

IEHP Pharmacy Program Manual (Jan 2010)

Category	Title	Guidance
Benefit	Argus Customer / Client number	Medi-Cal: 255-100; Healthy Families: 255-200; DualChoice: 411-800 255-400 Riv. Co. Healthy Kids 255-500 Open Access 255-700 S.B. Co. Healthy Kids
Benefit	Healthy Families Plan Code	<p>GROUP Plan Code Description Copay Level</p> <p>RVC-HFI HI Hf Member Up to 1yr of age (based upon age on the first day of the month) \$0</p> <p>SBC-HFI HI Hf Member Up to 1yr of age (based upon age on the first day of the month) \$0</p> <p>RVC-HFP HI HF Member Up to 2yr of age (based upon age on the first day of the month) \$0</p> <p>SBC-HFP HI HF Member Up to 2yr of age (based upon age on the first day of the month) \$0</p> <p>RVC-HFP HO HF Member Copay Maximum Out of Pocket Met \$0</p> <p>SBC-HFP HO HF Member Copay Maximum Out of Pocket Met \$0</p> <p>RVC-HFP HC HF Member \$5 Copay Benefit Package \$5</p> <p>SBC-HFP HC HF Member \$5 Copay Benefit Package \$5</p> <p>RVC-HFP HT HF Member \$10 Copay Benefit Package \$10</p> <p>SBC-HFP HT HF Member \$10 Copay Benefit Package \$10</p>

Benefit	Home Infusion	<p>Home Infusion Pharmacy</p> <ul style="list-style-type: none"> a. IEHP Members (other IPA) <ul style="list-style-type: none"> i. Drugs and drug-related per diem codes (i.e. TPN, antibiotics)- submit to IEHP ii. Home Infusion Supplies and administration-prior authorization and claims must be submitted to IPA b. IEHP Members (IEHP Direct) <ul style="list-style-type: none"> i. Drugs and drug-related per diem codes (i.e. TPN, antibiotics)- submit to IEHP ii. Home Infusion Supplies and administration-submit to IEHP c. IEHP DualChoice Members <ul style="list-style-type: none"> i. Home infusion drugs are covered under Part D. Part B covered drugs is covered IEHP ii. Home Infusion Supplies and administration-prior authorization and claims must be submitted to IPA (or IEHP Direct)
Benefit	Lost or stolen/ vacation override	<ul style="list-style-type: none"> a. Lost or stolen medication may be approved for no more than a 60-day supply (or 90 days for maintenance). Only one replacement will be approved per member per calendar year. Pharmacy should inform the Prescriber if the lost/stolen medication is a narcotic medication. IEHP will not authorize vacation supplies beyond a 60 day supply as eligibility for Medi-Cal is questionable when the Member is absent from the area for more than 2 months. b. Pharmacy may submit vacation override on behalf of a Member by submitting PER to IEHP. Only one vacation override will be approved per member per calendar year.
Benefit	Medical Supplies	<p>Medical supplies such as incontinence supplies (IEHP Direct Members), Ostomy Supplies (IEHP Direct Members), and Diabetic Supplies may be provided through Pharmacy Providers. Please refer to the Diabetic Test Strip Criteria for details.</p>
Benefit	Oral/ Enteral Nutrition Products	<p>Enteral nutrition products may be covered only in patients with medically diagnosed conditions that preclude the full use of regular food. Approvals may be granted for member who has permanent nonfunctional disease of the structures or disease of the small bowel which impairs digestion and absorption of an oral diet. A nutrition evaluation form must be submitted to IEHP for evaluation. Oral nutrition products may only be approved if there is a medical conditions and BMI/growth chart is below normal level. Regular milk based products should be obtained through WIC.</p>

Benefit	Smoking Cessation	<p>Chantix</p> <p>The approval of varenicline (Chantix) is limited to one (1) 12-week course, and may extend to additional one (1) 12-week course if physician determines that you have successfully quite smoking. You are required to enroll into the Chantix Smoking Cessation Program before the refill can be obtained (www.get-quit.com or 1-877-CHANTIX (242-6849)- the certificate must be provided to the pharmacist).</p>
Benefit	Smoking Cessation	<p>Zyban</p> <p>The approval of varenicline (Chantix) is limited to one (1) 12-week course, and may extend to additional one (1) 12-week course if physician determines that you have successfully quite smoking. You are required to obtain smoking cessation certificate by calling 1-800-NO-BUTTS (1-800-668-8887) for the second refill (the certificate must be provided to the pharmacist).</p>
Benefit	Smoking Cessation	<p>Nicotine</p> <p>Nicotine replacement product should be used according to the instruction. Therapy is restricted to 8 weeks to 12 weeks only, and may extend to additional one (1) 8-12 week course. You are required to obtain smoking cessation certificate by calling 1-800-NO-BUTTS (1-800-668-8887) for the second refill (the certificate must be provided to the pharmacist). Non-compliant Members who utilize more than 8-12 weeks therapy should consider alternative treatment plan.</p>
Benefit	Test Strips-Medicare	<p>Test strips are covered under Part B for Medi-Medi Members. Pharmacy should bill FFS Part B copay balance to IEHP. For IEHP DualChoice Members, Pharmacy should bill 411.</p>
Benefit	Vaccine-Part D	<p>Adult vaccines are covered under Part D and may be provided by the Pharmacy Provider. Please see the Argus Instruction on Vaccine administration thru IPNS.</p>

Claim Submission	Compounding	<p>Compounded prescription (non-injectable) request must be submitted to IEHP using the PER form and the Compounded Drug Information Sheet. All active ingredients must be clearly printed on the "compound info sheet" and submit to IEHP for approval. Standard compounding fee is \$7.5 per prescription, however, IEHP will consider the time for preparation and will make exceptions on a case by case basis.</p> <ul style="list-style-type: none"> • Submit NDC of the highest cost ingredient item • Submit the total quantity of the amount dispensed • Compound Indicator=2
Claim Submission	National Provider Identifier (NPI)	Pharmacies must submit Pharmacy's NPI number and Prescriber's NPI number on each pharmacy claim
Claim Submission	NDC requirement	All physician administered drug claims must have NDCs along with the HCPCS codes
Claim Submission	Retro Prior Authorization (PER)	<p>Prior Authorization submission Timeliness Guidance for Retroactive Pharmacy Exception Request - All Prior Authorization (PER) request must be submitted prior to the service. A retroactive PER may be considered for review only under the following conditions:</p> <ol style="list-style-type: none"> a. If the request is received within 15 business days of the date the drug was dispensed (retail pharmacy)- pharmacy needs to justify for the delay. b. If the request is received within 10 days of the date from the date of service for SNF or outpatient non-retail pharmacy settings (i.e. dialysis center, outpatient infusion center) Retroactive PER requests must include all medical justifications and cannot be submitted as urgent. c. When other healthcare coverage denied payment of a claim of services. Pharmacy must submit PER with 60 calendar days from the date of denial from other health plan. d. When a Member has obtained retroactive eligibility. Pharmacy must submit PER with 60 calendar days from the date retroactive Medi-Cal eligibility was established.
Claim Submission	Timeliness of Submitted Claims	Pharmacies have up to 60 days from the date of service to submit claims online. The exceptions are: 1) retroactive eligibility- 60 days from the date retroactive eligibility was established; 2) Other health care coverage- 60 days from the time the other health care coverage rendered a payment determination

Claims Submission	California Children Services (CCS)	The California Children's Services (CCS) Program services children with certain physical limitations and chronic health conditions or disease through their 21st birthday. Covered services include physician services, drugs, and specialty medical care. The CCS authorization (SAR- service authorization request) includes coverage for prescribed medications used to treat the CCS eligible condition. All CCS covered services (services or medications) for CCS eligible conditions must be submitted to CCS as the primary payor.
Claims Submission	COB Screen in Argus	<p>a. Under POS screen, Other Amount Claimed field if it has a value populated in the Sub1 radio button</p> <p>b. Under the WrkComp radio button, the Other Coverage indicator: Here is a list of what those indicators mean.</p> <p>Coordination of Benefits (COB) Processing Code</p> <p>Code indicating whether or not the patient has other insurance coverage.</p> <p>00 Not Specified</p> <p>01 No other coverage indentified</p> <p>02 Other coverage exists-payment collected</p> <p>03 Other coverage exists-this claim not covered</p> <p>04 Other coverage exists-payment not collected</p> <p>05 Managed care plan denial</p> <p>06 Other coverage denied-not a participating provider</p> <p>07 Other coverage exists-not in effect at time of service</p> <p>08 Claim is a billing for a copay</p>
Claims Submission	Coordination of Benefits (Medicare)-	Medicare is the primary payer for Medi-Medi patients). Medicare crossover claims (from Part B) must be submitted electronically to the PBM. IEHP cannot cover co-payments for covered Medicare Part D drugs (from any Medicare Part D plans or IEHP DualChoice). IEHP is responsible for excluded Part D Drugs only.

Claims Submission	Coordination of Benefits (other primary payors)	IEHP Members may have prescription coverage through other payment sources. If Member has other primary health insurance coverage, pharmacy providers must submit claims to the other payment source first. The State law requires the Medi-Cal Members and Providers to notify the Department of Health Services if they believe a member has "other health coverage". Providers may also contact IEHP Pharmaceutical Services Department regarding the coverage information. IEHP is the payer of last resort for coordination of benefits claims. IEHP is responsible for co-insurance, and co-payments only after all prior authorization processes through the primary payer have been exhausted. All COB claims must be submitted electronically to the PBM. Please refer to the PBM's payer sheet for instruction. Per Title 22 of the California Code of Regulations, Providers may not refuse treatment of IEHP Members because 1) IEHP Member has other health care coverage 2) the Provider may be required to bill IEHP as a secondary (electronically or manually).
Claims Submission	Coordination of Benefits (other primary payors)	Submit information to Ops. Primary information should be updated in the master file. State and Federal statutes provide for Medi-Cal to be the payer of last resort. Generally, the provider must bill a recipient's Other Health Coverage (OHC) before billing Medi-Cal when OHC is known to exist. When other entitlements are discovered after billing Medi-Cal, the provider is prohibited from billing the third party because Medi-Cal payment (regardless of the percent of the provider's billed amount) constitutes payment in full.
Claims Submission	Emergency supplies	pharmacists are allowed to dispense up to 72 hours of supplies of any non-formulary medications under emergent situation. Pharmacist should document the "emergent situation" and submit the information to IEHP for approval.
Claims Submission	Member billing-cash payment	Under no circumstances may a Medi-Cal recipient (including IEHP Members) be billed or charged directly for after hours or delivery services (title 22). Pharmacies are not permitted to fill non-formulary prescriptions for cash payment in lieu of the PA process.
Claims Submission	Member Eligibility	Medi-Cal Automated Eligibility Verification System (AEVS) at 1-800-456-2387, or IEHP IVR hotline at 1-888-440-4340 (1-909-890-3800) Website: https://www.medi-cal.ca.gov/Eligibility/Login.asp

Claims Submission	Members with lost Part D Coverage	Transition: Pharmacy needs to submit claims to Wellpoint.
Claims Submission	New borns	Newborns are covered for the month of birth and the following month, provided their mother is an eligible IEHP Member. Pharmacies may submit claims for the Newborns by using mother's IEHP Member ID Number, the mother's full name, and date of birth. Newborns' eligibility after one month will be determined by Medi-Cal eligibility requirements.
Claims Submission	Part D Transition Override	To override a non-formulary or PA restriction: enter 21000 in the prior authorization field <ul style="list-style-type: none"> • The Temporary Supply Override Code will allow approval of claims for up to a 60- day supply. • The Temporary Supply Override Code will only be active for a Member's initial 90 days of eligibility with IEHP Medicare DualChoice. • The Temporary Supply Override Code applies to Part D Covered Drugs only, it does not apply to Conditional Part B drugs. IEHP will extend the transition coverage if Provider cannot be reached after the initial transition period.
Claims Submission	PCN/BIN	IEHP MEDICARE DUALCHOICE (For all Part D covered drugs) PCN: 04110000 BIN: 012353 IEHP MEDI-CAL, HEALTHY FAMILIES, HEALTHY KIDS & COMMERCIAL PCN: 02550000 BIN: 600428
Internal Resources	Drug	Mirena is available through Theracom Pharmacy NABP: 2121604 (888) 326-1001
Internal Resources	Drug	Rhogam- Optioncare can arrange for next day shipment except Friday; Accredo can arrange for delivery 42-72 hours.

Internal Resources	Drug	<p>Test strips- HDI: For requests regarding "non functional" meters...</p> <ol style="list-style-type: none"> Members can call the 1800 number on the back of the meter- 800-803-6025 Or we can call HDI and ask them to make outbound call to the member. (refer to the document) <p>Lost meter:</p> <ol style="list-style-type: none"> Need a new rx and call wellpoint again
Pharmacy Policy	Auto-Refill	All refill requests must be requested by the Member. Pharmacies are not allowed to enroll Medicaid Members to the auto-refill program. Pharmacies will be subjected to audit for compliance purposes.
Pharmacy Policy	Benefit	<p>Glucometer: For requests regarding "non functional" meters...</p> <ol style="list-style-type: none"> Members can call the 1800 number on the back of the meter- 800-803-6025 Or we can call HDI and ask them to make outbound call to the member. (refer to the document) <p>Lost meter:</p> <ol style="list-style-type: none"> Need a new rx and call wellpoint again
Pharmacy Policy	Carve-out list	List is maintained by DHCS, refer to Formulary book or reference doc; google keyword: non-capitated DHCS
Pharmacy Policy	Credentialing	IEHP maintains a credentialed pharmacy network. IEHP surveys network pharmacy annually to update the information. Any change in credentialing information between the annual updates must be submitted to Argus Health System and IEHP.
Pharmacy Policy	Formulary Update	IEHP publishes formulary booklet annually. The Formulary Books are sent to all network Physicians and Pharmacy Providers. In addition, the Formulary is updated on our Website periodically. A summary of the P&T changes is also available under Pharmaceutical Services section on our Website.
Pharmacy Policy	Healthy Families / Healthy Kids Annual Deductible	There is no copayment once the Annual Family Deductible exceeds \$250. Member must submit the receipt (Medical or pharmacy) to IEHP. IEHP will change the copayment status to "no copay".
Pharmacy Policy	Hospital Discharge medication	Contracted hospital and emergency room should provide sufficient discharge medication (normally 3-day supply) until the prescription can be filled at one of the network pharmacy.

Pharmacy Policy	Medicare As Secondary Payer (Medicare)	Medicare may be secondary payer in certain circumstances- when Member has health care coverage thru employer group, or other coverage such as workers' compensation. Please refer to the reference
Pharmacy Policy	Medicare- Best Available Evidence (BAE)	IEHP will update the LIS level if Member provides evidence that supports a different LIS level (resulting in a different copay level). Please review the reference for guidance.
Pharmacy Policy	Medicare- CMS Sanctioned Provider Exclusion Policy	Argus has a global edit to block all CMS Sanctioned Providers (via the Ingenix file) at POS. NCPDP error message #71- Prescriber is not covered and Argus error #261 Prescriber currently sanctioned. Argus will provide report to IEHP in a timely manner. IEHP is required to send notifications to Members regarding this. IEHP may audit claims that were paid before the information is available using RXfocus report.
Pharmacy Policy	Medicare- LICS Level	Level 1: not Full dual-eligible; Level 2: Full Dual-eligible- G: \$0; B: \$3.20; Level 3: institutionalized- Copay \$0
Pharmacy Policy	Medicare- Prescription Origin Code	Pharmacy Providers must submit Prescription Origin Code as of Jan 1, 2010. The value of 0 will be rejected for New Rx. 0=Not Specified; 1=written; 2=telephone; 3=electronic; 4=facsimile. POC is a mandatory requirement in the NCPDP Telecommunication Standard 5.1 option field 419DJ.
Pharmacy Policy	Member Reimbursement	While pharmacies should not seek reimbursement from IEHP Members, IEHP will review Member Reimbursement requests if the prescription label and the cash receipt are provided. IEHP will review and determine the decision based on medical necessity. Members may be issued a letter reminding them of the reimbursement and PER policy, and future reimbursement requests may not be granted.
Pharmacy Policy	Out of Area Pharmacy	IEHP provides health care coverages to residents in Riverside and San Bernardino Counties. IEHP contracts with pharmacies that operate within these two counties. All other contracting requests will not be granted unless there is a specific need that cannot be obtained within Riverside and San Bernardino Counties.

Pharmacy Policy	Pharmacy Audit	IEHP conducts Pharmacy Audits on a monthly basis (desktop and onsite) to ensure compliance with IEHP Pharmaceutical Services Policies and Procedures. IEHP may request Pharmacies to submit Corrective Action Plan (CAP) based on the results of the Audit. Pharmacies that are found to be consistently non-compliant may be terminated from the network.
Pharmacy Policy	Pharmacy Complaints and Grievance	Pharmacy must respond to IEHP's complaints and/or grievance requests in writing within 5 business days. Late responses will not be submitted to the IEHP Grievance Department for consideration. Pharmacies that are found to have a high unresolved grievance and complaint rates may be terminated from the network.
Pharmacy Policy	Return to Stock	Pharmacies should reverse all prescriptions filled and submitted for payment, but not picked up by the Member within 14 calendar days of date of service. Claims that are not reversed according to this policy is subject to recoupment via onsite and desktop audit.
Pharmacy Policy	Signature Log Requirement	<p>a. The Pharmacy must maintain a signature log at all time. The Pharmacy must obtain signature from the Member during pick up (Members' ID must be verified). The log must contain the prescription number or a description of the drugs dispensed, the signature, and the date the medication was picked-up. The Pharmacy must make the signature log record available for a minimum of five years for audit purposes.</p> <p>b. Delivery log- For drugs that are delivered to the Member's home, a signature must be obtained. The Member Name, address, prescription number, date, time of the delivery, signature and name (printed) must be present in the delivery log.</p>
Pharmacy Policy	Vaccine Administration	H1N1- \$9 per administration (MC, HF, HK) ; report must be provided by the pharmacy; DualChoice- part D rate
Prior Authorization	Part D Requirement	Standard- 3 days; expedited- 1 day. Expedited requests may be submitted by physicians, or by the Member (must have physician's supporting document).
Prior Authorization	PER Submission	PERs may be submit via online at www.iehp.org (please call IEHP to obtain login password) or via fax at 909-890-2058
Prior Authorization	PER Timeline	PERs are reviewed and determined (approved, denied, deferred or misdirected) within 1 business day if all necessary information is provided.