Questions

Question: Some E1 transactions are coming back with no information except an invalid phone number of 1-800-222-2222. Do we know who that number belongs to?

Answer: CMS is continuing to work with all payers to make sure accurate information is on file.

Question: Is there an update on the PCN of all 9's?

Answer: Some E1 transactions are returning a PCN of all 9's. CMS is continuing to work with all payers to make sure accurate information is on file.

Question: What happens if the member's coverage changes after the claim has been filled?

Answer: Once the member is enrolled in a plan, the permanent coverage assigned to the member will prevail.

Question: Medicaid has provided us conflicting information. Some states say they should cover scripts if the recipient is not eligible until the following month. Others say they will not cover and bill facilitated enrollment. Can we confirm what the correct policy is and can CMS get this out to the states?

Answer: WellPoint will cover the member through the POS Facilitated Enrollment process.

Question: How will formulary discrepancies be handled if they have to reverse the claim and submit to another Payer? Will the other Payer pay for a non-formulary drug?

Answer: All Part D plans have submitted a first fill transition policy of at least 30 days, so we do not believe claims for non-formulary drugs will present a problem between different Part D plans for new enrollees. CMS will provide additional guidance on this issue.



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Summary

Question: I need clarification on the POS Facilitated Enrollment program. I've had our pharmacies using this program when we are unable to confirm enrollment in a plan. Is this acceptable?

Answer: The pharmacy should verify the member's "dual eligible" status before submitting a claim via POS Facilitated Enrollment. If the member "dual" status has been validated, then yes, the claim can be processed using the POS Facilitated Enrollment plan.

Question: Is POS Facilitated Enrollment a long term solution?

Answer: The program is long term, however the member coverage should be short term.

Question: Can claims continue to be submitted to POS Facilitated Enrollment indefinitely?

Answer: WellPoint limits fills to 30 days (this is primarily to protect the pharmacy), but allows multiple 30 day fills if the dual has not been enrolled in a plan by the end of the fill. Once the beneficiaries enrollment is confirmed, the POS Facilitated Enrollment record will be terminated.

Question: What is the role of Z-Tech?

Answer: Dual Eligible status will be validated by Z-Tech. In addition, we are working with Z-Tech to provide valuable information to assist you with point-of-sale.

Question: The CMS Q&A indicates that the response back to the pharmacy will include a copay, but does not address whether the remainder of the claim will be paid. How will claims be paid?

Answer: All Anthem Prescription contracted pharmacies will be paid via the normal payment process. Non-contracted pharmacies will receive payment at the address listed on file with NCPDP.

Question: Will WellPoint be able to block any future claims for any individual who has been previously deemed ineligible so the need for future reversals will be prevented?

Answer: During the dual status validation process, all Medicare ID numbers are validated. Any Medicare ID numbers found to be ineligible will be terminated

Question: Could WellPoint establish a deadline for reversals, after which WellPoint would assume responsibility for collection from any ineligible individual?

Answer: WellPoint is making every effort to minimize the impact to pharmacies as part of this process.