Ohio Department of Medicaid

Ohio Medicaid Enterprise System

Fee-for-Service Pharmacy Reference Guide

Single Pharmacy Benefit Manager

October 2023

Version 2.0

Submitted to: Ohio Department of Medicaid (ODM)

Change Index:

Date Published	Date Effective	Section(s) Updated	Description of Change
May 31, 2023	July 1, 2023	Initial Creation	Initial Creation
October 1, 2023	October 1, 2023	1.2.4 Technical Problem Resolution 1.3 Fraud, Waste, and Abuse 4.3.2 Timely Filing Limits 5.2.13 Medicare-Covered Drugs 8.4 Provider Remittance Advice 8.6 Pharmacy Claim Reimbursement Disputes and Resolution	• Added hours of operation • Added hours of operation • Added hyperlink and revised B2 date • Updated language for when member doesn't have Medicare coverage • Updated portal link • Clarification to section heading

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1 INTRODUCTION

Effective October 2022, Gainwell Technologies is the Single Pharmacy Benefit Manager (SPBM) for the Ohio Department of Medicaid (ODM) pharmacy program. Included in the SPBM is the management of Fee-For-Service (FFS) pharmacy claims effective July 1, 2023. Gainwell Technologies uses a computerized point-of-sale (POS) system and requires National Council for Prescription Drug Program (NCPDP) D.0 standards for pharmacy claim transactions.

Pharmacy providers must be enrolled through ODM and have an active status for any dates of service submitted. The system provides such enrolled pharmacies with real-time claim adjudication, including access to member eligibility, drug coverage, pricing, and payment information. The system incorporates prospective drug utilization review (ProDUR) across all enrolled pharmacies.

This manual is intended to provide an overview of pharmacy services for pharmacies enrolled with the Ohio Department of Medicaid (ODM).

Currently, this Pharmacy Reference Guide only applies to FFS and OhioRISE pharmacy claims. This guide does not pertain to managed care and MyCare plans.

1.1 PROGRAM CONTACT INFORMATION

When pharmacy providers require assistance with processing a claim for an Ohio Medicaid member, they may contact the Gainwell Technologies Call Center, which is available 24 hours per day, 7 days per week, except for Thanksgiving Day and Christmas Day.

1.1.1 Help Desk Telephone Numbers

All calls to the Gainwell Technologies Call Centers are recorded and may be monitored for quality assurance and training purposes. By contacting the Gainwell Technologies Call Centers, you agree to these terms.

Table 1 Help Desk Telephone Numbers, Emails, and Hours of Operation

Department	Contact Department for Assistance With	Contact Information	Operating Hours
Gainwell Technologies Technical Help Desk and Technical Prior Authorizations	Claims processing and prior authorization inquiries	Phone: 1-833-491-0344 (TTY 1-833-655-2437) Fax: 1-833-679-5491 OH_MCD_PBM@gainwelltechnologies.com	Daily Available 24 hours per day
Gainwell Technologies	Remittance advice/835 inquiries	OH_MCD_PBM_network@ gainwelltechnologies.com	Monday – Friday

Department	Contact Department for Assistance With	Contact Information	Operating Hours
Network Department			8 am – 5 pm (ET)
Gainwell Technologies Claims Department	Claim reimbursement inquiries	OH_MCD_CLAIMS@gainwelltechnologies.com	Monday – Friday 8 am – 5 pm (ET)
Gainwell Technologies Grievance and Appeals	Prior authorization appeals	OH_MCD_PBM_GA@gainwelltechnologies.com Fax: 1-833-616-4658	Monday – Friday 8 am – 5 pm (ET)
Gainwell Technologies Clinical Prior Authorizations	Prior authorization inquiries	Phone: 1-833-491-0344	Monday – Friday 8 am – 8 pm (ET)
ODM Provider Enrollment/ Revalidation Hotline	Pharmacy enrollment inquiries	Phone: 1-800-686-1516	Monday – Friday 8 am – 4:30 pm (ET)
Ohio Medicaid Consumer Hotline	Medicaid member who has questions about benefits	Phone: 1-800-324-8680 Website: http://ohiomh.com/	Monday – Friday 7am – 8 pm (ET) Saturday 8 am – 5 pm (ET) Voicemail is available at other times with calls returned by the next business day.

Department	Contact Department for Assistance With	Contact Information	Operating Hours
Reporting Fraud, Waste, or Abuse (FWA)	Reporting fraud, waste, or abuse from prescribers, pharmacies, or members	Phone: 1-833-220-9970 OH_MCD_Compliance@gainwelltechnologies.com	Phone: Available 24 hours per day

1.1.2 ODM Website Addresses

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

The Ohio Medicaid Drug Program
https://pharmacy.medicaid.ohio.gov/

The Gainwell Technologies SPBM searchable database of covered drugs
https://spbm.medicaid.ohio.gov/PreferredDrugSearch/NDCSearch

1.1.3 Mailing Addresses

Gainwell Technologies
PO Box 3908
Dublin, OH 43016-0472

1.1.4 Web Portal Address

https://spbm.medicaid.ohio.gov

1.2 SERVICE SUPPORT

1.2.1 Online Certification

Providers must submit claims using the NCPDP version D.0 standard. Claims received in any other format will be denied.

1.2.2 Routine Maintenance Window

Gainwell Technologies conducts routine maintenance on the POS system to implement changes and upgrades and maintain data.

The system may be unavailable for routine maintenance weekly on Sundays from 1-3 a.m. ET. In this event, providers will need to resubmit the claim when the system is available. Claims submitted during this maintenance window may be denied for any of the following:

Table 2 NCPDP Reject Code

NCPDP Reject Code	Message
85	Claim Not Processed
87	Reversal Not Processed
92	System Unavailable/Host Unavailable

1.2.3 Point-of-Sale System Not Available

If, for any reason, the POS system is not available, providers should attempt to reprocess claims when the system is back online. Non-maintenance outages are addressed in Section 7.2 - Host System Problems. The provider's software should have the ability to submit backdated claims to accommodate this eventuality.

1.2.4 Technical Problem Resolution

At times, technical problems unrelated to the member's or provider's eligibility may arise that require in-depth troubleshooting by Gainwell Technologies claims experts, the pharmacies' software vendor or corporate IT desk, or support staff. The Gainwell Technologies Technical Call Center is available 24 hours/day 7 days per week to assist with these or other technical issues at 1-833-491-0344.

1.3 FRAUD, WASTE, AND ABUSE (FWA)

Members, providers, prescribers, and other third parties can report suspected FWA directly to Gainwell Technologies by using Gainwell Technologies' OH SPBM reporting hotline which is available 24 hours/day 7 days per week at1-833-220-9970 or email: OH_MCD_Compliance@gainwelltechnologies.com. Suspected FWA may also be reported directly to the state by calling 1-800-642-2873 or online to the Ohio Attorney General: https://www.ohioattorneygeneral.gov/About-AG/Service-Divisions/Health-Care-Fraud/Report-Medicaid-Fraud.

See Section 2.2.2 for instruction on reporting potential FWA as part of the claims processes.

2 PHARMACY ENROLLMENT

2.1 ODM ENROLLMENT

Pharmacy provider agrees to maintain Ohio Department of Medicaid enrollment at all times while providing covered services to enrollees. Please visit https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx to enroll or update your current enrollment.

2.1.1 Licensure and Certification

The pharmacist-in-charge is required to ensure that staff are actively licensed, registered, certified, or otherwise appropriately credentialed. The pharmacist-in-charge will ensure that staff are supervised (when and as required by law), qualified by education, training, experience to perform their professional duties, act within the scope of their licensure and/or certification, and remain in compliance with all laws.

2.1.2 Information Updates

Information updates will be provided on the Gainwell Technologies website at: https://spbm.medicaid.ohio.gov. Additionally, pharmacy providers may elect to receive email updates when information changes or through the secure portal inbox. Gainwell Technologies will provide notice of changes to this manual.

2.2 AUDITS

The SPBM maintains an ongoing provider quality assurance review, audit, and investigation program as a service to the Ohio Department of Medicaid to ensure providers are complying with the terms of their provider agreement. The SPBM, or the SPBM's audit vendor, may conduct pre and/or post payment audits or claim reviews of pharmacy claims to ensure compliance with all provisions of the provider agreement. All claims are subject to review regardless of whether a claim successfully adjudicates, and the SPBM reserves the right to review any claims. This may include concurrent claims review, onsite audits, or desk audits. Please note, for all audits and/or claim reviews, interest will be calculated pursuant to Ohio Administrative Code (OAC) Section 5160-1-25.

2.2.1 On-Site and Desk Audits

Gainwell Technologies will review pharmacies to evaluate performance. Gainwell Technologies, Ohio Department of Medicaid (ODM), and all regulatory authorities including, but not limited to, the Auditor of State, Health and Human Services Office of the Inspector General, the Centers for Medicare and Medicaid Services, or any subcontractors of the aforementioned shall have the right, at reasonable intervals and during regular business hours, to audit pharmacies' records and may inspect pharmacies' premises, records and operations to ensure that they are adequate to perform the pharmacies' obligations under the agreement. Gainwell Technologies may perform such audits at any time during the term of the Pharmacy Agreement or for a period 10 years from the final date of the Pharmacy Agreement, or from the completion

of any audit, whichever is later pursuant to Ohio Revised Code (ORC) Chapter 117. For prescriptions filled for enrollees who have coverage through Medicare plans, there is no time limit for audits.

For a desk audit, the pharmacy will receive notification of the audit via fax or e-email as a request for documentation. The pharmacy must submit documentation in the time frame specified in the notification letter or the pharmacy will be considered non-compliant. During the desk audit, targeted documentation is requested from the pharmacy and compared to claims information. Desk audits may occur weekly, monthly or quarterly.

For an on-site audit, the authorized SPBM representative visits the pharmacy location or the pharmacy's central location to perform a comprehensive review of selected claims, quality assurance documentation, procedures and credentialing information and documentation. On-site audits are normally scheduled with two weeks prior written notice which can be emailed, mailed, or faxed. The SPBM may or may not opt to give the pharmacy a list of prescriptions in advance of the on-site audit.

2.2.2 Fraud, Waste, and Abuse

If any pharmacy identifies potential FWA during any point of claims processing, please notify Gainwell and send all supporting documentation to: OH_MCD_Compliance@gainwelltechnologies.com.

2.3 Claims Review

Gainwell Technologies performs randomized claims reviews to ensure provider compliance with state and federal laws and all ODM policies as agreed upon in the provider agreement process. During the process of these claims' reviews, pharmacies may be contacted to supply additional documentation related to the ordering, filling, pricing, or delivery of a medication. Such requests for additional documentation should be responded to in a timely fashion in accordance with the timeline listed on the request (typically 10 days).

2.4 Proof of Medication Receipt

Gainwell 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 the 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.

2.5 Patient Counseling

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 OAC 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 (6) years from the date of reimbursement.

3 RIGHTS AND RESPONSIBILITIES

3.1 CONFIDENTIALITY

The Department of Health and Human Services (HHS) Office for Civil Rights enforces:

- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information.
- The HIPAA Security Rule, which sets national standards for the security of electronic protected health information.
- The HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information.
- The confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Gainwell Technologies, ODM, and all enrolled providers are required by law to maintain the privacy of certain confidential healthcare information, known as protected health information (PHI). All enrolled providers and their employers and contractors are expected to abide by all state and federal laws regarding protecting member PHI including, but not limited to, ORC 5160.45 and 42 CFR Part 431 Subpart F and the Health Information Portability and Accountability Act (HIPAA) Privacy Rule 45 CFR Parts 160 and 164.

3.1.1 Reporting a HIPAA Violation

To report a HIPAA violation to Centers for Medicare and Medicaid Services, please navigate to: https://www.hhs.gov/hipaa/filing-a-complaint.

Reporting a HIPAA violation is addressed in Gainwell Technologies' Privacy Complaints Policy (CMPL0025). This policy states:

> "Any Gainwell Technology workforce member who receives a potential privacy complaint or who becomes aware of a potential privacy incident, or an inadvertent disclosure, must immediately report the incident to the Compliance and Ethics Department and the assigned Account Security Officer ("ASO"), using the applicable privacy incident forms and/or systems of record ("Privacy Incident Record"). For additional information regarding reporting potential privacy complaints, incidents, or inadvertent disclosure, please contact: OH_MCD_compliance@gainwelltechnologies.com."

3.2 PHARMACY RIGHTS AND RESPONSIBILITIES

3.2.1 Reporting Fraud and False Claims

Gainwell Technologies has implemented written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) and Section 5162.15 of the Ohio Revised Code, regarding the detection, prevention, and reporting of false claims, and

whistleblower protections for employees who make such claims. All ODM-enrolled pharmacy providers must agree to abide by these policies and to require their employees and subcontractors to comply with these policies. Potential member fraud is reported to ODM through email at: Program_Integrity_County_Referral@medicaid.ohio.gov.

Gainwell Technologies has implemented practices to monitor compliance with provider requirements and take corrective action as needed. Gainwell Technologies will perform reporting activities to support review, monitoring, and auditing efforts for FWA. Reporting activities include billing and payment, drug utilization, provider utilization, geographical radius, monitoring HS-OIG (Health and Human Service Office of Inspector General) and state licensure and exclusion, and corrective action activities. ODM-enrolled providers agree to abide by the federal and state False Claims Acts.

Gainwell Technologies has specific controls in place to prevent and detect potential or suspected fraud, waste, and abuse. Gainwell Technologies conducts data analysis using data-mining tools to prevent, detect, and correct noncompliance and FWA. We utilize payment integrity tools to detect FWA schemes and aberrant patterns and behaviors by members and providers/prescribers, such as:

a. Fraud alerts.
b. Retrospective drug utilization review (RDUR) claim audits.
c. Concurrent DUR claim audits.
d. Member drug abuse audits.
e. Pharmacy audits.

On a quarterly basis, Gainwell Technologies reviews member pharmacy prescriptions and claims for potential FWA issues, such as high quantities of controlled substances, high-cost utilization, multiple prescriber utilization, and multiple pharmacy dispensing.

3.2.2 Reporting Overpayments (OAC 5160-1-19)

All providers are required to report overpayments found to Gainwell Technologies within 60 days of the overpayment. Reported overpayments will be investigated and, if validated, recouped.

3.2.3 Member Unable to Pay Copay

If a member indicates they are not able to afford a copay on a Medicaid-covered service, participating pharmacies cannot refuse provision of services and must provide the medication to the member. The member remains liable for the copayment and the pharmacy may bill the member for the copayment or request payment for a prior uncollected copayment (OAC 5160-1-09).

3.3 Gainwell Technologies Responsibilities

Gainwell Technologies will:

a. Receive claims in its claim adjudication system at the point-of-sale from the pharmacy;
b. Verify that the enrollee is eligible;
c. Process claims;

d. Report whether a claim received through the designated claim adjudication system will be paid, reversed, or denied;
e. If applicable, prepare and distribute remittance advice monthly and mail disbursements within 10 days of the end of a financial cycle to pharmacies or applicable Pharmacy Services Administration Organization (PSAO), when pharmacies utilize the services of a PSAO;
f. Provide access through a toll-free telephone number to a Gainwell Technologies Help Desk, and;
g. Provide processing messages, including drug utilization review messages and covered pharmaceutical information.

3.4 Record Maintenance

All records of prescriptions must comply with federal and state regulations and shall be retained by the provider for a period of ten years from the date of payment of the claim and if an audit is initiated during this time, records must be retained until the audit is resolved.

4 PROGRAM SETUP

4.1 CLAIM FORMAT

Gainwell Technologies complies with all state and federal guidelines governing claim submission and, as such, requires that all electronic claims be submitted in accordance with NCPDP D.0 formatting. Claims received in any other format will be denied.

4.1.1 Point-of-Sale Claims

Claims are first evaluated by an NCPDP vendor, which will perform Strategic National Implementation Process (SNIP) edits to validate that the claim meets the minimum requirements of NCPDP. If the claim fails these edits, it will be denied.

Payer sheets for claims transmission are available at: https://spbm.medicaid.ohio.gov.

The NCPDP transactions that pass validation are then sent to the FI Integration Gateway via the System Integrator. The SPBM claims are loaded to Administrator in an OPEN status and staged for adjudication.

The SPBM NCPDP Claims Submission Process ends when the pharmacy claims are loaded into Administrator, ready for adjudication, and any accepted SPBM transactions have been assigned a unique Internal Control Number (ICN).

4.1.2 Paper Claims

Gainwell Technologies does not accept paper claims of any format.

4.1.3 Web Portal Claims

Enrolled providers can submit claims via the web portal by logging in using their trading partner account information. Once logged in, click on the View Claims icon, and select the appropriate billing provider from the Billing Provider drop-down list, then click the Create Claim button. Once the pertinent claim information has been entered, the claim may be submitted.

All fields submitted will be validated to ensure compliance with NCPDP claims guidelines and claims not meeting requirements will be denied. If the claim is accepted, the claim will be adjudicated in real time and a response returned through the web portal interface.

For a detailed manual on submitting claims via the web portal, see: https://spbm.medicaid.ohio.gov.

4.1.4 Batch Claims

Gainwell Technologies does not accept batch claims transmission of any format.

4.2 TRANSACTION TYPES

NCPDP establishes the following transaction codes for use in claims processing. While each pharmacies' ability to use these transaction types may vary, at a minimum a

pharmacy is required to possess the ability to process original claims and reverse claims (Transaction types B1 and B2, respectively).

4.2.1 Claims Adjudication: Transaction Code B1

This transaction type represents an original claim submission. Gainwell Technologies will return a response to submission of either paid or denied.

4.2.2 Claims Reversal/Void: Transaction Code B2

This transaction type represents a cancellation or withdrawal of an original or rebilled (B1, B3) claim submission. Claim Voids/Reversals can only be submitted for claims which are currently in "Paid" status. To successfully reverse/void a claim, the following data elements must match the original claim:

a. Service Provider ID (201-B1);
b. Prescription number (402-D2);
c. Date of service (date filled) (401-D1), and;
d. NDC (407-D7).

4.2.3 Claims Rebill/Resubmission: Transaction Code B3

This transaction represents an update to a claim that is currently in "Paid" status. A rebilled claim will reverse and resubmit the claim in a single transaction and, as such, must meet the same reversal requirements as listed in Section 4.2.2 above.

4.2.4 Eligibility Verification: Transaction Code E1

This transaction represents only an eligibility inquiry and will return a response verifying member status.

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 believes they have coverage, the pharmacy can submit a cardholder ID or other identifiers such as Social Security Number (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.

4.2.5 Pre-Determination of Benefits: Transaction Code D1

This transaction verifies whether a member is eligible to receive the intended service and, if so, the anticipated reimbursement for the claim. 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.

4.3 NCPDP-Required Data Elements

4.3.1 Processing Information

Table 3 Processing Information

Data Element	Required Value and Format	NCPDP Field ID
Bank Identification Number (BIN)	024251	101-A1
Processor Control Number (PCN)	OHRXPFFS	104-A4
Group number	Not Needed	
Cardholder ID	Member's Medicaid Cardholder Number	302-C2

Gainwell Technologies requires that all claim transactions comply with NCPDP version D.0 standards of billing, regardless of submission pathway. In addition to the processing information above, Gainwell Technologies requires that some fields are populated in order to accurately process claims. For a listing of all required and optional fields, the current vendor spec sheet is available online at: https://spbm.medicaid.ohio.gov/SPContent/DocumentLibrary/Billing%20Instructions.

Please note, the SPBM is also responsible for the pharmacy benefits for members enrolled in managed care. If the incoming pharmacy claim is for a member indicated as having MCP coverage on the date of service, the POS system will deny the claim. Please utilize BIN 024251 and PCN OHRXPROD to bill those managed care pharmacy claims.

4.3.2 Timely Filing Limits (OAC 5160-9-06)

ODM accepts claims for up to 365 days from the date of service. In the event of retroactive eligibility or delayed Third Party Liability (TPL), the Gainwell Technologies Help Desk has the ability to do a manual override for timely filing limits. Otherwise, claims that exceed the prescribed timely filing limit will be denied.

Table 4 Timely Filing Limits

Claim Type	Timely Filing Limit	NCPDP Reject Code
Original Claims **B1 Transactions**	365 days from the date of service on the claim	81 – Claim Too Old
Reversal/Voids **B2 Transactions**	545 days after the date of the original claim's payment	M4 – Prescription/Service Reference Number/Time Limit Exceeded
Rebill/Resubmissions **B3 Transactions**	365 days from the date of service on the claim OR Beyond 365 days if the rebill is within 90 days of the original claim's payment date	81 – Claim Too Old M4 – Prescription/Service Reference Number/Time Limit Exceeded

4.4 Unique Claim Criteria

4.4.1 Original or Resubmission Claims

The POS system will use three NCPDP data elements to identify a unique incoming claim or resubmission (B1/B3):

a. Member ID: NCPDP field #302-C2;
b. Date of Service: NCPDP field #401-D1, and;
c. Product/Service ID: NCPDP field #407-D7.

If the incoming submitted claim (B1/B3) matches the three NCPDP elements to any other non-voided claim for the member, Gainwell Technologies will return NCPDP Reject code: 83 - Duplicate Paid/Captured Claim on the response transaction.

4.4.2 Reversal/Void Claims

The POS system will use four NCPDP data elements to match an incoming reversal (B2) to an existing paid claim.

a. Date of Service: NCPDP field #401-D1;
b. Product/Service ID: NCPDP field #407-D7;
c. Provider ID: NCPDP field #444-E9, and;
d. Prescription/Service Reference Number: NCPDP field #402-D2.

If the incoming submitted reversal (B2) fails to match any one of the four required data elements listed above, it will deny with NCPDP Reject code: 87 – No claim on file to reverse.

4.5 Member Identification Cards

FFS member identification cards can be obtained by requesting from the county department of job and family services, or by obtaining a copy of the notice containing the most recent card through the member self-service portal at benefits.ohio.gov.

4.6 Claims Summary

Claims received will first be passed through a series of checks to validate the billing provider, the member's eligibility, the prescriber's eligibility, and Third-Party Liability (TPL). If the claim fails any of those, it will be denied, and a message will be returned explaining the reason. If it passes, the details of the claim will then be reviewed for compliance with pharmacy policy guidelines, Unified Preferred Drug List (UPDL), prior authorization requirements and more. If any claim denies, a message will be returned explaining the reason and next steps. If the claim passes, a message will be returned indicating that the claim has paid and the amount due to the provider.

4.6.1 Claims Status

The claim status reflected in the secure section of the Gainwell portal will show the following statuses based on when the claim is processed for payment.

Table 5 Claims Status

Pre-financial	Post-financial
Pay or Waitpay	Paid
Deny or Waitdeny	Denied
Reverse or Waitrev	Reversed

5 PROGRAM POLICIES

5.1 340B CLAIMS PROCESSING AND IDENTIFICATION

Claims for drugs purchased through the 340B drug discount program must be identified at the time of the original submission, in accordance with NCPDP standards, by way of both of the following:

a. Submission Clarification Code = 20 (NCPDP field #420-DK), and;
b. Basis of Cost Determination = 08 (NCPDP field #423-DN).

5.2 DISPENSING LIMITS

5.2.1 Days' Supply Limits

Medications dispensed to Ohio Medicaid members may not exceed a 34-day supply for most medications. Medications from drug classes that are prescribed for the maintenance of long-term or chronic conditions may be filled for up to a 102-day supply. The following drug classes may be considered maintenance medications for the purposes of day supply allowances.

Where possible and supported by the UPDL, the drug classes listed below should be filled in their generic form. Brand names, when not required by the UPDL, may be limited to a 34-day supply even when classified as a maintenance medication.

Table 6 Drug Class Examples

Drug Class	Drug Class
Alzheimer's Disease	Hypertension
Analgesic Agents: Gout	Immunosuppressant Agents
Angina	Inhaled Respiratory
Antiarrhythmics	Lipotropics
Anticonvulsants	Mood Stabilizers
Antidepressants	Movement Disorders
Antihistamines	Nasal Preparations
Antipsychotics	Ophthalmic Antihistamines
Benign Prostatic Hyperplasia	Oral Anticoagulants
Blood Formation	Oral Herpes Antiviral Agents
Calcimemetics	Oral Respiratory Agents
Coagulation	Osteoporosis
Corticosteroids	Parkinson's Disease
Diabetes	Phosphate Binders
Diabetic Supplies	Potassium Agents
Diuretics	Prenatal Vitamins
Estrogenic/Hormonal Agents	Supplements
Gastrointestinal Agents	Thrombosis Agents
Genitourinary Other Agents	Thyroid
Heart Failure	Vitamin D Analogs
HIV Antiviral Drugs	Vitamins

Claims that exceed the day supply limit of 34 or 102 days, respectively, may be denied.

5.2.2 Quantity Limits

When clinically appropriate, Gainwell Technologies, in consultation with ODM, may establish daily or monthly limits to ensure that medications are used and prescribed in accordance with FDA approvals and patient safety guidelines. These limitations may be established regardless of the UPDL status of the medication in question and include, but are not limited to:

1. Limitations on the dose allowed per day.
2. Limitations on the duration allowed for the medication.
3. Limitations on the total number of prescriptions allowed in a time frame.
4. Limitations on the total equivalent dose of therapeutically similar products.

Claims received in excess of the established limitations will be denied and may be overridden when appropriate clinical justification is provided though a prior authorization.

For a complete listing of established quantity limitations, please refer to: https://spbm.medicaid.ohio.gov/SPContent/DocumentLibrary/UPDL.

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.

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.

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.

5.2.3 Date Written

Ohio Admin. Code 4729:5-5-10; Ohio Admin. Code 4729:5-5-15

a. For the first fill for non-opioid DEA Schedule 2 medications, the Date of Service (NCPDP field #401-D1) must be within 6 months of the date written (NCPDP field #414-DE) on the prescription. For opioid-type DEA Schedule 2 medications, the Date of Service must be within 14 days of the date written on the prescription. No refills are allowed on any DEA Schedule 2 medications.
b. The date of service for subsequent fills must be within 366 days from the date written
    - Partial fills of any DEA Schedule 2 medication are allowed for members who are terminally ill or residing in a long-term care (LTC) facility, or when requested by the member or prescriber so long as the total quantity dispensed does not exceed the original quantity written. The remaining portion of partially filled DEA Schedule 2 medications must be dispensed within thirty (30) days of original date written.
c. For all refills of DEA Schedule 3 or 4 medications, the Date of Service (NCPDP field #401-D1) must be within 6 months of the Date Written (NCPDP field #414-DE) on the prescription and may be refilled a maximum of 5 additional times after

the initial fill. Refills of DEA Schedule 5 medication, like non-controlled medications, may be refilled up to one year from the date written.

Any claims received exceeding these guidelines will deny and return NCPDP Reject Code 73 – TOO OLD TO REFILL.

5.2.4 Refills

All refills must be dispensed in accordance with State and Federal requirements. Gainwell Technologies requires that most of the dispensed medication be utilized before a refill will be paid. Reject code 79 is the “Refill Too Soon” rejection edit. For the purposes of this edit, a refill is defined as any fill of the same medication, strength, and daily dose, regardless of the Prescription Number or Fill Number submitted on the claim. The refill rate 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 prescription 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 a new prescription has been issued. The pharmacy will receive the NCPDP Reject code: 79 – Refill Too Soon. 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#42Ø-DK). The dosage (quantity/days’ supply) on the submitted claim MUST be greater than the previous claim it is denying against. This override will NOT be available for controlled substances.

Thresholds for the early refill will be determined based on the DEA Schedule of the medication:

Table 7 DEA Schedule

DEA Schedule	Early Refill Threshold
No schedule	80% utilization required
Schedule 2-5	90% utilization required

If the required threshold is not exhausted upon an attempt to fill the same medication, dosage, and quantity per day, the claim will be denied. If a new prescription has been issued by the prescriber that requires increased dosing frequency, the existing prescription must be utilized until the days’ supply percent threshold has been met, calculated using the increased dosing frequency.

Denials may be overridden at the discretion of Gainwell Technologies for the following documented reasons:

a. Previous supply was lost, stolen, or destroyed. Gainwell Technologies, in consultation with ODM, may limit the number of instances denials may be overridden or may request additional documentation before an override is authorized;
b. Previous claim was submitted with wrong days’ supply;
c. Vacation or travel;

d. Multiple supplies of the same medication are needed, and the packaging of the medication is such that it cannot be broken into multiple containers to accomplish this. For example, to allow rescue inhalers to be kept in a school or workshop setting;
e. Hospital or police kept the medication;
f. Children in foster care removed from home to placement;
g. Brand or generic was ineffective, and the patient was switched to generic or brand, or;
h. Synchronization fills as outlined below in Section 5.2.6.
i. Readmission into a long-term care facility
j. Claims from long-term care pharmacies for emergency kits/emergency boxes

5.2.5 Automatic Refills

Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules, and regulations. Automatic refills are not allowed. All prescription refills shall be initiated by a request from the prescriber, member, or other person acting as an agent of the member. In the event the member is residing in a long-term care facility or other institution, a nurse or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refill.

5.2.6 Synchronization Fills

Ohio Rev. Code 5164.7511

Medication synchronization (Med Sync) means a pharmacy synchronizes the filling or refilling of prescriptions in such a way that allows a member's routine medications to be obtained on the same date each month. To accomplish this, Gainwell Technologies may authorize a single early refill of no more than 29 days' supply. Re-synchronization will not be allowed except in cases of dose change.

Synchronization fills for Medicaid members are allowed in the event that all of the following conditions are met:

a. The recipient elects to participate in medication synchronization, and;
b. The recipient, the prescriber, and pharmacy participating in the Medicaid program agree that medication synchronization is in the best interest of the recipient, and;
c. The medication(s) to be included in the synchronization meets the following requirements:
    1. Covered by ODM;
    2. Considered a maintenance medication and be of such a drug class that refills are allowable;
    3. Satisfy all relevant prior authorization criteria;
    4. Remain in compliance with all applicable quantity limits, dose optimization requirements, or other requirements for the medication in question;
    5. Not have special handling or sourcing needs that require a single, designated pharmacy to fill, or refill the prescription;
    6. Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization, and;
    7. Not be a DEA Schedule 2 controlled substance, opioid analgesic, or benzodiazepine.

Medications eligible for Med Sync are those allowed to be filled for a day supply of 102 days. The pharmacy will need to submit a Submission Clarification Code (NCPDP field #42Ø-DK) 61 to indicate medication synchronization.

5.2.7 Partial Fills

Gainwell Technologies will cover partial and completion fills where appropriate. If the member does not return to receive the remainder of the partial fill, the partial fill should be reversed and rebilled as a completed prescription accurately reflecting the amount dispensed.

5.2.8 Initial Partial Fill

To bill a partial fill prescription, a value “P” should be submitted 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).

Ingredient cost will be calculated on the actual amount dispensed in the partial fill. The full dispensing fee will be paid on the initial partial fill only. 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 partial fills does not exceed the intended quantity and days’ supply.

Partial fills are still subject to all TPL edits, prior authorization requirements, and applicable limitations.

5.2.9 Completion Fill

To bill a completion fill, a value of “C” should be submitted in the Dispensing Status (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). 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.

Completion fills are still subject to all TPL edits, prior authorization requirements, and applicable limitations.

5.2.10 DAW and Generic Substitution Policy

Drugs 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). While ODM encourages generic drug use, there may be instances where brand medications are preferred over a generic medication. In these instances, pharmacies will need to submit a DAW 9 to have the claim process appropriately. The following DAW codes are accepted:

Table 8 Accepted DAW Code Values

Value	Value Meaning
0	Not Product Selection Indicated
1	Substitution Not Allowed by Prescriber
4	Substitution Allowed-Generic Drug Not in Stock
5	Substitution Allowed-Brand Drug Dispensed as a Generic NOTE: Paid at lowest generic rate
8	Substitution Allowed-Generic Drug Not Available in Marketplace
9	Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed

5.2.11 Drug Coverage

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

5.2.12 Medications Not Covered (OAC 5160-9-03)

Drugs that fall into one of the following categories are non-covered by ODM:

a. Drugs for the treatment of obesity;
b. Drugs for the treatment of infertility;
c. Drugs for the treatment of erectile dysfunction;
d. DESI (Drug Efficacy Study Implementation) drugs or drugs that may have been determined to be identical, similar, or related;
e. Drugs that are covered or are eligible to be covered by Medicare part D, when prescribed for a member who is eligible for Medicare, unless Medicaid coverage is for a dual eligible as designated in the subsequent paragraphs;
f. Over-the-counter drugs that are not listed at: https://spbm.medicaid.ohio.gov; in accordance with OAC 5160-9-03;
g. Drugs being used for indications not approved by the Food and Drug Administration unless there is compelling clinical evidence to support the experimental use, or;
h. Drugs provided by sanctioned providers.

5.2.13 Medicare-Covered Drugs (OAC 5160-9-03; 5160-9-06)

Gainwell Technologies 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 member 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 member is eligible for Part D or has Part A or Part B on the claim Date of Service, then it will deny with NCPDP Reject code: 41 – PART D SERVICE – BILL MEDICARE.

The Gainwell Technologies Help Desk will NOT override a denial if the member is identified as a Medicare beneficiary. If the member indicates that he or she does not

have Medicare, the Gainwell Help Desk agent will assist the member. The Help Desk agent will contact Medicare along with the member to verify coverage. If the member does not have active Medicare coverage, the member's eligibility will be updated within the Gainwell system. If the member does have active Medicare coverage, the Gainwell Help Desk agent will assist the pharmacy with claim submission. In the event the member is in transition to receive a Medicare Part D plan, the Gainwell Help Desk will assist the member with applying for Limited Income Net Program (LI-Net).

5.2.14 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 members 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: https://spbm.medicaid.ohio.gov/PreferredDrugSearch/NDCSearch.

5.3 Member Payment Information

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

Table 9 Copayments

Description	Copayment Amount
Medications the 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

5.3.1 Copayment Exemptions

Medications administered to a member 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 12-month post-partum period which begins the last day of pregnancy;

- Persons receiving hospice care or identified as breast and cervical cancer patients;
- Living arrangement is in a nursing home or intermediate care facility for members with intellectual disabilities;
- The prescription is for family planning (contraceptives).

Contact the Gainwell Technologies Help Desk at 1-833-491-0344 for an appropriate override if the member 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 (Pregnancy) 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.

5.3.2 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 the copayment charged is the highest single copayment.

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

Limited equipment and supplies as outlined in OAC 5160-9-02 are covered through the pharmacy program when billed by a pharmacy provider. These supplies should be billed using the NDC or UPS on the package through the pharmacy POS claim system.

DME/DMS claims submitted to Gainwell Technologies for services not listed in OAC 5160-9-02 will be denied. Equipment and supplies not listed in OAC 5160-9-02 including enteral nutrition products, should be billed as DME.

DME claims for Medicaid members 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.

5.4 PRIOR AUTHORIZATION

Prior authorization is the process of obtaining additional information from the prescriber of a medication or service for the purpose of ensuring eligibility, benefit coverage, medical necessity, location, and appropriateness of services.
Prior authorization requests are accepted via toll-free telephone, facsimile, web portal, or mail.

Table 10 Prior Authorization Contact Information

Prior authorization phone number	1-833-491-0344
Prior authorization fax number	1-833-679-5491

Prior authorization web portal	https://spbm.medicaid.ohio.gov
Prior authorization mail address	PO BOX 3908 Dublin, OH 43016-0472

Requests are submitted utilizing prior authorization forms specified by ODM, which are available via the Gainwell Technologies public portal located at: https://spbm.medicaid.ohio.gov under “Reference Material” then “Useful Links” and then “Forms”, or fax-on-demand.

In accordance with OAC 5160-9-03 as applicable, only the prescribing provider or a member of the prescribing provider’s staff may request prior authorization.

Prior authorization requests that contain sufficient information upon which to render a determination will be completed within 24 hours of receipt of the request (including provider and member notification of the decision) in accordance with Section 1927 of the Social Security Act.

Prior authorization requests containing insufficient information to render a determination will be worked by the Gainwell Technologies Clinical Help Desk. The Clinical Help Desk will outreach to the prescribing provider to obtain the missing information needed to render a decision within 24 hours. If the prescriber does not supply the required information within 72 hours after outreach from the Gainwell Technologies Clinical Team, a denied decision will be assigned to the request. 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. An edit override is required to process these emergency supplies by entering a 99 in submission clarification code (420-DK). Do not enter a days’ supply larger than 3. Controlled substances, partial claims, and members assigned to a Coordinated Services Program (CSP) are excluded from this override process. The Gainwell Technologies Clinical Help Desk is accessible at 1-833-491-0344 from 8 a.m. to 8 p.m. (ET) Monday through Friday excluding Thanksgiving and Christmas Day – except for downtime approved in advance by ODM.

5.4.1 Grievance and Appeals (G&A)

Upon denial of a prior authorization or any other adverse benefit determination, Gainwell will provide a written notice to both the member and provider informing them of both the determination and their appeals rights.
Members must exhaust Gainwell Technologies’ appeals process prior to filing a state hearing request as described in OAC 5160-26-08.4. Grievances and appeals may be initiated by contacting the Gainwell Clinical Help Desk. Grievance and appeals submissions from both members and prescribers are accepted via toll-free telephone, facsimile, web portal, or standard mail.

Table 11 Grievance and Appeals Contact Information

G&A telephone number	1-833-491-0344

G&A fax	1-833-616-4658
Web portal	https://spbm.medicaid.ohio.gov
G&A mail address	PO BOX 3908 Dublin, OH 43016-0472

5.5 COORDINATION OF BENEFITS (COB)

Ohio Admin Code. 5160-1-08; 5160-1-05; 5160-1-60

5.5.1 Definitions

- "Coordination of benefits (COB)" means the process of determining which health plan or insurance policy will pay first or determining the payment obligations of each health plan, medical insurance policy, or third-party resource when two or more health plans, insurance policies, or third-party resources cover the same benefits for a Medicaid-covered member.
- "Coordination of benefits claim (COB claim)" means any claim that meets either the definition of third-party claims or the definition of Medicare crossover claim.
- "Explanation of benefits (EOB)" or "remittance advice" means the information sent to providers or plan beneficiaries (covered members) by any other third-party payer, Medicare, or Medicaid to explain the adjudication of the claim.
- Medicare benefits have the same meaning as in OAC 5160-1-05.
- "Third party (TP)" has the same meaning as in Section 5160.35 of the Revised Code. Third-party benefit means any healthcare service available to members through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the third-party payer (TPP) or in part the obligation of the member, the third-party payer, or Medicaid (examples of a third-party benefit include private health or accidental insurance, Medicare, CHAMPUS, or worker's compensation).
- "Third-party claim" means any claim submitted to the Ohio Department of Medicaid (ODM) for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third-party claims by ODM:
    - Any claim received by ODM that shows no prior payment by a TPP but ODM's records indicate the Medicaid-covered member has third-party benefits, and;
    - Any claim received by ODM that shows no prior payment by a TPP but the provider's records indicate the Medicaid covered member has third party benefits.
- "Third-party liability" (TPL) means the payment obligations of the third-party payer for healthcare services rendered to eligible Medicaid covered members when the member also has third-party benefits.
- "Third-party payer" (TPP) means an entity, other than the Medicaid or Medicare programs, responsible for adjudicating and paying claims for third-party benefits rendered to an eligible Medicaid-covered member.

5.5.2 TPL Billing Instructions

The TPL denial can be overridden through prior authorization. The pharmacy provider can also call the Help Desk if there are questions regarding TPL.

If the provider determines that the member 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

Form: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM06614fillx.pdf

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

5.5.3 COB Claims Submission

When submitting COB claims, the following information is required.

a. Other Payer ID and Qualifier (NCPDP field #340-7C and 339-6C);
b. 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;
c. When OCC= "4", the Other Payer Amount Paid cannot be greater than $0;
d. 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;
e. 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, and;
f. Other Payer Reject Code (NCPDP field #472-6E): The Other Payer Reject Code is required when the OCC= 3.

5.5.4 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:

Table 12 Other Coverage Codes

Code	Description
0	**Not specified** Code is used to document that the pharmacy cannot verify the availability of additional insurance coverage beyond the primary insurance. An OCC of 0 can only be used on the patient's primary insurance.
1	**No other coverage identified** Code is used to document that the pharmacy has verified that there is no additional insurance coverage available for this patient.
2	**Other coverage exists-payment collected** Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received.

Code	Description
3	**Other coverage billed-claim not covered** 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.
4	**Other coverage exists-payment not collected** 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.

5.6 Long-Term Care (LTC) Claims

Select over-the-counter (OTC) drugs are payable to the pharmacy when dispensed to members residing in a nursing facility. OTC medications are the responsibility of the facility and reimbursed through the facility per diem fee. This applies only to residents of nursing facilities (NF), and not to residents of intermediate care facilities for members with intellectual disabilities (ICF-IIDs).The following drug classes that contain OTC drugs are NOT payable through POS:

a. Analgesics, including urinary analgesics;
b. Compounding vehicles and bulk chemicals;
c. Cough and cold preparations and antihistamines;
d. Ear preparations;
e. Gastrointestinal agents (except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide);
f. Hemorrhoidal preparations;
g. Nasal preparations (except nasal corticosteroids);
h. Ophthalmic agents (except antihistamines);
i. Saliva substitutes;
j. Sedatives;
k. Topical agents (except antifungal and acne preparations), or;
l. 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. One dispensing fee per month per medication will be provided, regardless of the number of fills of that medication.

If the pharmacy has knowledge that the member does not reside in a long-term care facility, the pharmacy should call Gainwell Technologies at 1-833-491-0344 to request an override. The member or member's representative should be advised to have their Medicaid eligibility caseworker change the living arrangement in the eligibility record.

5.7 Coordinated Services Program (CSP) (OAC 5160-20-01)

"Coordinated services program" (CSP) means a program that requires a member to obtain services related to the reason for enrollment from an assigned provider. A member enrolled in CSP is eligible for all medically necessary services covered by Medicaid. Enrollment for this program is determined by Gainwell Technologies and the Ohio Department of Medicaid. A list of frequently asked questions (FAQ) for members

can be found by navigating to https://ohiomh.com/resources/coordinatedservicesprogramfaq.

5.7.1 Initial Assignment

a) A member enrolled in CSP may request an assigned provider within 30 days of the mailing date on the initial enrollment notification. This provider will serve as the member's assigned provider. The assigned provider must be enrolled with ODM unless otherwise permitted by ODM.
b) Gainwell Technologies and the Ohio Department of Medicaid will select an assigned provider for the member for any of the following reasons:
    i) The member does not select an assigned provider within 30 days of the mailing date on the initial enrollment notification;
    ii) The member's selected assigned provider is denied by ODM or by Gainwell Technologies , or;
    iii) The selected assigned provider is unwilling or unable to accept the member.

5.7.2 Changing an Assigned Provider

a) A member may request to change, or Gainwell Technologies and the Ohio Department of Medicaid may require an alternative selection of an assigned provider, under the following circumstances:
    i) The assigned provider's office is no longer accessible to the member for any of the following reasons:
        (1) The assigned provider's office has relocated or closed;
        (2) The member has moved or is unable to travel to the provider;
        (3) The assigned provider is no longer an eligible provider;
        (4) The assigned provider chooses not to provide services to the member, or;
        (5) The member transfers from the fee-for-service program to an MCO or from an MCO to the fee-for-service program.
    ii) The medical needs of the member require assignment of a provider with a different specialty.
b) If the Ohio Department of Medicaid denies the member's request to change the assigned provider, the department shall notify the member by issuing the "Notice of Denial of Assigned Provider or Pharmacy in the Coordinated Services Program (CSP)" (ODM 01718, 1/2022) in accordance with division 5101:6 of the Administrative Code.

5.8 COMPOUNDS

Compounds 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. These denied claims 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 deny for

reasons other than product coverage (such as refill too soon, duplicates, etc.) The use of SCC 08 will result in no reimbursement for the noncovered product.

Payable active pharmaceutical compounding ingredients and excipients can be located at: https://spbm.medicaid.ohio.gov under “Reference Material”, then “Unified Preferred Drug List”. All compound claims should be submitted with a compound code (NCPDP field #4Ø6-D6) = 2.

5.8.1 Sterile compounds

Sterile compounds will have a dispensing fee based on days of supply. This dispensing fee can be found in Section 8.2 - Provider Dispensing Fees. Sterile compounds are limited to a seven-day supply per claim.
In addition to a compound code = 2, sterile compounds should be submitted with a Compound Type (NCPDP field #996-G1) = 99, and the applicable SNOMED CT route of administration code in Route of Administration segment (NDPCP field #995-E2). Valid SNOMED CT route of administration codes for sterile compounding can be found in the following table.

Table 13 Route of Administration Codes

SNOMED CT Code	Route of Administration
424109004	Injection route
429817007	Interstitial route
419396008	Intraabdominal route
372458006	Intraamniotic route
58100008	Intra-arterial route
12130007	Intra-articular route
404819002	Intrabiliary route
419778001	Intrabronchial route
372459003	Intrabursal route
418821007	Intracameral route
372460008	Intracardiac route
418331006	Intracartilaginous route
372461007	Intracavernous route
420719007	Intracerebroventricular route
372462000	Intracervical route

SNOMED CT Code	Route of Administration
418892005	Intracisternal route
418608002	Intracorneal route
418287000	Intracoronal route
372463005	Intracoronary route
418987007	Intracranial route
372464004	Intradermal route
372465003	Intradiscal route
417989007	Intraductal route
418887008	Intraduodenal route
89947002	Intraepithelial route
372466002	Intralesional route
37737002	Intraluminal route
372467006	Intralymphatic route
60213007	Intramedullary route
78421000	Intramuscular route
418133000	Intramyometrial route
372468001	Intraocular route
417255000	Intraosseous route
419631009	Intraovarian route
38239002	Intraperitoneal route
372469009	Intrapleural route
419810008	Intraprostatic route
420201002	Intrapulmonary route
419231003	Intrasinal route
418418000	Intraspinal route
372470005	Intrasternal route

SNOMED CT Code	Route of Administration
418877009	Intrasynovial route
418586008	Intratendinous route
418947002	Intratesticular route
72607000	Intrathecal route
417950001	Intrathoracic route
404818005	Intratracheal route
418091004	Intratympanic route
62226000	Intrauterine route
418114005	Intravenous central route
419993007	Intravenous peripheral route
404817000	Intravenous piggyback route
404816009	Intravenous push route
47625008	Intravenous route
420287000	Intraventricular route - cardiac
372471009	Intravesical route
418401004	Intravitreal route
54485002	Ophthalmic route

5.8.2 Total Parenteral Nutrition (TPN)

TPNs will have a dispensing fee based on days of supply. This dispensing fee can be found in Section 8.2 - Provider Dispensing Fees. TPNs are limited to one claim per day and a 10-day supply per claim and must include an amino acid or lipid emulsion.

In addition to a compound code = 2, compounded TPNs should be submitted with a Compound Type (NCPDP field #996-G1) = 05.

5.9 Vaccine and Medication Administration

Pharmacies may bill for administration of seasonal influenza vaccine from June 1-May 31 of the following year for each influenza season. Payment for influenza vaccine administration will be made to pharmacies only for Medicaid members who do not reside in a long-term care facility (LTCF) and who are not eligible for Medicare. Pandemic influenza vaccine and other immunizations recommended by the Advisory

Committee on Immunization Practices (ACIP) are covered when administered to an adult over the age of 18 by a pharmacy provider in accordance with ORC 4729.41. Immunizations for members 18 years of age or younger may be covered under the pharmacy benefit only if they are not covered by the Vaccines for Children (VFC) program and are administered in accordance with ORC 4729.41.

The 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 will only be provided an administration fee. Reimbursement for vaccines will include product cost and an administration fee. No dispensing fee will be paid when the administration fee is billed.

COVID-19 vaccines are reimbursed at the rates specified in the "Provider-Administered Pharmaceuticals" fee schedule located at: https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates.

Administration Fees

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

Table 14 Administration Fees for Non-COVID Vaccines

Category	Administration Fee
Vaccine in LTCF	See Provider Dispensing Fees (Section 8.2)
Influenza vaccine administered at the pharmacy	$19.35 administration fee
Other pediatric or adult immunizations pursuant to ORC 4729.41	$19.35 administration fee

Claim Submission for Administration at the Pharmacy

Medicaid will pay an administration fee for vaccinations when administered at the pharmacy. 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 member is in Medicare, has Part A, Part B or is Part D eligible, they will not be eligible for vaccines. Any claim submitted on a Medicare member will deny with the NCPDP Reject code: 41 – Submit Bill to Other Processor or Primary Payer – Submit to Medicare.

LTCF (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 or intermediate care facilities. Otherwise, these services will be reimbursed as physician services. Additional vaccines are covered for this patient population and receive a regular dispensing fee when administered by LTCF staff.

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

Medication Administration

Pharmacies may bill for administration of drugs as outlined in OAC 4729:1-3-03.

Reimbursement for these products will be limited to an administration fee plus an ingredient cost. No dispensing fee will be paid when the administration fee is billed.

Administration Fees

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

Table 15 Administration Fees

Category	Administration Fee
Patient resides in LTCF	See Provider Dispensing Fees (Section 8.2)
Product administered at the pharmacy	$19.35 administration fee

Claim Submission for Administration at the Pharmacy

Medicaid will pay up to an 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**.

5.9.1 COVID-19 Testing

At-home tests

At-home COVID-19 test kits are covered under the pharmacy benefit without a prescription and reimbursed using the pricing logic described in Section 8.3 - Provider Payment. Claims for at-home COVID-19 test kits should be submitted as a standard electronic NCPDP claim, using the Pharmacy NPI as the prescriber. The dispensing of these items without a prescription requires the use of Submission Clarification Code of 42 in field 420-DK to override prescriber validation. A limit of eight tests per member per month will apply in accordance with federal guidance.

Point-of-care tests

Pharmacies are responsible for ensuring that testing complies with all state and federal laws, regulations, and guidance around testing activity (e.g., CLIA certification/waiver, ODH testing guidance, etc.). Pharmacies also are responsible for ensuring proper notification of testing results to the appropriate entities.
Pharmacies may bill for COVID-19 diagnostic point-of-care testing using any FDA-authorized testing platforms. This includes both antigen and molecular diagnostic assays.

Table 16 Administration Fees for COVID Testing

Professional Service Code Field (440-E5)	Description	Ingredient Cost Submitted Field (409-D9)	Dispensing Fee Paid
MA **Medication Administration**	**Swab and Send** Indicates that 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 the 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 to designated entities when required.	$0.00	$28.46*

*The 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.

Providers that obtain no-cost testing kits are expected to indicate this on the NCPDP claim with a Basis of Cost code of “15” and will be eligible to receive only the incentive payment. Quantity and days’ supply should be “1” and the pharmacy name and NPI can be used in place of a prescriber name and NPI for billing.

5.10 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.

5.11 Prescriber Validation

During adjudication, Gainwell Technologies will validate that prescribers are enrolled with the Ohio Department of Medicaid.

5.11.1 Psychiatry Exemption

Applicable for: CNS Agents; Antidepressants

Prescribers (as identified below) are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred drug, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

Prescribers are defined as:

Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.

Applicable for: CNS Agents; Atypical Antipsychotics

Prescribers (as identified below) are exempt from prior authorization of any non-preferred second-generation antipsychotic, or step therapy of any preferred drug, in the standard tablet/capsule and long-acting injectable dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

Prescribers are defined as:

Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.

5.12 Requirement for Tamper-Resistant Prescription Forms

All written prescriptions billed to Medicaid must be on tamper-resistant forms per OAC 5160-9-06. This includes written prescriptions when ODM is not the primary payer and pays only a portion of the claim. To be considered tamper-resistant a prescription form must contain all three of the following tamper-resistant characteristics.

Table 17 Tamper-Resistant Prescription Pad Requirements

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	• Text that appears when photocopied or scanned (e.g., “void” or “illegal”) • Microprint borders that cannot be copied
2. One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	• Erasure or use of solvents will discolor background • Check-off boxes to indicate the quantity prescribed (e.g.,1-24, 25 -49, 50-74, etc.)
3. One of more features designed to prevent the use of counterfeit prescription forms	• Thermochromic ink • High security watermark • Sequentially numbered • Duplicate or triplicate blanks

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

- Payment for prescriptions made by the SPBM for managed care claims
- 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
- Order for medication administered in a long-term care facility, provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a long-term care facility resident is considered tamper-resistant if the patient does not have the opportunity to handle the written order.

5.12.1 Emergency Fill of Non-Tamper Resistant Prescriptions

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 judgement 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.

5.12.2 Presumptive Eligibility

Members 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 the date of issuance, pharmacy providers must verify eligibility in the POS system. Pharmacy providers may contact the Gainwell Technologies Help Desk to assist with verifying eligibility.

5.12.3 Retroactive Eligibility

If a member 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 by phone, prior to billing the claim to ODM.

5.13 MISCELLANEOUS

Miscellaneous 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 deny with NCPDP Reject code: **33 - M/I Prescription Origin Code.**
- 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 deny 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 - Nonmatched Product Package Size. Compounds are exempt from this edit.

6 DRUG UTILIZATION REVIEW

Ohio pharmacy law (OAC § 4729-5-20) requires that all pharmacists perform Prospective Drug Utilization Review (ProDUR) counseling services to all patients prior to dispensation of any medication. Gainwell Technologies utilizes a real-time, web-based POS system to exchange electronic information with pharmacies to assist pharmacies with the ProDUR requirements.

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.

In accordance with OAC 4729:5-5-08, providers should check the PDMP as required.

6.1 PRODUR THERAPEUTIC EDITS (OAC 5160-9-04)

Pharmacy providers must perform Prospective Drug Utilization Review (ProDUR) for Medicaid members in accordance with Chapter 4729-5 of the Administrative Code. 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. Gainwell Technologies recognizes that the pharmacist uses their education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing their professional duties.

Drug utilization criteria may be reviewed and approved by a DUR Board, ODM, and/or ODM's Pharmacy and Therapeutics Committee. Claims may be denied that exceed the established limitations set by this board, committee and/or ODM. Denials may be overridden by the Gainwell Technologies Help Desk in cases where medical necessity has been determined.

Age, dose, disease, and pregnancy edits for therapeutically appropriate and safe medication use will also generate warning messages or result in a rejection requiring appropriate NCPDP DUR codes or a call to the Gainwell Technologies Help Desk to override the denial.

6.1.1 Therapeutic Duplication

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

6.1.2 Drug-Drug Interaction

Most drug-drug interaction notifications are derived from First Databank, ODM, and Gainwell Technologies-supported information. The DUR Board, ODM, and Gainwell

Technologies also identify a select list of drug-drug interactions that are classified as having major significance in causing severe harm to patients. This select list will generate a claim denial requiring the pharmacist to review and submit the appropriate NCPDP DUR codes to override the denial or in rare circumstances a call to the Gainwell Technologies Help Desk.

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

6.1.3 ProDUR Override Codes

Table 18 ProDUR Override Codes

Field Name	NCPDP Field Number	Allowable Values
Reason for Service Code (Conflict Code) **NOTE: This code must match the denial received on the claim in order to bypass the error.**	439-E4	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
Professional Service Code (Intervention Code)	440-E5	AS – Patient Assessment CC – Coordination of Care M0 – Prescriber consulted MA – Medication Administration MP – Patient will be monitored MR – Medication Review P0 – Patient consulted PH – Patient Medication History PM – Patient Monitoring PT – Perform Laboratory Test R0 – Pharmacist consulted other source SW – Literature Search/Review TH – Therapeutic Product Interchange
Result of Service Code (Outcome Code)	441-E6	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

Field Name	NCPDP Field Number	Allowable Values
		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

6.1.4 RetroDUR

Retrospective DUR (RetroDUR) evaluates patterns of drug therapy on medications already dispensed to the patient. Interventions are aimed at patients who are at risk for a drug-related problem such as drug-induced illness, potential drug overutilization, and medication misuse. There is also monitoring of prescribing activities to ensure patients are receiving appropriate care.

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

Beginning October 1st, 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.

7 EDITS

7.1 ONLINE CLAIMS PROCESSING MESSAGES

Following an online 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 denied will also return an NCPDP message. Gainwell Technologies has a responsibility to adjudicate claims with a maximum response time of no longer than one second. For denied claims, the NCPDP error code is returned with an NCPDP message, along with a returned text string that provides the pharmacy with additional information in order to rectify the error, as needed. Where applicable, the NCPDP field that should be checked is referenced. For further assistance, contact Gainwell Technologies Technical Call Center at 1-833-491-0344.

For specific field requirements, please refer to the ODM NCPDP FFS Vendor Spec Sheet available online at: https://spbm.medicaid.ohio.gov located under “Reference Material”, “Useful Links”, then “Billing Information”.

7.2 HOST SYSTEM PROBLEMS

The Gainwell Technologies SPBM system may be unavailable for routine maintenance weekly on Sundays from 1-3 a.m. ET. While Gainwell Technologies makes every effort to keep the POS system available at all times outside of this window, technical issues may arise. During such unplanned outages, Gainwell Technologies will post a notice on the provider web portal.

In the event of an unplanned outage, providers may see one of the following NCPDP responses when submitting claims to Gainwell Technologies. In this event, providers will need to resubmit the claim when the system is available.

Table 19 NCPDP Reject Codes

NCPDP Reject Code	Message
85	Claim Not Processed
87	Reversal Not Processed
92	System Unavailable/Host Unavailable

8 PROVIDER REIMBURSEMENT

8.1 INGREDIENT COST

Pharmacy providers are paid a dispensing fee and a drug ingredient cost on dispensed medication with some exceptions (*refer to section 8.2*), as determined by the claim's date of service. 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 member. 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 pharmacy.

For any drug purchased under the 340B program, the ingredient cost will be the lesser of the submitted ingredient costs or fifty percent of wholesale acquisition cost (WAC). If no WAC exists, then pay at lesser of submitted ingredient cost or Ohio Actual Acquisition Cost (OAAC).

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.

For all other ingredients, the ingredient cost 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 submitted usual and customary (UAC), submitted ingredient cost, submitted Other Payer Patient Responsibility Amount (OPPRA), WAC,OAAC, or the submitted gross amount due (GAD).

8.1.1 OAAC Rate Review

Providers that would like to request an OAAC rate review should contact Myers and Stauffer for an initial review. Providers may contact Myers and Stauffer's OAAC Pharmacy Help Desk by calling 1-800-591-1183 or by emailing OHPharmacy@mslc.com. Providers may view more information or download the OAAC Rate Review Form at: https://myersandstauffer.com/client-portal/ohio. If Myers and Stauffer denies the initial review, providers may contact ODM at: MedicaidSPBM@medicaid.ohio.gov and request an OAAC Rate Appeal. ODM will review the request and provide a response. ODM's decision is final and no additional appeal rights are available. Providers may be asked to submit additional documentation to substantiate the request.

8.2 PROVIDER DISPENSING FEES

Gainwell Technologies will pay billing providers 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.
For tiering and reimbursement, refer to the table below.

Table 20 Provider Dispensing Fees

Pharmacy Volume	Dispensing Fee Amount
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.	
Other Dispensing Fees	
Total Parenteral Nutrition (TPN) Dispensing Fee	$15 per day, capped at $150
Sterile Compounding Dispensing Fee	$10 per day, capped at $70

Long-Term Care Facility (LTC) members identified as living in a long-term care facility, including nursing facility (NF) or intermediate care facility for members with intellectual disabilities (ICF/IID), will be reimbursed for one dispensing fee per drug/strength/formulation, per recipient, per pharmacy, per month for all medications:

Refer to Section 5.8 - Compounds, for additional instructions on submitting a sterile compound or TPN claim.

8.3 Provider Payment

Pharmacy providers will be paid for each prescription dispensed. Reimbursement will include the ingredient cost, as noted in Section 8.1 – Ingredient Cost. The dispensing fee, as noted in Section 8.2 – Provider Dispensing Fees, less any member copay and TPL payment amount. In lieu of a dispensing fee, a medication administration fee will be paid when applicable.

8.4 Provider Remittance Advice

For remittance advice, please visit the SPBM web portal at: https://spbm.medicaid.ohio.gov. In the upper right-hand corner of your screen, sign into the "secure" portion of the SPBM web portal (using your OH|ID credentials) and navigate to "File Exchange" then "Reports" and "Remittance Advice."

8.5 Provider Form 1099

Any provider who receives payments from Gainwell Technologies on behalf of the Ohio Department of Medicaid meeting or exceeding the $600 threshold for reporting will receive an IRS form 1099 from ODM**.** In accordance with federal guidelines, the 1099 form will be electronically filed with the IRS by the due date annually.

8.6 Pharmacy Claim Reimbursement Disputes and Resolution

To file a reimbursement dispute, please contact the Claims Department via any of the following:

Table 21 Claims Department Contact Information

Contact Method	Information
Web Portal	https://spbm.medicaid.ohio.gov
Email	OH_MCD_CLAIMS@gainwelltechnologies.com
Mail	Gainwell Technologies Attn: Claims Dispute PO BOX 3908 Dublin, OH 43016-0472

Where possible, please direct the inquiry to Attention: Claims Dispute

8.6.1 Dispute Timely Filing

To be eligible for reconsideration, claims disputes must be filed in a timely manner. Disputes must be received by the latter of:

- Within 12 months of the DOS of the claim in dispute
  OR
- 60 calendar days after payment/denial of the claim in dispute.

Any disputes received for claims outside of these guidelines will not be considered.

8.6.2 Process Overview

Upon receipt of a valid dispute, the initiating provider will be sent an acknowledgement letter within five business days. The dispute will be investigated, and a status update will be provided within 15 business days.

If it is determined that the claim did not adjudicate or price in accordance with policy, Gainwell Technologies will implement the required system changes and notify the disputing provider once the corrections are made so that the claim in question may be reversed and resubmitted.

If it is determined that the claim adjudicated and priced in accordance with policy, no further action will be taken. If an additional reconsideration is requested, directions will be included on the letter explaining the determination. Enrolled pharmacies are not permitted to balance bill members.