



# Department of Medicaid

## Pharmacy Provider Manual Billing Procedure Guide

Administered by:  
Change Healthcare

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**Change Index:**

<b>Date Published</b>	<b>Date Effective</b>	<b>Section(s) Updated</b>	<b>Description of Change</b>
5/31/2016	6/12/2016	<b>1.1</b> Help Desk Telephone Numbers <b>1.2</b> Mailing Addresses <b>2.4</b> Required Data Elements <b>2.6</b> Unique Claim Criteria <b>3.8</b> Coordination of Benefits (COB)	<ul style="list-style-type: none"> <li>• Initial publication of Provider Manual under Goold Health System (GHS) system</li> <li>• Changed Administered by from Xerox to Goold Health Systems</li> <li>• Changed name from Ohio Department of Job &amp; Family Services (ODJFS) to Ohio Department of Medicaid (ODM)</li> <li>• [1.1] Change in Prior Authorization hours of operation from 7am to 7pm to 8am to 8pm</li> <li>• [1.2] Change in mailing addresses</li> <li>• [2.4] Change in BIN/PCN and other processing information</li> <li>• [2.6] Added section</li> <li>• [3.8] Changes in requirements for claims submissions of COB claims</li> </ul>
12/21/2016	1/1/2017	<b>2.1</b> Claim Format <b>3.2</b> Dispensing Limits	<ul style="list-style-type: none"> <li>• Changed Administered by from Goold Health Systems to Change Healthcare</li> <li>• [2.1] Updated website address</li> <li>• [3.2] Added additional drugs to 102-day supply</li> <li>• [3.2] Added information regarding Medication Synchronization (Med Sync)</li> </ul>
3/24/2017	4/1/2017	<b>3.3</b> Provider's Dispensing Fees <b>3.5</b> Drug Coverage <b>3.9</b> Long Term Care (LTC) Claims <b>3.16</b> Influenza Vaccine Administration <b>3.20</b> 340(B) <b>6.1</b> Provider Payment <b>6.2</b> MAC Pricing	<ul style="list-style-type: none"> <li>• [3.3] Updated Provider Dispensing Fee structure</li> <li>• [3.5] Continuous Blood Glucose Testing added to DME product coverage</li> <li>• [3.9] Updated LTC vaccination information</li> <li>• [3.16] Updated dispensing fee information for Influenza Vaccine</li> <li>• [3.20] New section created to address changes required for 340(B) claim submission</li> <li>• [6.1] Updated to reflect change to NADAC pricing methodology</li> <li>• [6.2] Updated section to identify MAC rate setting being based upon estimate of actual acquisition cost</li> </ul>
9/15/2017	N/A	Change Index <b>3.15</b> Compounds	<ul style="list-style-type: none"> <li>• Added Change Index to Provider Manual</li> <li>• [3.15] Added clarification to SCC 08</li> </ul>
2/15/2018	N/A	<b>3.7</b> Prior Authorization	<ul style="list-style-type: none"> <li>• Added information regarding NCPDP e-prior authorization support</li> </ul>
12/19/2018	1/1/2019	<b>3.5</b> Drug Coverage <b>3.17</b> Pharmacist administration of dangerous drug by injection <b>APPENDIX A</b>	<ul style="list-style-type: none"> <li>• New logo added</li> <li>• Expanded list of covered DME items</li> <li>• New section added to discuss payment for pharmacist administered drug by injection</li> <li>• Removed Suboxone/Zubsolv prior authorization form; Updated Hepatitis C prior authorization form</li> </ul>

Date Published	Date Effective	Section(s) Updated	Description of Change
5/28/2019	6/1/2019	<b>3.1</b> Requirement for Tamper-Resistant Prescription Forms	<ul style="list-style-type: none"> <li>Added information regarding presumptive eligibility</li> </ul>
12/9/19	1/1/2020	<b>3.1</b> Tamper Resistant Prescription Forms <b>3.2</b> Dispensing Limits <b>3.3</b> Provider Dispensing Fees <b>3.5</b> Drug Coverage <b>3.5</b> Drug Coverage <b>3.8</b> Coordination of Benefits <b>3.9</b> Long Term Care (LTC) Claims <b>3.10</b> Managed Care Plan (MCP) Consumers <b>3.13</b> Medicare-Covered Drugs <b>3.14</b> Qualified Medicare Beneficiary (QMB) <b>3.20</b> Miscellaneous <b>Appendix A</b> Prior Authorization Forms	<ul style="list-style-type: none"> <li>[3.1] Added language regarding Presumptive Eligibility</li> <li>[3.2] Added policy regarding PRN dosing on prescriptions</li> <li>[3.3] Added notification of rejection/PA requirement for high cost compounds</li> <li>[3.5] Added policy dictating pharmacies cannot utilize one beneficiary's Medicaid ID# for another beneficiary</li> <li>[3.8] Provided instruction on when/how to process pharmacy claims with OCC/Other Coverage Code 01.</li> <li>[3.9] Added ICF patients to the covered vaccine exceptions</li> <li>[3.9] Clarified the distinction between ICF and LTC patient residencies</li> <li>[3.10] Updated the Managed Care eligibility assistance process</li> <li>Combined Sections <b>3.13</b> and <b>3.14</b> into section <b>3.5</b> Covered Drugs</li> <li>[3.20] Added policies for test claims and discount cards</li> <li>[Appendix A] Prior Authorization Forms updated</li> </ul>
9/17/20	9/21/20	<b>3.2</b> Dispensing Limits <b>Appendix A</b> Prior Authorization Forms	<ul style="list-style-type: none"> <li>[3.2] Added language regarding CII prescriptions must have quantity greater than zero populated in the NCPDP Quantity Prescribed Field (460-ET).</li> <li>[Appendix A] Hepatitis C Treatment Prior Authorization Form updated</li> </ul>
11/17/2020	11/17/2020	<b>1</b> Introduction <b>1.1</b> Help Desk Telephone Numbers <b>5.2</b> Host System Problems	<ul style="list-style-type: none"> <li>[1] Introduction</li> <li>[1.1] Hours of Operation updated</li> <li>[5.2] Removed reference to 24/7 business hours</li> </ul>
06/01/2021	04/01/2021	<b>1</b> Introduction <b>1.1</b> Help Desk Numbers <b>1.3</b> Mailing Address <b>2.1</b> Claim Format <b>3.2</b> Dispensing Limits <b>3.4</b> Generic Substitution Policy <b>3.5</b> Drug Coverage <b>3.9</b> LTC <b>3.14</b> Vaccine Administration <b>3.20</b> Miscellaneous <b>Appendix A</b> Prior Authorization Forms	<ul style="list-style-type: none"> <li>[1] Reference to paper claims removed</li> <li>[1.1] Telephone numbers updated</li> <li>[1.3] Removed mailing address for paper claims</li> <li>[2.1] Paper claims no longer accepted</li> <li>[3.2] Updated 102 days supply table</li> <li>[3.4] Acceptable DAW code use added</li> <li>[3.5] Reordered DME section for clarity</li> <li>[3.9] COVID-19 vaccine added</li> <li>[3.14] COVID 19 Vaccine language and billing instructions added</li> <li>[3.20] COVID-19 Testing Kit language added, billing instructions added, and PDMP requirement added</li> <li>[Appendix A] Prior Authorization Forms removed</li> </ul>
08/01/2022		<b>3.14</b> Vaccine Administration <b>3.15</b> Pharmacist Administration of Dangerous Drugs <b>3.20</b> Miscellaneous	<ul style="list-style-type: none"> <li>[3.14] Additional Dose/Booster billing instructions added</li> <li>[3.15] Update added</li> <li>[3.20] COVID-19 Testing Kit language updated; At-Home COVID-19 Testing language and billing instructions added</li> </ul>

Date Published	Date Effective	Section(s) Updated	Description of Change
04/01/2023		<b>3.1</b> Requirement for Tamper-Resistant Prescription Forms <b>3.10</b> Managed Care Plan (MCP) Consumers <b>3.20</b> Patient Counseling <b>3.21</b> Proof of Medication Receipt <b>Appendix A</b> Prior Authorization Forms	<ul style="list-style-type: none"> <li>• [3.1] Language updated regarding Single Pharmacy Benefit Manager</li> <li>• [3.10] Point of Sale (POS) reject message updated to reflect Single Pharmacy Benefit Manager BIN and PCN; Medicaid MCPs website link updated</li> <li>• [3.20] Patient Counseling section added</li> <li>• [3.21] Proof of Medication Receipt section added</li> <li>• [Appendix A] Sublocade PA form removed</li> </ul>

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## Section 1: Introduction

Change Healthcare is the claims processor for the Ohio Department of Medicaid (ODM) fee-for-service pharmacy benefit management program. Change Healthcare uses a computerized point-of-sale (POS) system, utilizing NCPDP D.0 telecommunications standards for claim transactions.

The system allows participating pharmacies real-time access to consumer eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through ODM and have an active status for any dates of service submitted.

This manual is intended to provide pharmacy claims submission guidelines to the users of the Change Healthcare on-line system. While there are a variety of different pharmacy operating systems, the information contained in this manual addresses only the response messages related to the interaction with the Change Healthcare on-line system.

When pharmacy providers require assistance with processing a claim for an Ohio Medicaid consumer in the fee-for-service pharmacy program, they may contact the **Change Healthcare Technical Call Center at: 1-877-518-1545**, which is available **Monday - Friday 8am - 8pm**.

### 1.1 Help Desk Telephone Numbers

Department	Contact Information
<b>Change Healthcare Technical Helpdesk and Technical Prior Authorizations</b>	1-877-518-1545 Monday – Friday 8am - 8pm (ET)
<b>Change Healthcare Clinical Prior Authorizations</b>	1-877-518-1546 Fax: 1-800-396-4111 Monday – Friday from 8am – 8pm (ET)
<b>Ohio Medicaid Provider Enrollment Line</b>	1-800-686-1516 Monday – Friday from 8am – 4:30pm (ET)
<b>Ohio Medicaid Consumer Hotline</b>	1-800-324-8680 TTY 1-800-292-3572 Monday – Friday from 7am – 8pm (ET); Saturday from 8am – 5pm (ET) Voice mail is available at other times with calls returned the next business day <a href="http://ohiomh.com/">http://ohiomh.com/</a>

## 1.2 ODM Web Site Addresses

<http://medicaid.ohio.gov> The Ohio Medicaid Program

<http://pharmacy.medicaid.ohio.gov> The Ohio Medicaid Drug Program and a searchable database of covered drugs

<https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx> Ohio Medicaid Information Technology System (MITS) web portal

## 1.3 Mailing Address

### ***Prior Authorization Appeals (consumers only)***

Ohio Department of Medicaid  
Bureau of State Hearings  
P.O. Box 182825 Columbus,  
OH 43218-2825

## 1.4 Service Support

### ***On-line Certification***

Providers must submit claims using NCPDP version D.0 of the telecommunications standard.

### ***On-line System Not Available***

If for any reason the on-line system is not available, providers should submit claims when the on-line capability resumes. In order to facilitate this process, the provider's software should have the capability to submit backdated claims.

### ***Technical Problem Resolution***

Technical problems that may arise unrelated to the standard claims processing rejections, may require technical expertise from the pharmacy provider software vendor, the pharmacy's internal technical support team, or network support staff. The **Change Healthcare Technical Call Center (1-877-518- 1545)** is available for assistance related to technical issues involving the Change Healthcare POS system and questions related to the payer sheet.

## Section 2: Program Setup

### 2.1 Claim Format

#### *Electronic*

Change Healthcare will accept electronic claims submitted via NCPDP version D.0 telecommunications standards. Payer sheets for claims transmission are available at:

<http://pharmacy.medicaid.ohio.gov/pharmacy-billing-information>

Note: Ohio Medicaid no longer accepts paper claims. Any paper claims mailed to Change Healthcare will not be paid and will be returned to the sender.

### 2.2 Media Options

ODM does not accept Batch Claim submissions. Mandatory POS submission is required for all providers except:

- Clinics
- Other providers with prior approval from ODM

### 2.3 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally, Change Healthcare will also accept re-bill claims (Transaction Code B3).

#### *Claims Adjudication (Transaction Code B1)*

This transaction captures and processes the claim and returns a paid or denied claim response to the pharmacy.

#### *Claims Reversal (Transaction Code B2)*

This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system.

**NOTE:** The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- Service Provider ID
- Prescription number
- Date of service (date filled)
- NDC

#### *Claims Re-bill (Transaction Code B3)*

Use this transaction to adjust and resubmit a claim that has previously been processed and received a **Paid** status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction.

**Eligibility Verification (Transaction Code E1)**

Use this transaction to transmit patient billing number and receive a real time response verifying eligibility.

**2.4 Required Data Elements**

The Change Healthcare system has program-specific requirements for data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields.

**ODM claims will not be processed without all the required data elements.** Required fields may or may not be used in the adjudication process. The complete ODM Payer Specifications, including NCPDP field number references, are in the payer sheet, posted online at: <http://pharmacy.medicaid.ohio.gov>. Fields "not required for this program" at this time may be required at a future date.

**NOTE:** The following list provides important identification numbers for this program:

- ANSI BIN # **015863**
- Processor Control # **OHPOP**
- Group # **Not needed**
- Provider ID # **National Provider Identifier (NPI) Number**
- Cardholder ID # **Ohio Medicaid ID Number**
- Prescriber ID # **NPI**
- Product Code **National Drug Code (NDC), Universal Product Code (UPC), National Health Related Items Code (HRI)**

**2.5 Timely Filing Limits**

In accordance with OAC 5160-9-06, ODM accepts claims for up to 365 days from the date of service. The Change Healthcare Help Desk has the ability to do a manual override for timely filing limits in such cases where retro-active eligibility or delayed TPL have occurred. Claims that exceed the prescribed timely filing limit will deny with the NCPDP Reject Code: 81 - Claim Too Old. A summary of the timely filing limits is provided below.

Claim Type	Timely Filing Limit
<b>Original Claims</b> (B1 transaction)	Within 365 days of the date of service.
<b>Reversals</b> (B2 transaction)	Within 575 days of the date of original claim adjudication date.
<b>Re-bills</b> (B3 transaction)	Within 365 days of the date of service or beyond 365 days if the re-bill is within 120 days original claim adjudication date.
<b>Denied Claims</b>	Denied claims may be re-submitted beyond 365 days if the re-submission is within 90 days of the original claim denial.

## 2.6 Unique Claim Criteria

The POS system will use three NCPDP data elements to identify a unique claim:

1. Date of Service: NCPDP field #401-D1
2. Service Provider ID: NCPDP field #201-B1
3. Prescription Reference Number: NCPDP field #402-D2

If the incoming submitted claim (B1/B3) matches the three NCPDP elements to a non-voided claim then, NCPDP Reject code: 83 - Duplicate Paid/Captured Claim will display. An incoming reversal (B2) or resubmit (B3) must also match on the same 3-part key or it will reject with NCPDP Reject code: 87 - No claim on file to reverse.

## 2.7 Submitted Fill Number (NCPDP field #403-D3)

The submitted fill number for the same Service Provider ID and Prescription Reference Number do not need to be sequential, but it should be higher than the previous fill number. If criteria are not met, the provider will receive the NCPDP Reject code: 17 - M/I Fill Number – Fill number must be greater than previous fill number.

The subsequent fill number for the submitted claim must match the prior claim on drug, strength and formulation. If the provider changes the drug, dose or formulation, the rejection message sent is NCPDP Reject code: M4 - PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT - Different Medication from Previous Fill Contact Help Desk.

## Section 3: Program Policies

### 3.1 Requirement for Tamper-Resistant Prescription Forms [OAC 5160-9-06]

All written prescriptions billed to Medicaid must be on tamper-resistant forms. This includes written prescriptions when ODM is not the primary payer and pays only a portion of the claim.

Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing are exempt from this requirement. To be considered tamper resistant a prescription form must contain all three of the following tamper-resistant characteristics.

Required Characteristic	Examples include but not limited to:
1. One or more features designed to prevent unauthorized copying of a completed or blank prescription form	<ul style="list-style-type: none"> <li>• Text that appears when photocopied or scanned (e.g., "void" or "illegal")</li> <li>• Microprint borders that cannot be copied</li> </ul>
2. One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	<ul style="list-style-type: none"> <li>• Erasure or use of solvents will discolor background</li> <li>• Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.)</li> </ul>
3. One or more features designed to prevent the use of counterfeit prescription forms	<ul style="list-style-type: none"> <li>• Thermochromic ink</li> <li>• High security watermark</li> <li>• Sequentially numbered</li> <li>• Duplicate or triplicate blanks</li> </ul>

**The tamper-resistant requirement does NOT apply in the following situations:**

- Payments for prescriptions made by the Single Pharmacy Benefit Manager
- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone.
- Orders for medications administered in a provider setting and billed by the administering provider.
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have the opportunity to handle the written order.

***Emergency Fill of Non-Tamper-Resistant Prescription***

If a written non-tamper resistant prescription is presented, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber **within 72 hours of dispensing**. The pharmacist should use professional judgment to define an emergency situation. A compliant tamper-resistant prescription may be obtained by the following methods:

- A compliant written prescription, fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription.
- The pharmacy may verify the prescription by telephone documenting (on the prescription) the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

**Presumptive Eligibility**

- Individuals may have temporary Medicaid coverage under *Presumptive Eligibility*.
- A Presumptive Eligibility letter is proof of Medicaid eligibility **on the date the form is issued**. After date of issuance, pharmacy providers must verify eligibility in the point-of-sale (POS) system.
- Pharmacy providers may contact the Change Healthcare help desk to assist with verifying eligibility.

**Retroactive Eligibility**

- If a consumer is determined to be retroactively eligible for Medicaid coverage, and the pharmacy has filled a prescription for a date of service that falls into the retroactive eligibility period, the pharmacy must verify that the original prescription was tamper resistant.
- If the original prescription was not tamper resistant, the pharmacy may follow the procedures listed above to obtain a replacement tamper-resistant prescription or verify the prescription by phone, prior to billing the claim to ODM.

**3.2 Dispensing Limits [OAC 5160-9-03]****Days Supply**

The maximum days supply per claim is 34 days for most drugs. Certain exceptions may apply to specific drug classes or medications. Medications that are typically prescribed for long-term maintenance therapy are allowed up to 102-day supply. The following is a sample of drug classes that allow a higher day's supply to be dispensed:

DRUG CLASS	EXAMPLES
<b>CARDIOVASCULAR</b>	
ANTIARRHYTHMICS	Disopyramide, Quinidine, Digoxin
ANGINA, HYPERTENSION, HEART FAILURE	Amlodipine, Atenolol, Enalapril, Irbesartan
LIPOTROPICS	Atorvastatin, Cholestyramine, Fenofibric Acid, Ezetimibe
DIURETICS	Acetazolamide, Amiloride, Chlorthalidone, Furosemide
<b>CENTRAL NERVOUS SYSTEM</b>	
ALZHEIMER'S	Donepezil, Galantamine, Memantine,
ANTICONVULSANTS	Carbamazepine, Topiramate, Lamotrigine
ANTIDEPRESSANTS	Amitriptyline, Duloxetine, Sertraline
ANTIPSYCHOTICS	Quetiapine, Risperidone, Ziprasidone
PARKINSON'S	Amantadine, Bromocriptine, Carbidopa/Levodopa
<b>ENDOCRINE</b>	
DIABETES	Metformin, Insulin Glargine, Dapagliflozin
ESTROGENIC/HORMONAL AGENTS	Desogestrel /Ethinyl Estradiol, Ethinyl Estradiol, Medroxyprogesterone Acetate
OSTEOPOROSIS	Alendronate
THYROID	Levothyroxine
<b>GENITOURINARY</b>	
BENIGN PROSTATIC HYPERPLASIA	Finasteride, Tamsulosin
OTHER AGENTS	Oxybutynin, Tolterodine
<b>RESPIRATORY</b>	
INHALE AND ORAL	Albuterol, Formoterol, Ipratropium, Montelukast, Salmeterol/Fluticasone, Tiotropium
NASAL PREPARATIONS	Saline Nasal gel, Azelastine, Cromolyn Sodium
<b>OTHER</b>	

DRUG CLASS	EXAMPLES
ANALGESIC AGENTS: GOUT	Allopurinol, Colchicine, Probenecid
ANTIHISTAMINES	Loratadine, Diphenhydramine
BLOOD FORMATION, COAGULATION, THROMBOSIS AGENTS, ORAL ANTICOAGULANTS	Aspirin, Clopidogrel, Cilostazol
CORTICOSTEROIDS	Budesonide, Dexamethasone, Methylprednisolone
GASTROINTESTINAL AGENTS	Famotidine, Lansoprazole, Omeprazole
IMMUNOSUPPRESSANT AGENTS	Cyclosporine, Everolimus, Mycophenolate
OPHTHALMIC AGENTS: ANTIHISTAMINES	Olopatadine
OTC/VITAMINS/PRENATAL/SUPPLEMENTS	Calcium+D, Daily Multivitamins, Ferrous Sulfate, Magnesium, Prenatal Vitamins
POTASSIUM AGENTS	Potassium Chloride ER

### **Quantity Limitations: Dose/Duration**

All prescriptions written with PRN dosing or “use as directed” verbiage must verify with the prescribing entity an actual dosing regimen to calculate the days supply. This must be documented on the prescription hard copy.

Maximum prescription quantities represent the largest number of units per drug that may be dispensed at any one time for a single prescription or the largest number of units per drug per day (or other time period) of therapy. Proposed quantity limitations are reviewed and approved by the ODM DUR Board. Claims submitted that exceed either the days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the Change Healthcare Technical Call Center in cases where medical necessity has been determined.

In an effort to combat the risk of acetaminophen toxicity and opioid overuse, ODM has established a maximum quantity on opioid-acetaminophen combination products. The maximum allowed dose is 3,000mg per day of acetaminophen. Additional quantity limits are available online at: The Ohio Medicaid Drug Program: <http://pharmacy.medicaid.ohio.gov>.

To combat opioid overuse, ODM has established a limit of five opioid claims per 30 days. If a sixth opioid claim is received within 30 days, the claim will deny. The prescriber may request prior authorization if medical necessity is documented.

### **Date Rx Written to Date of Service (DOS) Edits**

In accordance with Ohio pharmacy regulations [OAC 4729-5-21], all prescriptions must be filled within six months from the date written. The Change Healthcare point-of-sale system will display a ‘soft’ message back to the pharmacy if the Date Written (NCPDP field #414-DE) is not within 183 days of the first fill.

For all subsequent fills, the Date of Service (NCPDP field #401-D1) must be within 366 days from the Date Written. [OAC4729-5-30] The POS system will produce a hard rejection when the limit is exceeded with NCPDP Reject code: 28 - M/I DATE PRESCRIPTION WRITTEN – Fill date exceeds Ohio Dept of Medicaid 366 days.

Please note, prescriptions for opioid analgesics must be filled within 14 days of the prescription’s written date.

### **Refills**

All refills must be dispensed in accordance with State and Federal requirements. As noted in the above section, refills may not exceed one year from the Date Written (NCPDP field #414-DE). The refill rate for the ODM pharmacy program is dependent upon the drug schedule for the product as defined by the federal drug enforcement administration (DEA). Non-scheduled drugs have a refill rate of eighty percent and scheduled drugs have a refill rate of ninety percent. The calculation is based upon the most recent script fill date and quantity. Refills requested **before** eighty percent of the days supply has been utilized will be denied, other than in cases where the dosage of a drug has been increased and has a new prescription number. The pharmacy will receive the NCPDP Reject code: 79 – Refill Too Soon Next Fill <Date>.

Pharmacy providers will have the ability to override the NCPDP Reject code: 79 – Refill too Soon for the same drug and same strength when a dosage change occurs. The pharmacy will need to submit a Submission Clarification Code = 05 (NCPDP field#420-DK). The dosage (quantity/days supply) on the submitted claim **MUST** be greater than the previous claim it is rejecting against.

**This override will NOT be available for controlled substances.**

**NOTE:** Claims will not pay for an early refill if the original quantity is not used up. The POS logic looks at the last fill and calculates if member has used up previous fill based on the dosage increase.

Denials may be overridden by the Change Healthcare Technical Call Center staff for the following documented reasons:

- Previous supply was lost, stolen, or destroyed. ODM may limit the number of instances denials may be overridden in cases of suspected fraud or abuse and may request additional documentation before an override is authorized.
- Pharmacist entered previous wrong day supply.
- Vacation or travel.
- Multiple supplies of the same medication are needed, for example in a workshop setting.
- Hospital or police kept the medication.

### **Controlled Substances**

- CII prescriptions cannot be refilled; a new prescription is required for each fill. Long-Term Care (LTC) can do partial fills of a CII drug as long as they follow the guidelines for partial fills.
- CIII and CIV controlled drugs may be refilled up to 5 refills (plus one original) or 6 months, whichever comes first. Change Healthcare will provide a 'soft' message back to the pharmacy if this limit is exceeded.
- CV controlled drugs, like non-controlled drugs, may be refilled up to one year.
- CII prescriptions must have quantity (greater than zero) populated in the NCPDP Quantity Prescribed (460-ET) field on or after date of service 09/21/2020.

### **Medication Synchronization (Med Sync) [ORC 5164.7511]**

Pharmacy providers (excluding LTC) will have the ability to override the NCPDP Reject code: 79 – Refill too Soon to provide for medication synchronization if the following are met:

- The individual elects to participate in medication synchronization
- The individual, the prescriber, and a pharmacist agree that medication synchronization is in the

best interest of the enrollee

- The medication is eligible for medication synchronization

Medications eligible for Med Sync are those allowed to be filled for a day supply of 102 days. The pharmacy may need to submit a Submission Clarification Code (NCPDP field#42Ø-DK) as outlined below in processing the claim:

Submission Clarification Code	Definition
47	<b>Shortened Days' Supply Fill:</b> Used only to request an override for plan limitations when a shortened days' supply is being dispensed and to remove any copayment requirements
48	<b>Fill Subsequent to a Shortened Days' Supply Fill:</b> Used only to request an override for plan limitations when a fill subsequent to a shortened days' supply is being dispensed.

When one of the above codes is used to override a claim impacted by a 79 reject edit, it is important to document the code and reason for the override on the prescription.

### 3.3 Provider Dispensing Fees [OAC 5160-9-05]

ODM has a tiered dispensing fee with exceptions. The pharmacy tier is based upon the total number of prescriptions filled by the provider during the provider's last completed fiscal year and based upon the provider's responses to the dispensing fee survey required by OAC 5160-9-01. Sterile compounding and TPN products in compounds get a maximum dispensing fee based upon days supply.

Pharmacy Volume	Dispensing Fee
0-49,999 prescriptions	\$13.64
50,000-74,999 prescriptions	\$10.80
75,000-99,999 prescriptions	\$9.51
100,000 or more prescriptions	\$8.30*

\*Providers that fail to submit a complete response to the cost of dispensing survey required by OAC 5160-9-01 will receive a dispensing fee of \$8.30.

Exception Category	Dispensing Fee
Total Parenteral Nutrition (TPN)	\$15.00 per day, capped at \$150.00
Sterile Compounds*	\$10 per day, minimum of \$20, capped at \$70.00

\*To qualify for payment of the sterile compound, the compound must be mixed by the pharmacy to the final form under sterile conditions. Sterile compounds are identified by the pharmacy submitting Submission Clarification Code = 10 (NCPDP field#42Ø-DK).

***Long-Term Care Facility (LTC)***

Consumers identified as living in a long-term care facility, including nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID), have the following dispensing fee structure:

- **Non-controlled drugs:** one dispensing fee per drug/strength/formulation, per recipient, per pharmacy, per rolling 25 days.
- **Controlled drugs (CII – CV):** two dispensing fees per drug/strength/formulation, per recipient, per pharmacy, per rolling 25 days.

**A pharmacy can submit a '5' in the Prior Authorization Type Code (NCPDP field# 461-EU) that will override the LTCF dispensing fee limit only** (all other edits still apply). If a pharmacy is submitting a 72-hour override and a dispensing fee override, they can submit '8' in the Prior Authorization Type Code field and a '35' in the Prior Authorization Number Submitted field (NCPDP field #462-EV) to override both.

Acceptable criteria for a provider to utilize the override feature include cases where:

- The physician has prescribed a second round of medication within the 25-day period.
- The physician has increased the dose.
- The medication did not last for the intended days supply.
- The drug has been compromised by accident (e.g., contaminated or destroyed).
- The drug being dispensing is a controlled substance (limited to two dispensing fees per month).

***Compounds***

Standard compounds will receive a dispensing fee the same as a single-ingredient claim, with the exception of TPN and sterile compounds.

Sterile compounding dispensing fees are paid as \$10.00 multiplied by the number of days supply, up to a maximum of \$70.00 per claim. A minimum payment of \$20.00 will be provided for claims with a one- or two-days supply. TPN dispensing fees are paid as \$15.00 multiplied by the days supply, up to a maximum of \$150.00 per claim.

Only one TPN compound claim per day is allowed per Medicaid consumer. If more than one TPN compound claim is submitted for a recipient on the same date of service, the NCPDP reject code: 76 – 'Plan Limitations Exceeded – Plan does not allow multiple TPN claims per day' will be displayed.

Non-sterile, high-cost compound claims will reject with the NCPDP reject code 75 – Prior Authorization Required – Claim Exceeds Allowable Cost.

### 3.4 Generic Substitution Policy [OAC 5160-9-05]

While ODM encourages generic drug use, drugs included in the ODM Drug File are considered reimbursable, regardless of their brand or generic designation. When generic substitution is being performed, pharmacists should practice in accordance with ORC 4729.38. This includes only substituting when the prescriber has not indicated that the brand drug should be “dispense as written” (DAW).

ODM will reimburse participating pharmacies only when accepted DAW Codes are submitted. Only Dispense as Written (DAW) codes 0, 1, 4, 5, 7, 8, and 9 should be submitted by pharmacy providers. DAW codes 2, 3, and 6 are not accepted values and will cause the claim to reject for inactive DAW code. Incorrect use of these codes may result in recoupment. Pharmacies must submit the claim with the appropriate DAW Code in the Dispense as Written (DAW)/Product Selection Code field (408-D8). The following table shows information regarding DAW Codes:

DAW Code	Code Description	Accepted (Yes/No)
0	No product selection indicated	Yes
1	Substitution not allowed by prescriber	Yes
2	Substitution allowed – patient requested brand product be dispensed	No
3	Substitution allowed – pharmacist selected product dispensed	No
4	Substitution allowed-generic drug not in stock	Yes
5	Substitution allowed-brand drug dispensed as a generic	Yes
6	Override	No
7	Substitution not allowed-brand drug mandated by law	Yes
8	Substitution allowed-generic drug not available in marketplace	Yes
9	Brand drug preferred over generic drug per plan	Yes

To appropriately use DAW code 1, the pharmacy must submit the claim in compliance with Ohio Revised Codes 4729.38 and 4729.40.

### 3.5 Drug Coverage [OAC 5160-9-03]

#### *Overview*

Drugs covered by the Ohio Medicaid pharmacy program are limited to those that are manufactured or labeled by companies participating in the federal Medicaid Drug Rebate Program. Drugs must also be dispensed by duly Medicaid enrolled providers and are covered prescription, over-the-counter, or compounded medications.

Only medications prescribed to a beneficiary can be billed using the beneficiary’s Medicaid ID. If medications are needed to treat remaining family members (or otherwise), each prescription must be billed accordingly to each member’s Medicaid ID number. An improperly billed claim could include billing a child’s medication to a parent’s Medicaid ID number and vice-versa.

**Medications Not Covered**

The following list describes medications that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for the treatment of obesity.
- Drugs for the treatment of infertility.
- Drugs for the treatment of erectile dysfunction.
- DESI drugs or drugs that may have been determined to be identical, similar, or related.
- Drugs that are covered or may be covered by Medicare Part D, when prescribed for a consumer who is eligible for Medicare, unless Medicaid coverage is for a dual eligible as designated in the subsequent paragraphs.
- Over-the-counter drugs that are not listed at <http://pharmacy.medicaid.ohio.gov/drug-coverage>, in accordance with OAC 5160-9-03.
- Drugs being used for indications not approved by the Food and Drug Administration unless there is compelling clinical evidence to support the experimental use.

**Durable Medical Equipment (DME)/Disposable Medical Supplies (DMS)**

Limited equipment and supplies (listed below) are covered through the pharmacy program when billed by a pharmacy provider. These supplies should be billed using the NDC or UPC on the package through the pharmacy POS claim system.

HCPCS Code*	Description
A4245	Alcohol wipes or swabs
E2100	Blood glucose monitor with integrated voice synthesizer
A4253	Blood glucose test or reagent strips for home blood glucose monitor
A4252	Blood ketone test or reagent strip
A9274 <sup>†</sup>	External ambulatory insulin delivery system (i.e. Omnipod)
A9277 <sup>†</sup>	Continuous Glucose Monitoring (CGM): Transmitter
A9278 <sup>†</sup>	CGM: Receiver
A9276 <sup>†</sup>	CGM: Sensor
A4268	Contraceptive supply, condom, female
A4267	Contraceptive supply, condom, male
E0607	Home blood glucose monitor complete
S5560	Insulin delivery device, reusable pen; 1.5ml size
S5561	Insulin delivery device, reusable pen; 3ml size
A4259	Lancets
A4215	Needles only, sterile, any size, including pen needles
A4256	Normal low and high calibration solutions or chips
A4614	Peak Expiratory Flow Rate Meter, handheld
A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler
A4258	Spring-powered device for lancet
A4206	Syringe with needle, sterile less than or equal to 1 cc
A4250	Urine test or reagent strips or tablets

\*The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. These supplies will be paid by the NDC number instead of the HCPCS code.

<sup>†</sup>Prior authorization required for CGM supplies.

DME/DMS claims submitted to Change Healthcare for services not listed in the table above will be denied. Equipment and supplies not listed above including enteral nutrition products, should be billed as DME.

DME claims for Medicaid recipients billed to Medicare Part B or a Medicare Advantage plan as the primary payer must be billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). Cost sharing for Medicare Part B services shall not be billed in a pharmacy claim format.

### **Qualified Medicare Beneficiary [QMB]**

Consumers with a QMB card are eligible only for payment of cost sharing associated with Medicare Part B-covered drugs not payable through the Change Healthcare system (*refer to [Section 3.5](#)*). The Change Healthcare Technical Call Center will NOT override a rejection if the consumer is identified as having Medicare Part B on the ODM eligibility file. The pharmacy provider should contact the client's Medicare Prescription Drug Plan for assistance.

### **Medicare-Covered Drugs [OAC 5160-9-03; 5160-9-06]**

Change Healthcare will verify Medicare Part A and B eligibility as well as the Part D eligible date. Drugs in therapeutic classes that are covered or may be covered under Medicare Part D are not available for prior authorization for a consumer who is eligible for Medicare. If a claim comes to the state as primary payer for a Part B or Part D drug and the recipient is eligible for Part D or has Part A or Part B on the claim Date of Service, then it will reject with NCPDP Reject code: 41 - PART D SERVICE - BILL MEDICARE.

The Change Healthcare Technical Call Center will NOT override a rejection if the consumer is identified as a Medicare beneficiary. The pharmacy provider should contact the consumer's Medicare Prescription Drug Plan for assistance. If the consumer indicates that he or she does not have Medicare, the consumer should be advised to call his/her county eligibility caseworker.

### **Medicare Part B**

Consumers indicated as having Medicare Part B on the Date of Service are not covered for Part B drugs (see examples below) under Medicaid and these claims will reject with some exceptions. Cost sharing for drugs covered by Medicare Part B must not be billed to the Medicaid consumer. Medicaid will pay the claim through the standard Medicare crossover process. If payment has not been received from Medicaid within 90 days, follow the professional claim billing instructions found at:

<http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535543-provider-billing-instructions> .

Category	Description
Anti-emetic Oral Drugs	When used as a part of a chemotherapeutic regimen.
Antigens (some)	If prepared by a physician and given by a properly instructed individual under appropriate supervision.
Blood-clotting Factors	Patients with hemophilia that give themselves their own injections.
Chemotherapeutic Oral Drugs	Some oral cancer drugs are covered if the same drug (or prodrug) is available in injectable form.
DME infused Drugs	Medicare covers drugs infused through equipment such as albuterol nebulizer solution and IV medications.

Category	Description
End-Stage Renal Disease (ESRD) Oral Drugs	Some oral ESRD drugs are covered if available in the injectable form and covered by Part B.
Erythropoiesis-stimulating Agents	Patients with ESRD or using the drug to treat anemia related to other conditions.
Injectable and Infused Drugs	Medicare covers most injectable and infused drugs given by a licensed medical provider.
IV Immune Globulin (IVIG)	Patients with primary immune deficiency disease when IVIG is administered in the home.
Nutrition, Parenteral/Enteral	Certain nutrients may be paid for patients who can't absorb nutrition through their intestinal tracts or take food by mouth.
Osteoporosis Injectable Drugs	Women with the home health benefit and a bone fracture certified as related to post-menopausal osteoporosis.
Self-administered Drugs	Medicare may cover some self-administered drugs provided in hospital outpatient settings.
Transplant Drugs (Immunosuppressants)	If Medicare paid for the organ transplant, transplant drug therapy may be covered.
Vaccinations	Influenza, Pneumococcal, Hep B and other shots directly related to the treatment of an injury or illness.

<https://www.medicare.gov/coverage/prescription-drugs-outpatient.html>

### **Medicare Part D Dual Eligibles**

ODM will use the Part D Eligible Date in addition to Part A and Part B eligibility to determine drug coverage. Prescription drug coverage for dually eligible consumers is limited to those drugs that are excluded from coverage by Medicare Part D under the Social Security Act Sections 1927(d)(2) and 1935(d)(2). The following categories of Medicare-excluded drugs are covered for the dually- eligible population:

- Cough Suppressants
- Vitamin and mineral products, except prenatal vitamins and fluoride preparations
- Select over-the-counter drugs

To determine if a drug is excluded from Medicare Part D and covered by the state Medicaid pharmacy program, the online drug search tool is available at: <http://pharmacy.medicaid.ohio.gov>.

### **3.6 Consumer Payment Information [OAC 5160-9-09]**

Medicaid consumers may be subject to a copayment for medication if they are eligible adults age 21 years and over for Medicaid benefits. The copayments that may be charged are as follows:

Description	Copayment Amount
Medications that require a prior authorization	\$3.00
Select trade name medication	\$2.00
Multi-source brands with a non-preferred generic or preferred generic	\$0.00

### ***Copayment Exemptions***

Medications administered to a consumer in a hospital, emergency department, office, clinic, or other facility, are not subject to copayments. Additionally, certain patient groups and situations are exempt from being charged a copayment. These include:

- Persons under 21 years of age.
- Pregnant women during the pregnancy and post-partum period (begins the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends).
- Persons receiving hospice care or identified as breast and cervical cancer patients.
- Living arrangement is in a nursing home or immediate care facility for individuals with intellectual disabilities.
- The prescription is for family planning (contraceptives).

Contact the **Change Healthcare Technical Call Center at 1-877-518-1545** for appropriate override if the consumer indicates that one of the above categories applies but the system has applied a copayment. Living arrangement, hospice, and pregnancy may be indicated as part of the online claim to override copayments when appropriate with the following overrides:

- Pregnancy Indicator = 2 (Pregnant) in NCPDP field #335-2C.
- Hospice patient with Patient Residence = 11 in NCPDP field #384-4X.
- LTCF living arrangement with Patient Residence = 3 (Nursing Facility) or 9 (Intermediate Care Facility) in NCPDP field #384-4X.

**NOTE:** Consumers subject to copayment, who indicate that they are unable to pay their copayment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the copayment. The consumer remains liable for the copayment and the pharmacy provider may bill the consumer for the copayment or request payment for a prior uncollected copayment.

If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid copayment imposed by the copayment program from a prior transaction as an outstanding debt and may refuse service to a Medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a Medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. [OAC 5160-1-09]

### ***Compounds***

Compounds are assigned the highest copayment applicable to each covered ingredient. If no ingredients have a copayment, then there is no copayment. If any one or more has a copayment, then copayment charged is the highest single copayment.

### 3.7 Prior Authorization [OAC 5160-9-03]

Prior authorizations (PAs) are administered in compliance with section 1927 of the Social Security Act, including a **response within twenty-four hours of receipt of a request for prior authorization**, and provisions for the dispensing of a seventy-two-hour supply of a covered outpatient prescription drug in an emergency situation.

#### **Technical Call Center Prior Authorizations**

For assistance with claims processing, eligibility, and third-party liability, the pharmacist may call the **Change Healthcare Technical Call Center at 1-877-518-1545**. Some common NCPDP rejection codes are noted below.

<i>NCPDP</i>	<i>Message</i>
<b>41</b>	Submit Bill to Other Processor
<b>52</b>	Non-matched Cardholder ID
<b>56</b>	Non-matched Prescriber ID
<b>65</b>	Patient is Not Covered
<b>75</b>	Criteria Not Met
<b>79</b>	Refill Too Soon
<b>81</b>	Claim Too Old
<b>M2</b>	Recipient Locked In

#### **Clinical Call Center Prior Authorizations**

Medications or treatment parameters (e.g., dose, duration, age) that require prior authorization must be initiated by the **prescribing provider or member of the prescribing provider's staff**. Requests may be submitted by telephone or by fax.

A pharmacist may request prior authorization for an alternative dosage form of a drug to be administered through a tube for patients who are tube fed, if no comparable covered drug can be administered through a tube. **A pharmacist may also submit a seventy-two-hour supply of a covered outpatient prescription drug in an emergency situation if the prescribing provider or prescribing provider's staff is not available to request prior authorization for a drug denied with NCPDP code 75, as outlined below.**

<i>NCPDP</i>	<i>Message</i>
<b>75</b>	Prior Authorization Required
<b>76</b>	Plan Limitations Exceeded
<b>76</b>	Quantity Exceeds Max
<b>76</b>	Days Supply Exceeds Max
<b>76</b>	Age Requirement Not Met
<b>76</b>	Max Quantity Allowed is Exceeded

- Upon a call from the prescriber, Change Healthcare will work with the prescriber to determine the outcome of the prior authorization request. The requested drug may be authorized or denied. When a request for prior authorization is denied, the consumer will be informed in writing of the denial and the right to a state hearing.
- Prior authorization may also be requested by using a Prior Authorization Form (see *Appendix A*)
- Change Healthcare clinical staff associates are available from 8AM – 8PM (ET) Monday through

Friday

- Change Healthcare will respond to all prior authorization requests within 24 hours of initiation of the request by the prescriber

### ***72-hour Emergency Supply***

Pharmacy providers can utilize a 72-hour emergency fill when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. This emergency 72-hour fill provision is federal law (Title 19, Section 1927(D)(5)(b)) and is applicable only to medications requiring prior authorization that are included by the State's Medicaid pharmacy program.

In order to process a claim for an emergency 3-day supply, the pharmacy must submit a Prior Authorization Type Code (NCPDP field #461-EU) = 2 and Prior Authorization Number Submitted (NCPDP field #462-EV) = 72. Certain requirements apply for the pharmacy override:

- The prior authorization will not override other edits on the claim (e.g. exceeding the daily dose).
- **Controlled substances, partial claims, and consumers assigned to a Coordinated Services Program (CSP) are excluded from this override process.**
- Overrides are limited to one unique drug entity per consumer, per month

The Change Healthcare Help Desk may be contacted when an override is necessary for an emergency situation and the pharmacy override process described above is unable to process the claim.

### ***Medicare Part D Drugs***

Drugs in therapeutic classes that are covered or may be covered under Medicare part D are not available for prior authorization for a consumer who is eligible for Medicare. Prior authorization may be requested for drugs in drug classes or portions of drug classes that may be covered for a dual eligible and are subject to any stated limits.

### ***NCPDP Electronic Prior Authorizations (e-PA)***

Support for the electronic submission of prior authorization (e-PA) requests via the NCPDP electronic prior authorization standard is supported through EvincedMed. Providers who are interested in connecting their electronic health records (EHR) or submitting electronic prior authorizations should contact EvincedMed at 855-742-5594.

## **3.8 Coordination of Benefits (COB) [OAC 5160-9-06; 5160-1-08]**

Starting in June 2016, **ODM switched to COB3 methodology** for the processing of claims submitted with primary cost avoidable coverage on the date of service. Prescription pricing will utilize Other Payer Amount Paid (NCPDP field #431-DV) **and** Other Payer Patient Responsibility Amount (NCPDP field #352-NQ) to determine the ODM payment for the claim. The details are fully described in this section.

### ***Overview***

Medicaid is the payer of last resort. Claims can only be submitted to Medicaid as primary payer when there is no other payer on file for the participant on the date of service. The only exception to this situation is when the consumer is covered by the Bureau for Children with Medical Handicaps (BCMh) and Medicaid is billed as the primary payer. BCMh will continue to be processed under BIN/PCN: 610084/ DRBCPROD.

Other coverage will be identified by the presence of other carrier information on the consumer's ODM eligibility file and/or information communicated by the provider on the claim. A rejection will occur if the pharmacy provider bills Medicaid as the primary payer when the consumer has other coverage as follows:

*NCPDP Reject code:* 41 - Submit Bill to Other Processor or Primary Payer

*Secondary message:* Carrier Name – consumer's TPL policy number – Carrier phone number  
(if available)

**NOTE:** If no other insurance is on the ODM eligibility file, Change Healthcare will process the claim as a TPL claim if the pharmacy provider submits TPL data. Also, Change Healthcare will process as a TPL claim if other insurance is indicated on the ODM eligibility file. The TPL rejection can be overridden by the pharmacy if the patient or primary insurance has confirmed that the primary insurance is no longer active. This can be done by submitting the claim with an other coverage code (OCC) or other payer code of 1 (NCPDP field # 308-C8).

If the provider determines that the consumer no longer has other coverage as identified by the ODM eligibility file, the ODM Cost Avoidance Unit may be contacted via email or fax. A form is available online to submit changes. The contact information is:

Fax: 614-728-0757

Email: [tpl@medicaid.ohio.gov](mailto:tpl@medicaid.ohio.gov)

Form: <http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM06614fillx.pdf>

The pharmacy may also request the recipient contact their eligibility caseworker to update TPL information.

### **COB Claims Submission**

When submitting COB claims, the following information is required (*see payer sheet for additional requirements*):

- Other Payer ID and Qualifier (NCPDP field #340-7C and 339-6C)
- Other Payer Amount Paid (OPAP) and Qualifier (NCPDP field #431-DV and 342-HC): Required on claims where the Other Coverage Code (OCC)= "2". Other Payer Amount Paid is the dollar amount of the payment received from the primary payer(s); this amount must be greater than \$0.
  - When OCC= "4", the Other Payer Amount Paid cannot be greater than \$0.
- Other Payer-Patient Responsibility Amount (OPPRA) and Qualifier (NCPDP field #351-NP and 352-NQ): Required on claims where OCC= "2" or "4" and amount must be greater than or equal to \$0.
- Other Payer Date (NCPDP field #443-E8): Required on all COB claims. The Other Payer Date is the payment or denial date of the claim submitted to the other payer.
- Other Payer Reject Code (NCPDP field #472-6E): The Other Payer Reject Code is required when the OCC= 3.

**Other Coverage Code (OCC)**

The Other Coverage Code (NCPDP field #308-C8) is sent in the claim segment and is required on all COB claims. The following Other Coverage Codes (OCC) codes **are** allowed for COB claims billed to Medicaid:

<b>Code</b>	<b>Description</b>
<b>2</b>	<b>Other coverage exists- payment collected</b> Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received.
<b>3</b>	<b>Other coverage billed- claim not covered</b> Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered.
<b>4</b>	<b>Other coverage exists- payment not collected</b> Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received.

**TPL Processing Summary and Chart**

- When TPL is on file and OCC submitted is "0", the claim will reject with NCPDP error: 41 Submit Bill to Other Processor or Primary Payer.
- If a claim would reject, regardless of the TPL on file, when OCC is "2", "3", or "4", the pharmacy provider will be sent a message to contact the help desk.
- If OCC= 0, 1, 3, or 4 and a positive other payer amount paid amount is sent, the claim will reject as only an OCC = 2 can have a positive dollar value.
- If OCC= 4 and other payer amount paid amount is negative, it will be treated as a \$0.00 and processed.
- If OCC= 0, 1 or 3 and other payer amount paid amount is negative, it will reject.
- If OCC= 2 and the dollar amount is less than \$2.00, it will reject as NCPDP Reject code: DV – M/I Other Payer Amount Paid – Amount under minimum allowed.
- For OCC = 3, if the rejection code is '70' (drug not covered), the claim will be paid if Medicaid covers the drug. Otherwise, it will reject as NCPDP Reject code: 6E – M/I Other Payer Reject Code - Contact Help Desk.
- For OCC=2, the following edit types will be bypassed by Medicaid: NCPDP Reject code: 75- Prior Authorization Required and NCPDP Reject code 76 -Exceeds Max Days Supply, Quantity Limits, Age Criteria, and Gender Criteria.

OCC	Description	TPL on ODM File	TPL Not on ODM File
0	No insurance	Reject claim: NCPDP code 41 Help Desk can override with prior authorization  Any COB segment submitted: reject	Process claim  Any COB segment submitted: reject
1	Pharmacy/Patient indicates no other coverage	Process claim  Any COB segment submitted: reject	Process claim  Any COB segment submitted: reject
2	TPL insurance billed, payment collected  <b>NOTE:</b> OCC=2 claim, regardless of TPL on file or not on file, will process the same	OPAP < \$2.00: Reject claim Help Desk can override with prior authorization  OPPRA < \$0.00: Reject claim	OPAP < \$2.00: Reject claim Help Desk can override with prior authorization  OPPRA < \$0.00: Reject claim
		OPAP ≥ \$2.00: Process claim  OPPRA ≥ \$0.00: Process claim	OPAP ≥ \$2.00: Process claim  OPPRA ≥ \$0.00: Process claim
3	TPL insurance billed, drug/service not covered	Require reject codes to be submitted; if missing, Reject 6E – M/I Other Payer Reject Codes Help Desk can override with prior authorization  OPAP > \$0.00: Reject claim Reject Codes provided with OCC=3 Pay Claim with Reject Code = 70 Reject all other Reject Codes	Require reject codes to be submitted; if missing, Reject 6E – M/I Other Payer Reject Codes Help Desk can override with prior authorization  OPAP > \$0.00: Reject claim Reject Codes provided with OCC=3 Pay Claim with Reject Code = 70 Reject all other Reject Codes
4	TPL insurance billed, payment not received  <b>NOTE:</b> OCC=4 claim, regardless of TPL on file or not on file, will process the same	OPAP > \$0.00: Reject claim OPPRA ≤ \$0.00: Reject claim  OPAP < \$0.00: Process claim as 0 OPAP = \$0.00: Process claim  OPPRA > \$0.00: Process claim	OPAP > \$0.00: Reject claim OPPRA ≤ 0 Reject claim  OPAP < \$0.00: Process claim as 0 OPAP = \$0.00: Process claim  OPPRA > \$0.00: Process claim

**OPAP = Other Payer Amount Paid**

**OPPRA = Other Payer Patient Responsibility Amount**

### 3.9 Long Term Care (LTC) Claims

#### ***Copayments [OAC 5160-9-09]***

ODM identifies consumers who reside in a long-term care facility (LTCF), including nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID).

Prescriptions for medication given to these eligible consumers are excluded from copayments at the time of dispensing.

Contact the **Change Healthcare Technical Call Center at 1-877-518-1545** for appropriate override if the consumer indicates that one of the above categories applies but the system has applied a copayment. Living arrangement may be indicated as part of the online claim to override copayments when appropriate with the following overrides:

- Patient residence with living arrangement indicated as Long-Term Care Facility (LTCF or Nursing Facility) = 3 in NCPDP field #384-4X
- Patient residence with living arrangement indicated as Intermediate Care Facility (ICF) = 9 in NCPDP field #384-4X

#### ***Dispensing Fees [OAC 5160-9-05]***

Please refer to [Section 3.3](#) for information on dispensing fees.

#### ***Over-the-counter (OTC) Medications [OAC 5160-9-03]***

Selected over-the-counter drugs are payable to the pharmacy when dispensed to consumers residing in a nursing facility. OTC medications are the responsibility of the facility and reimbursed through the facility per diem fee. Please note that this applies only to residents of nursing facilities, and not to residents of ICF-IIDs. The following drug classes that contain OTC drugs are **NOT** separately reimbursable:

- Analgesics, including urinary analgesics
- Compounding vehicles and bulk chemicals
- Cough and cold preparations and antihistamines
- Ear preparations
- Gastrointestinal agents (except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide)
- Hemorrhoidal preparations
- Nasal preparations (except nasal corticosteroids)
- Ophthalmic agents (except antihistamines)
- Saliva substitutes
- Sedatives
- Topical agents (except antifungal and acne preparations)
- Vitamins and minerals (except prenatal vitamins and fluoride)

Claims for the OTC drugs listed above will be denied for patients whose Medicaid eligibility records show they reside in a nursing facility. If the pharmacy has knowledge that the patient does not reside in a long-term care facility, the pharmacy should call Change Healthcare at 1-877-518-1545 to request an override. The patient or patient's representative should be advised to have their Medicaid eligibility caseworker change the living arrangement in the eligibility record.

***Tamper-resistant Prescriptions [OAC 5160-9-06]***

The prescription is considered tamper resistant if the patient does not have opportunity to handle the written order. Orders for medications administered in a LTCF qualify if the order is written in the patient's medical record and given by medical staff directly to the pharmacy.

***Vaccines [OAC 5160-9-03]***

Vaccines, inoculations, and immunizations (other than seasonal/pandemic influenza vaccines or COVID-19 vaccines), are covered as a pharmacy benefit only for residents of nursing facilities/long-term care facilities (LTCF) or intermediary care facilities (ICF). Otherwise, these services will be reimbursed as physician services.

**NOTE:** Some injectable drugs are covered for consumers with a LTCF living arrangement or may be authorized for those receiving home health services.

**3.10 Managed Care Plan (MCP) Consumers [OAC 5160-26]**

The Single Pharmacy Benefit Manager (SPBM) is responsible for the pharmacy benefits for members enrolled in managed care. If the incoming pharmacy claim is for a consumer indicated as having MCP coverage on the date of service, the POS system will reject the claim with NCPDP Reject code: AF- - EFF 10/1/2022 USE BIN: 024251 PCN: OHRXPROD CONTACT GAINWELL HELP DESK 1-833-491-0344.

If the pharmacy has billed the Single Pharmacy Benefit Manager, Gainwell, and has contacted the Gainwell help desk to verify that the patient is not currently covered, Change Healthcare can assist with verifying Managed Care coverage. If applicable, Change Healthcare will notify the Ohio Department of Medicaid if the patient requires expedited assistance.

For information on the Ohio Medicaid MCPs, please visit:

<https://medicaid.ohio.gov/families-and-individuals/mcare/Managed+Care>

**3.11 Program of All-Inclusive Care for the Elderly (PACE) [OAC 5160-36]**

PACE is a managed care plan that provides participants with all of their needed health care, medical care, and supplementary services in acute, sub-acute, institutional, or community settings. If the consumer is identified as being a PACE program participant on the date of service and the pharmacy claim is submitted to Change Healthcare, the pharmacy provider will receive the NCPDP Reject code: AF - Patient Enrolled In Managed Care - Bill PACE site.

**3.12 Coordinated Services Program (CSP/“Lock-in”) [OAC 5160-20-01]**

Change Healthcare will be reviewing claims to identify patients that meet the clinical criteria for a pharmacy Coordinated Services Program. Criteria are approved under the guidance of the Ohio Medicaid DUR Board [OAC 5160-9-04]. Providers should call the Change Healthcare Technical Call Center (1-877-518-1545) for override consideration. Overrides will only be granted in the following situations:

- The dispensing provider has identified that the lock-in provider cannot dispense the medication (e.g., pharmacy closed or drug out of stock), *and* has determined the situation to be an emergency.

**3.13 Compounds [OAC 5160-9-03; 5160-9-05]**

Compounded drugs must be submitted using each national drug code (NDC) that is a part of the compound. Specific drug products and bulk ingredients utilized in compounds that are not covered will

require prior authorization. If a prior authorization is not approved or if a component drug is not eligible for authorization (e.g. manufacturers not participating in the federal Medicaid rebate program), the pharmacy provider may elect to receive payment only for those items in the compound that are directly reimbursed by ODM. This can be processed by:

- Submitting the claim with the Submission Clarification Code (SCC) (NCPDP field #42Ø-DK) of '08'.
  - Note: SCC of 08 should not be utilized for claims that reject for reasons other than product coverage (such as refill too soon, duplicates, etc.)

Certain POS edits are different on compounded drugs. The below list is a summary of these differences:

Edit Type	Description
Age	Age limits will be applied to compounds.
Duplicate therapy	If the single ingredient is a duplicate of another claim, it will not reject as a duplicate claim.
Refill too soon	Refill too soon edits will be bypassed except if sent more than once in the same compound.

### **Dispensing Fees**

Please refer to [Section 3.3](#) for information on dispensing fees.

### **Compound Claims Submission**

The following NCPDP fields are required to submit a claim for a compound via POS:

- Compound Code (NCPDP field #4Ø6-D6) is '2'
- Product/Service ID (NCPDP field #4Ø7-D7) must be '0' Product/Service ID Qualifier (NCPDP field #436-E1) is '00'
- Compound Dosage Form field (NCPDP field #45Ø-EF) is to contain a value between "01"- "18"
- Compound Dispensing Unit field (NCPDP field #451-EG) is to contain a value of 1,2 or 3
- Compound Ingredient Component Count field (NCPDP field #447-EC) is to contain a value between "2"- "25"
- Compound Product ID Qualifier field (NCPDP field #488-RE) is to contain a value of "01", "02", or "03"
- Compound Product ID field (NCPDP field #489-TE) is to contain the eleven-digit NDC for the ingredient
- Compound Ingredient Quantity field (NCPDP field #448-ED) is to be populated with numeric value greater than zero for each ingredient
- Compound Ingredient Drug Cost field (NCPDP field #449-EE) is to be populated for each individual ingredient
- Compound Ingredient Basis Of Cost Determination (NCPDP field #49Ø-UE) is to contain a value between "01"- "14" for each ingredient

### 3.14 Vaccine Administration

#### *Influenza Vaccine*

Pharmacies may bill for administration of seasonal influenza vaccine through May 31 of each influenza season, and pandemic influenza vaccine when indicated. Payment for influenza vaccine administration will be made to pharmacies only for Medicaid consumers who do not reside in a long-term care facility (LTCF) and who are not eligible for Medicare. Vaccines are also not covered in the pharmacy setting for patients 18 years of age and younger (vaccine must be obtained from Vaccines for Children program).

Reimbursement for any pandemic influenza vaccine will be limited to an administration fee of no more than \$19.35. The pandemic influenza vaccine is supplied by the Ohio Department of Health at no cost to the provider, so no reimbursement will be made for the vaccine itself. Reimbursement for the seasonal influenza vaccine will include product cost and an administration fee of no more than \$19.35. No dispensing fee will be paid when the administration fee is billed.

#### *Dispensing Fees*

The summary provided below lists the current dispensing fees for vaccinations covered through the ODM pharmacy program.

Category	Dispense Fee
Vaccine in LTCF	See Section 3.3 Provider Dispensing Fees
Influenza vaccine administered at the Pharmacy	\$19.35 administration fee

#### *Claim Submission for Administration at the Pharmacy*

Medicaid will pay up to a \$19.35 administration fee for the influenza when administered at the pharmacy. In order to receive payment for this fee, the provider will need to submit the administration fee in the Incentive Amount Submitted field (NCPDP field #438-E3) along with a Professional Service Code (NCPDP field #440-E5) = **MA**.

#### *Medicare Eligible*

If a consumer is in Medicare, has Part A, Part B or are Part D eligible, they will not be eligible for vaccines. Any claim submitted on a Medicare consumer will reject with the NCPDP Reject code: 41 – Submit Bill to Other Processor or Primary Payer – Submit to Medicare.

#### *LTCF*

Additional vaccines are covered for this patient population and receive a regular dispensing fee in accordance with OAC 5160-9-05.

#### *COVID-19 Vaccine*

The pandemic COVID-19 vaccine is supplied by the Ohio Department of Health at no cost to the provider, so no reimbursement will be made for the vaccine itself. Pharmacies may bill for administration of COVID-19 vaccine beginning December 15th, 2020.

**Claim Submission for Administration at the Pharmacy**

Pharmacies should bill the vaccines and administration via an electronic NCPDP claim according to the following instructions:

- Submit each vaccine with the specific approved vaccine NDC for an eligible member.
- Submit claim with a **Basis of Cost Determination (423-DN)** of “15” (Free product or no associated cost) with an associated **Ingredient Cost Submitted (409-D9)** value of \$0.00.
- Submit claim with the **Professional Service Code (440-E5)**, populated with an “MA” (Medication Administered) to identify that the product was administered.
- The **Quantity Dispensed (442-E7)** should be submitted with the value that represents the quantity of drug product administered in ML.
- **Days Supply (405-D5)** should be submitted with a value of “1”.
- Vaccines must be administered according to authorized labeling for appropriate ages and dosing interval.
- Submit the vaccine administration fee listed below in the **Incentive Amount Submitted field (438-E3)** on the same claim as the vaccine (i.e., ingredient).

Dose	Submission Clarification Code (420-DK)	Incentive Amount (Administration Fee 438-E3)	Ingredient Cost (409-D9)
Two-Dose Vaccine			
First Dose	02	\$37.66	\$0.00
Second Dose	06	\$37.66	\$0.00
Additional Dose/Booster	07 or 10	\$37.66	\$0.00
Single-Dose Vaccine			
Single Dose	Blank	\$37.66	\$0.00

- The payment rate for COVID-19 vaccine administration is \$37.66 to administer single-dose vaccines. For single-dose vaccine administration claims, the Submission Clarification Code (SCC) should remain blank.
- The payment rate for COVID-19 vaccine administration requiring a series of two or three doses is \$37.66 for each dose administered.
- For the second dose, submit 06 (the previous medication was a starter dose and now additional medication is needed to continue treatment) in the SCC field.
- For the additional dose/booster, submit 07 (medically necessary) or 10 (Meets Plan Limitations) in the SCC field.
- Pharmacies must enter the NPI of the prescriber in the **Prescribing Practitioner (411-DB)**. If the prescriber is the pharmacist, the NPI of the pharmacist may be submitted. If the pharmacy is using a pharmacist NPI, the pharmacy must submit a Submission Clarification Code (SCC) of “42”.

**Medicare Eligible**

If a consumer is in Medicare, has Part A, Part B or are Part D eligible, they will not be eligible for vaccines. Any claim submitted on a Medicare consumer will reject with the NCPDP Reject code: 41 – Submit Bill to Other Processor or Primary Payer – Submit to Medicare.

**3.15 Pharmacist Administration of Dangerous Drug by Injection [OAC 4729-5-40]**

Pharmacies may bill for administration of: (1) An opioid antagonist used for treatment of drug addiction and administered in a long-acting or extended-release form. An opioid antagonist may also be administered for the treatment of alcohol dependence in accordance with approved labeling by the United States food and drug administration. (2) An antipsychotic drug administered in a long-acting or extended-release form. (3) Hydroxyprogesterone caproate for pregnant women. (4) Medroxyprogesterone acetate for non-pregnant women. OR (5) Cyanocobalamin.

Reimbursement for these products will be limited to an administration fee of no more than \$19.35. No dispensing fee will be paid when the administration fee is billed.

If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy in OAC 4729:5-5-14.

**Dispensing Fees**

The summary provided below lists the current dispensing fees for pharmacist administration of dangerous drugs by injection covered through the ODM pharmacy program.

Category	Dispense Fee
Patient resides in LTCF	See Section 3.3 Provider Dispensing Fees
Product administered at the pharmacy	\$19.35 administration fee

**Claim Submission for Administration at the Pharmacy**

Medicaid will pay up to a \$19.35 administration fee for the product when administered at the pharmacy. In order to receive payment for this fee, the provider will need to submit the administration fee in the Incentive Amount Submitted field (NCPDP field #438-E3) along with a Professional Service Code (NCPDP field #440-E5) = **MA**.

**3.16 Newborns Without an Assigned Medicaid ID**

While newborns should be provided a Medicaid ID number, there may be cases where a newborn has not yet been assigned a Medicaid ID. Newborns are covered for prescriptions during the first 365 days after birth under the mother's Medicaid billing ID. The pharmacy provider will need to submit the claim with the mother's Medicaid ID and the baby's date of birth. The claim will be paid as long as the mother's Medicaid ID is used, and the date of birth is within 365 days from the date of service. When a Medicaid ID has been issued to the newborn, the pharmacy provider should update their system and utilize the appropriate assigned Medicaid ID.

### 3.17 Partial Fills

The POS system will accept multiple partial fill transactions per prescription except for vaccines and other exceptions noted in this section. This transaction may be necessary when the full quantity prescribed is not currently in stock. If copayment is required, the consumer will be charged the copayment on the first partial prescription. The dispensing fee will only be paid on the completed prescription (LTCF exception). When a partial fill prescription is dispensed, but the participant does not receive the remainder of the prescription, the pharmacy must void the partial fill prescription and bill the prescription as a completed prescription to receive the dispensing fee.

#### *Initial Partial Fill*

The initial partial fill is sent with a 'P' in the Dispensing Status field (NCPDP field #343-HD). The quantity and days supply intended to be filled must be supplied on the claim (NCPDP field #344- HF and 345-HG) as well as the actual quantity and days supply dispensed (NCPDP field #442-EF and 405-DF). The dispensing fee is \$0, but the copayment is charged.

**NOTE:** Drug reimbursement is only for the quantity being dispensed in the partial claim. Multiple partial fills may be processed if they are for the same drug/strength/formulation, on different dates of service, and the accumulation of the dispensed quantity and days supply for all of the partial fills does not exceed the intended quantity and days supply. The same TPL edits apply for a partial fill as on a regular claim.

#### *Completion Fill*

When filling the remainder of the prescription, the Dispensing Status (NCPDP field #343-HD) must be sent with a 'C'. Similar fields are required as with the initial partial field. The provider dispensing fee is paid on the completion fill (LTCF exception). Partial and their completed counterpart claims are not allowed on the same date of service. If the pharmacy receives stock on the same day as the partial was dispensed, the pharmacy must reverse the partial and resubmit the claim with the total quantity and days supply.

### 3.18 Prescriber Validation

A prescriber must be enrolled to participate in the Medicaid program both on the date the prescription was written, and the date dispensed for the pharmacy to be reimbursed for a prescription. All submitted claims must have the Prescriber ID Qualifier (NCPDP field #466-EZ) = '01', Prescriber ID (NCPDP field #411-DB), and the Prescriber last name (NCPDP field #427-DR). Any of these data fields missing will result in standard NCPDP rejection messages to the pharmacy provider.

If the prescriber NPI is in the ODM provider file, a last name match algorithm is applied using the first three to four characters of the prescribers last name or 'doing business as' name. **This is a new validation process.** Any mismatch will cause a rejection of NCPDP Reject code: DR - M/I Prescriber Last Name – Last Name mismatch with name on file. NPIs not found within the ODM provider file will result in a message back to the pharmacy as NCPDP Reject code: 25 - M/I Prescriber ID – 1339 Prescriber must register with Ohio Dept. of Medicaid. Other rejection messages pertaining to a non-active status and dates of service can occur.

#### *Help Desk Assistance*

The Help Desk will have a manual override to assist pharmacy providers. This override will be allowed

when it has been determined that the prescriber is valid, and he/she is not excluded from prescribing medications for the Ohio Medicaid program. This override will not be used as a substitute for the prescriber to not register with the Ohio Department of Medicaid as required by the Affordable Care Act. Prescribers may enroll online at:

<http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx>

### ***Psychiatry Exemption***

Physicians who have registered their psychiatry specialty with ODM are exempt from prior authorization for specific medications utilized to treat behavior health disorders. This only applies to non-preferred medication coverage and will not override other POS edits like maximum days supply.

### **3.19 340B**

Claims for drugs purchased through the 340B drug discount program shall be submitted with the provider's actual acquisition cost plus cost of dispensing. In order to identify drugs purchased through the 340B program, providers should utilize a Submission Clarification Code = 20 (NCPDP field #42Ø-DK) and a Basis of Cost Determination = 08 (NCPDP field #423-DN). Payment for the claim will be as described in Administrative Code rule 5160-9-05, no higher than the 340B ceiling price plus any applicable professional dispensing fee. **Ohio Medicaid has established no arrangements with contract pharmacies, and in this way prohibits the use of contract pharmacies for 340B drugs dispensed/administered to Medicaid patients.**

### **3.20 Patient Counseling (OAC 4729:5-5-09)**

A pharmacist or the pharmacist's designee must offer to provide the service of counseling for all prescriptions dispensed. Patient counseling must be conducted in accordance with Ohio Administrative Code 4729:5-5-09. All refusals must be documented at the time of refusal. Records pertaining to counseling, including documentation of refusals, must be retained for at least six years from the date of reimbursement.

### **3.21 Proof of Medication Receipt**

ODM requires each pharmacy keep a dated log that maintains a record of when a member or member's representative picks up, or takes delivery of, every prescription paid for by ODM. All signatures must be original at the time each prescription is dispensed; electronic or other methods of reproducing past signatures are not acceptable. ODM will accept documentation showing the sold date in lieu of a signature. The signature log can either be manual or electronic and should comply with all State and Federal regulations. This policy applies to prescriptions dispensed at the provider's physical location as well as those delivered off-site to the member's residence or other setting. Prescriptions mailed to members shall be recorded in a dated log that must contain the prescription number, date of fill, member's name and address that the prescription is mailed to, as well as the name of the person mailing or delivering the mail to the mail carrier. These policies apply to all members including those living in nursing and other institutional facilities.

### **3.22 Miscellaneous**

Additional information to assist in claims processing are noted below. Additional items not addressed elsewhere will be added, as necessary, to assist the pharmacy providers.

- The Prescription Origin Code (NCPDP field #419-DJ) is required. If this is not sent on the claim, it will reject with NCPDP Reject code: 33 - M/I Prescription Origin Code.
- Pharmacies are not allowed to test claims to determine eligibility, coverage, or reimbursement rates. Pharmacies should also not reverse paid claims at a later date and resubmit those claims to determine if the reimbursement is higher. To determine client eligibility, the pharmacy must perform an E1 Eligibility Verification Transaction. The E1 Eligibility Verification transaction is used as an eligibility finder method for pharmacies. If a pharmacy has a customer who thinks they have coverage, the pharmacy can submit a Cardholder ID or other identifiers such as SSN, Last Name, First Name, Date of Birth, and Gender to the POS. Based on specific search criteria, if a match is found in the ODM eligibility file, additional validation is done to determine if the participant is eligible on Date of Service. An E1 transaction must match on one of the following combinations:
  - Medicaid ID
  - Last 4 digits of SSN and DOB
  - First 5 characters of last name, first 3 characters of first name, exact DOB, and gender
- Members who present discount cards at the pharmacy may not use those discount cards in conjunction with their Medicaid benefits. Discount cards cannot be used on any claims that are paid for in whole or in part by any government program.
- A subsequent fill number on a prescription must be for the same drug/strength/formulation. If the pharmacy changes the drug without issuing a new prescription, it will reject with NCPDP Reject code: M4 - PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT.
- Package limits will be applied to various package sizes and formulations. This edit prevents incorrect billing of quantities that are not divisible by the package size in whole number increments for the product being dispensed. This edit applies to specific package types and dosage forms. If the Quantity Dispensed divided by the Package Size has a remainder (e.g. is not a whole number) the claim will message the pharmacy with NCPDP Reject code: 55 - Non-Matched Product Package Size. Compounds are exempt from this edit.
- Vancomycin 5-gram and 10-gram vials for injection were previously billed by the milligram. Providers will need to submit the claims by the standard unit of measure: by each (per vial).

### ***Covid-19 Testing at the Pharmacy***

Two types of COVID-19 tests are covered under the pharmacy benefit, the "Swab and Send" and "Point of Care" tests.

- The Pharmacy NPI & Pharmacy Name may be used in the Physician ID & Physician Name fields
- The quantity and days' supply must equal "1"
- Use a Basis of Cost Determination of "15" to indicate free product
- Use Professional Service Code "MA" or "PT" to indicate type of test provided

Professional Services Code Field (440-E5)	Description	Ingredient Cost Submitted Field (409-D9)	Dispensing Fee Paid
MA Medication Administration	Swab and Send Indicates the test has been administered and the kit dispensed to the patient.	\$0.00	\$23.46
PT Perform Laboratory Test	Point of Care Indicates that test analysis has been performed and results interpreted. Includes services as defined above in MA in addition to informing the patient of test results and reporting the results to designated entities when required.	\$0.00	\$28.46*

\*The fee-for-service reimbursement rate for COVID-19 point-of-care testing is \$74.77 for molecular testing and \$40.01 for antigen testing. This reimbursement rate includes an incentive payment of \$28.46 to perform all aspects of the testing process, in addition to payment for the materials utilized to perform testing. **Providers that obtain no-cost testing kits are expected to report this as required on the payer sheet and will be eligible to receive only the incentive payment.**

### ***COVID-19 Testing At Home***

Coverage for At-Home COVID-19 tests without a prescription are allowed for up to a quantity of eight tests per member in a 30-day period. Fee-For-Service will reimburse ingredient cost at the lower of AWP, WAC, or U&C, plus the standard dispensing fee. Pharmacies should bill the at-home COVID-19 test via an electronic NCPDP claim according to the following instructions:

- Submit the claim with the NDC of the product being dispensed
- Input the Pharmacy NPI into the Physician ID field during claim submission
- Dispensing without a prescription requires the use of Submission Clarification Code (SCC) of "42" in field 42Ø-DK to override prescriber validation

### ***Ohio Automated RX Reporting System (OARRS) Prescription Drug Monitoring Program (PDMP) Requirements [Title 19 Section 1944(d)]***

Beginning October 1<sup>st</sup>, 2021 Medicaid providers must check OARRS in accordance with such timing, manner, and form as specified by the State according to OAC 4731-11-11 when prescribing or personally furnishing a reported drug. In the case that the provider is not able to conduct such a check despite a good faith effort:

- (A) The provider must document such good faith effort, including the reasons why the provider was not able to conduct the check; and
- (B) Medicaid may require the provider to submit, upon request, such documentation to the State.

## Section 4: Prospective Drug Utilization Review [OAC 5160-9-04]

Pharmacy providers must perform Prospective Drug Utilization Review (ProDUR) for Medicaid consumers in accordance with Chapter 4729-5 of the Administrative Code. ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening at the time of claim adjudication. The ProDUR system assists the pharmacist in these functions by addressing situations in which potential drug problems may exist to ensure that their patients receive appropriate medications.

Because the ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Change Healthcare recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

The ODM DUR Board approves drug utilization review criteria. Claims may be denied that exceed the established limitations set by this committee. Denials may be overridden by the Change Healthcare Help Desk in cases where medical necessity has been determined.

### 4.1 Therapeutic Edits

#### *Therapeutic Duplication*

When two or more medications from the same therapeutic drug class have the potential to increase the risk of adverse effects are targeted in therapeutic duplication. Currently, the ODM pharmacy program only allows one drug from each of the following drug classes dispensed in any three-week period:

- Antihistamines
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Proton Pump Inhibitors (PPIs)
- Sedative/Hypnotics
- Selective Serotonin Reuptake Inhibitors (SSRIs)

Pharmacy overrides using standard NCPDP intervention and outcome codes will be permitted for these therapeutic duplication edits and should be used only when the pharmacist believes it is clinically appropriate.

#### *Drug-Drug Interaction*

The ODM DUR Board has approved a select list of drug-drug interactions that are classified as having major significance in causing severe harm to patients. When different prescribers are listed on the prescriptions for this select list of severe drug interactions, a rejection will occur requiring the pharmacist to review and submit the appropriate NCPDP DUR codes to override the rejection.

**NOTE:** Anticoagulants and SMZ/TMP will require a pharmacist review regardless if the prescribers are the same or different on the prescriptions.

**Other DUR Edits**

Age, gender, dose and pregnancy edits for therapeutically appropriate and safe medication use, will require prior authorization by calling the Change Healthcare Clinical Call Center and cannot be overridden by the pharmacist.

**4.2 ProDUR Override Codes**

When a prescription rejects due to a ProDUR edit, the pharmacist has the ability to place in override codes after reviewing the claim. The below chart lists the three NCPDP fields required to allow an override and their common values.

NCPDP Field# & Name	Field Values
<b>439-E4</b> <b>Reason for Service Code</b> <b>(Conflict Code)</b>	TD= Therapeutic Duplication ER= Drug Overuse Alert DD= Drug-Drug Interactions DC= Inferred Drug Disease Precaution PG= Drug Pregnancy Alert PA= Drug Age Precaution LD= Low Dose Alert HD= High Dose Alert  NOTE: This code must match the rejection being overridden or the provider will receive a DUR reject error.
<b>440-E5</b> <b>Professional Service Code</b> <b>(Intervention Code)</b>	AS= Patient Assessment CC= Coordination of Care MO= Prescriber Consulted MA= Medication Administration MP= Patient Will Be Monitored MR= Medication Review PO= Patient Consulted PH= Patient Medication History PM= Patient Monitoring RO= Pharmacist Consulted Other Source SW= Literature Search/Review TH= Therapeutic Product Interchange
<b>441-E6</b> <b>Result of Service Code</b> <b>(Outcome Code)</b>	1A= Filled as Is, False Positive 1B= Filled Prescription As Is 1C= Filled with Different Dose 1D= Filled with Different Directions 1E= Filled with Different Drug 1F= Filled with Different Quantity 1G= Filled with Prescriber Approval 1K= Filled with Different Dosage Form 2A= Prescription Not Filled 2B= Not Filled, Directions Clarified 3A= Recommendation Accepted 3B= Recommendation Not Accepted 3C= Discontinued Drug 3D= Regimen Changed 3E= Therapy Changed 3F= Therapy Changed – cost increased acknowledged 3G= Drug Therapy Unchanged

## Section 5: Edits

### 5.1 On-Line Claims Processing Messages

Following an on-line claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a “**Paid**” message will be returned with the ODM allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message.

For rejected claims, the NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. For further assistance, contact Change Healthcare at:

**Technical Call Center**  
**1-877-518-1545**

For specific field requirements, please refer to the Ohio Medicaid NCPDP payer sheet available online at:

The Ohio Medicaid Drug Program: <http://pharmacy.medicaid.ohio.gov/pharmacy-billing-information>

### 5.2 Host System Problems

Occasionally providers may receive a message that indicates their network is having technical problems communicating with Change Healthcare. For assistance, please contact the phone number provided above.

NCPDP	Message	Explanation
90	Host Hung Up	Host disconnected before session completed.
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period. This rejection may indicate an issue originating with the switch vendor.
93	Planned Unavailable	Transmission occurred during scheduled downtime.
99	Host Processing Error	Do not retransmit claims.

## Section 6: Provider Reimbursement [OAC 5160-9-05]

### 6.1 Provider Payment

Pharmacy providers are paid a dispensing fee and a drug ingredient cost on dispensed medications with some exceptions (*refer to section 3.3*). For medications that are subject to a copayment, the amount reimbursed by ODM will be decreased by the amount equal to the copayment that is to be billed to the consumer. Reimbursement for the drug ingredient cost shall be the lesser of the submitted charge or the calculated allowable in accordance with OAC 5160-9-05.:

- No ingredient cost shall be allowed for pandemic vaccine that is provided by the Ohio department of health or other government agency at no cost to the provider.
- For any drug purchased under the 340B program, the ingredient cost will be the 340B ceiling price. If 340B ceiling price is not available, the ingredient cost shall be fifty percent of wholesale acquisition cost (WAC).
- For a clotting factor, the ingredient cost shall be the payment limit shown in the current Medicare Part B drug pricing file, minus the furnishing fee assigned by Medicare Part B. The Medicare part B pricing file is available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>
- For all other ingredients, the Actual Acquisition Cost is the ingredient cost. It shall be the National Average Drug Acquisition Cost (NADAC). If no NADAC has been published by CMS at <https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html>, the ingredient cost shall be the lesser of Wholesale Acquisition Cost (WAC) or Maximum Allowable Cost (MAC).

### 6.2 MAC Pricing

The Maximum Allowable Cost (MAC) has been determined by the federal Department of Health and Human Services for selected drugs. ODM shall not reimburse for these products, in the aggregate, at a rate higher than the Federal Upper Limit (FUL) prices. ODM has established a MAC for additional selected drugs where either bio-equivalency of the drugs has been established or bio-equivalency of the drugs has not been established. Reimbursement for state MAC drugs is an estimate of statewide AAC.

Pharmacy providers may request a review of a MAC price if they are unable to obtain the medication at a reasonable cost. To submit a MAC dispute, please contact the Ohio Medicaid MAC Help Desk at:

**Hours of Operation:** Monday through Friday 8:30AM - 5:00PM

**Phone:** (844) 559-0607

**Fax:** (844) 592-7008

**Email:** [PBA\\_OHSMAC@changehealthcare.com](mailto:PBA_OHSMAC@changehealthcare.com)

**Web site:** <https://pharmacy.medicaid.ohio.gov/help> (Ohio Medicaid MAC Help Desk and MAC Request Form)

### 6.3 Provider Reimbursement Schedule

Contact the ODM Provider Network Management (1-800-686-1516) or log on to the MITS web portal (<https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>) for questions regarding payment and Remittance Advices.

## APPENDIX A: Prior Authorization Forms

Prior authorization forms are available at: <https://pharmacy.medicaid.ohio.gov/prior-authorization>

- **Compound Prior Authorization Form**
- **Hepatitis C Direct Acting Antiviral Prior Authorization form**
- **Omnipod and V-GO Prior Authorization form**
- **Opioid Prior Authorization form**
- **Oral Medication Assisted Treatment of Opioid Use Disorder Prior Authorization Form**
- **Standard Prior Authorization form**
- **Step Therapy Exemption Form**
- **Synagis Prior Authorization form**