OneCare Pharmacy Services Program Procedures

CalOptima Health's OneCare (HMO D-SNP), a Medicare Medi-Cal plan, serves Orange County's dual-eligible beneficiaries. OneCare contracts with a pharmacy benefit manager (PBM) to assist in the administration of the OneCare Pharmacy Program. OneCare is responsible for pharmacy management, policy development and overall program administration. OneCare oversees the PBM in assisting the pharmacy network with claims processing and daily operations.

Confidentiality Requirements

OneCare is responsible for ensuring confidentiality and protecting the interests of its members. Personal information related to OneCare members is confidential and protected from unauthorized disclosure. The identity of an individual receiving public services/assistance is protected by federal law. In addition, all information, records, data and data elements collected and maintained by participating pharmacies pertaining to members shall be protected by the pharmacies from unauthorized disclosure. Provision of such information shall be limited only to purposes of pharmacy service delivery.

Determination of Eligibility for OneCare

Eligibility for Medicare benefits is determined by the federal government. CalOptima Health's role is to administer the Medicare Advantage Prescription Drug (MA-PD) plan benefits for those who choose OneCare for their Medicare benefits.

Member Eligibility Verification

Pharmacies are required to verify eligibility* and provide services to OneCare members in accordance with the Participating Pharmacy Agreement (PPA):

- Upon presentation at the pharmacy, ask to see the member's OneCare membership card.
- If the member is not eligible via online transmission, call CalOptima Health's Interactive Voice Response (IVR) System at **800-463-0935**. If this is not available, call **877-412-2734** to obtain member eligibility information from our Customer Service department.
- Pharmacies may also transmit an E1 query to Medicare/CMS. Pharmacists must include, at a minimum, the following patient information in the E1 request for a match to occur:

    1. Cardholder ID, which can be any one of the following:
        - The beneficiary's Medicare Beneficiary Identifier (MBI) as it appears on the beneficiary's Medicare card, or
        - The LINET Cardholder ID as returned on the E1 response or found on an enrollee's confirmation of enrollment letter
    2. Patient's last name

3. At least the first letter of the patient's first name
4. Patient's date of birth
5. ZIP/Postal Code

- Pharmacies will only be able to submit Medicare Part D as well as Medicare Part A/B eligibility queries in NCPDP version D.0 format. Payer sheets and an explanation of the services available are on the Medicare Part D Transaction Facilitator website at https://medifacd.mckesson.com.
- If the member is eligible for OneCare coverage, a Customer Service representative will add the member into the pharmacy system to enable online claims transmissions.

*** While the member's eligibility status is researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications pending eligibility verification.**

OneCare Part D Outpatient Prescription Drug Benefit Summary

The OneCare pharmacy benefit includes a formulary for brand-name and generic drugs. The OneCare formulary can be found on the OneCare website at https://www.caloptima.org/en/ForProviders/PharmacyInformation/OneCareMedicarePartD.aspx

OneCare members will have co-pays** of $0.00 for formulary generic drugs, and up to $10.35 for formulary brand drugs.

***Members who reside in a long-term care facility may have different out-of-pocket drug costs.*

The following drug categories are excluded from coverage under Medicare Part D, but may be covered by Medi-Cal Rx:

- Drugs for the symptomatic relief of cough and cold
- Drugs used for anorexia, weight loss or weight gain
- Some non-prescription (over-the-counter [OTC]) drugs
- Some prescription vitamin and mineral products (combination vitamin/mineral products or dietary supplements are not a benefit)

To determine if a drug is covered under Medi-Cal Rx, please visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home.

Claims Submission

Claims may be submitted or reversed online up to 180 days from the date of fill under OneCare. Below is the billing information to submit covered Part D Medication claims via point of service to OneCare and Medi-Cal Rx for excluded Part D medications:

OneCare Plan		**Medi-Cal Rx**	
Covered Part D medications		*Excluded Part D medications*	
BIN:	015574	BIN:	022659

PCN:	ASPROD1	PCN:	6334225
Group Number:	CAT04	Group Number:	MediCalRx

Becoming a Medicare Provider

In order to serve OneCare members, a pharmacy must have a Medicare supplier ID. The first step to becoming a Medicare provider is to contact the National Supplier Clearing House in Columbia, South Carolina, at 866-238-9652 and request an application for a Medicare supplier ID number.

OneCare Health Networks

Members will select a primary care provider (PCP) who is contracted with one of OneCare's Medical Groups:

- AltaMed Health Services
- AMVI Care Medical Group
- Family Choice Medical Group
- HPN-Regal Medical Group
- Noble Mid-Orange County
- Optum Care Network – Arta
- Optum Care Network – Monarch
- Optum Care Network – Talbert
- Prospect Medical Group
- United Care Medical Group

OneCare Identification Card

Each covered member is assigned a unique nine-digit alpha-numeric Client Index Number (CIN). The CIN on the member's OneCare identification card will be used for claims adjudication. In addition, the member's date of birth must be submitted on each claim.

For claims submissions, please do not submit a code (e.g., 01, 02, etc.).

Prescriber Identification Required

Only the pharmacy's National Provider Identifier (NPI) number and prescriber's individual NPI number may be submitted online for pharmacy claims.

The NPI Online Registry enables you to search for a provider's NPI number: https://npiregistry.cms.hhs.gov/search

If the prescriber does not have an individual NPI number or the prescriber's organizational NPI number is used, the claim will be rejected. Prescribers with no NPI number should refer to the following website to apply for an NPI number: https://nppes.cms.hhs.gov/#/

Online Drug Utilization Review (DUR)

The online Drug Utilization Review (DUR) process assists pharmacists in providing quality care by identifying potential therapeutic conflicts and drug-drug interactions. As claims are sent to the PBM, the DUR process assesses the safe and appropriate use of the prescription with regard to the claim's history of the patient. An online message is sent to the pharmacy when a potential problem exists and should be reviewed by a pharmacist. If assistance is required, please contact the PBM pharmacy help desk at 800-819-5532.

Prior Authorization (PA) Information

Online claims submitted for medications that require prior authorization (PA) may be rejected with any of the following online messages:

- "NDC Not Covered" or "Product/Service Not Covered"
- "Drug Requires Prior Authorization" or "Prior Authorization Required"
- "Plan Limitations Exceeded"
- "Cost Exceeds Maximum"

The purpose of prior authorization is to ensure the safe, effective and clinically appropriate use of medications that require prior authorization.

Prior to submitting a PA or exception request, the pharmacist should assess whether the prescribed medication may be changed to a OneCare formulary drug. If a clinically appropriate alternative exists on the OneCare formulary, pharmacists should discuss this option with the prescribing provider first.

An exceptions request or override may be required in the following situations:

- Prescriptions that exceed plan limitations for quantity, refill frequency, duration of therapy or cost
- Prescriptions that do not meet online DUR or step therapy restriction
- Lost/stolen/damaged medications
- Vacation supply requests
- Non-injectable compounded medications
- Most requests for brand drugs when generics are available

Pharmacies are not permitted to fill prescriptions for cash payment in lieu of the authorization process.

Every effort is made to provide a decision for each authorization request upon the initial submission. Pharmacists should make reasonable efforts to facilitate obtaining medical justification, including conferring with the prescriber to submit the necessary information. The decision to approve or deny each request is based upon the demonstrated medical necessity of the requested item for the condition and clinical circumstances stated by the prescriber.

If a request is **approved**, the pharmacy may dispense the prescription and submit the claim to the PBM. If a request is **denied**, OneCare will not be financially responsible for the medication.

Prior Authorization, Exceptions and Override Procedures

The PBM accepts PA, override and exception requests via phone, fax and online using the web submission form. Urgent requests can be submitted to the PBM's Prior Authorization department via phone or fax. An expedited review can be requested if the member or member's doctor believes that the member's health could be seriously harmed by waiting up to 72 hours for a decision. A decision will be made no later than 24 hours after we obtain a medical justification supporting statement from the prescriber.

Requests submitted by phone:

Prescribers may phone the PBM at 800-819-5532 for urgent or standard requests.

Requests submitted by fax:

Submit requests to the PBM's Prior Authorization department by fax at: 858-357-2556

- The PA form is revised periodically and is found on our website at https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Providers/Pharmacy/2022-09_CalOptimaHealthPAFaxForm_091422_508.ashx. Please use the most updated version of the form.
- The pharmacy should coordinate with the prescriber to assist in the completion and submission of the PA form.
- PA forms should be typed or printed. Forms that are illegible may be returned to the submitter or result in a delay in processing.
- Incomplete PA forms will be returned to the submitter for completion.
- Enter the diagnosis or the ICD-9-CM code that most accurately describes the member's diagnosis or indication for the medication. Include all medically relevant diagnoses for review purposes.
- Documentation of appropriate clinical information that supports the medical necessity of the requested item, quantity, refill frequency or duration of therapy must be noted on the form. Documentation of other drugs tried previously and their clinical outcomes is recommended. Include any additional documentation requested by the reviewer to support medical justification (e.g., questionnaires, letters of medical necessity, consultations, lab results, etc.).
- An authorization may be approved for a specific time duration, refill limitation or both. An authorization does not require the entry of an authorization number. Because of this, it is the responsibility of the dispensing pharmacy to process the approved item prior to releasing it to the member to guarantee payment.
- An authorization is not a guarantee of payment. Payment is subject to a member's eligibility and the pharmacy's participation in the pharmacy network.

Transition Fill Policy

New members in our plan may be taking drugs that are not on OneCare's List of Covered Drugs (formulary) or that are subject to certain restrictions, such as prior authorization or step therapy. Members should talk to their providers to decide if they

should switch to an appropriate drug that OneCare covers or request a formulary exception (a type of coverage determination) to get coverage for the drug.

While new members talk to their providers to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of membership. For each drug not on our formulary or that has coverage restrictions or limits, we will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy (and the drug is otherwise a Part D drug). After the first 30-day supply, we will not pay for these drugs, even if the new member has been a member of OneCare less than 90 days.

If the new member is a resident of a long-term care facility, we will cover at least a 91-day transition supply of drugs, and up to a 98-day supply, consistent with the dispensing increment (unless a member has a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new member. If a new member needs a drug that is not on our formulary or is subject to other restrictions, such as step therapy or dosage limits, but the new member is past the first 90 days of new membership, we will cover a 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to Part D drugs that are purchased at a network pharmacy. The transition policy cannot be used to purchase a non-Part D drug or drug out of network.

A transition supply can be obtained by contacting the PBM pharmacy help desk at 800-819-5532.

ESRD Medications

All end-stage renal disease (ESRD)-related injectable drugs, biologicals and oral equivalents are the financial responsibility of the patient's dialysis facility. These claims cannot be billed online through the PBM. Please contact the dialysis facility directly for contract information and billing instructions.

Step Therapy (ST) Restrictions

Claims for formulary drugs having step therapy protocols will process automatically if the specific criteria are met. Pharmacy manual override is not available. Please note if the claim is rejected, authorization is required. See the OneCare formulary for medications with step therapy restrictions.

Compounded Prescriptions

Compounded prescription drug products can contain: (1) All Part D drug product components, (2) Some Part D drug product components or (3) No Part D drug product components. Only costs associated with those components that satisfy the definition of a Part D drug are allowable costs under Part D because the compounded products as a whole do not satisfy the definition of a Part D drug.

Total Parenteral Nutrition (TPN) injectable and non-injectable compounded medications should be billed with the NCPDP version D.0 compound segment. TPN and non-injectable compound medications require prior authorization.

The claim will be reimbursed at OneCare's contracted rate for each ingredient and dispensing fee, plus a level of effort compounding fee. Additional information about online claim processing for compounds is available on the payer sheet.

Level of Effort			
LOE Rating	**DUR/PPS Code**	**Professional Allowance**	**Compound Type**
1	11	$15	• Single ingredient batched capsule • Any combination of commercially available products
2	12	$20	• Two or three ingredient batched capsule • Transdermal gel
3	13	$30	• Four or more ingredient batched capsule • Three or less ingredient cream/ointment/gel • Three or less ingredient capsule suppository • Two or less ingredient troche • Noncomplex suspension tablet triturate
4	14	$45	• Topical containing controlled ingredient • Three or more ingredient troche • Four or more ingredient cream/ointment/gel • Four or more ingredient capsule • Complex suspensions (e.g., pediatric) • Custom capsule (includes rapid dissolution preparations) • Chemotherapy cream/ointment/gel • Hormone therapy (capsules, troches and suppositories)
5	15	$7	• Sterile

TPN Billing:

Authorization for TPN is obtained through the PBM (TPN billing should include the non-standard additives*** and lipids; these should not be billed separately). Claims for TPN should be submitted online to the PBM using the NCPDP version D.0

compound segment. The claim will be reimbursed at CalOptima Health's contracted rate for each ingredient and dispensing fee plus a level of effort compounding fee.

*** Non-standard additives include added trace elements not from a standard multi-trace element solution (e.g., chromium, copper, iodine, manganese, selenium, zinc), added vitamins not from a standard multivitamin solution (e.g., folic acid, vitamin C, vitamin K) or products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran, famotidine, cyclosporine, ondansetron).

Durable Medical Equipment (DME)	Financial responsibility for DME varies depending upon the member's health network. For additional information on authorization and billing, please contact CalOptima Health's Claims department at **714-246-8885**.
Emergency Supply Policy	For an emergency override claim please call the PBM pharmacy help desk at 800-819-5532 for assistance.
Hospital Discharge Medication Supply	If a request is received via phone or fax by the PBM for a hospital discharge medication and the medication is not a benefit exclusion, the PBM may approve up to a 30-day supply of medication(s) for continuation of hospital discharge therapy. For an emergency override claim for hospital discharge medications, pharmacies should contact the PBM pharmacy help desk at 800-819-5532 for authorization.
Vaccines	Members may receive vaccines at a network pharmacy. The vaccine and administration fee of $20 can be billed online to the PBM.
Vacation Supply Request(s) and Lost or Stolen Medications	A vacation or replacement supply of medication requires authorization. Vacation supplies of medications may be approved for no more than a 90-day supply. For a vacation or replacement supply, please call the PBM pharmacy help desk at 800-819-5532 for assistance.
Return to Stock/Claim Reversal Required	Prescriptions filled and submitted for payment, but not picked up by the member within 14 calendar days of date of service, must be reversed online. This requirement applies to unused reusable stock in all types of pharmacies, including long-term care and home infusion pharmacies. Pharmacies will be audited for compliance with this procedure. Pharmacies are advised to maintain written or printed documentation of all reversals to demonstrate compliance with this requirement.

Third-Party Signature Log and Delivery Log

Third-Party Signature Log

The pharmacy must maintain a signature log acceptable to OneCare for every prescription dispensed to a OneCare member. The log must contain the prescription number or a description of the item or items dispensed and, if the recipient is not the member for whom the drug or device was ordered or prescribed, a notation of the recipient's relationship to that member and the date the medication was picked up. Logs must be available for a minimum of 10 years for audit purposes. OneCare does not require a separate signature log; the pharmacy's existing third-party signature log is sufficient. A member may sign once for more than one medication dispensed at the same time on the same day.

Delivery Log

The pharmacy must maintain a delivery log acceptable to OneCare for every prescription mailed or delivered to a OneCare member. The delivery log must include the following:

1. Member name and address
2. Prescription number
3. Date and time of the delivery
4. Signature and name (printed) of the delivery personnel
5. Recipient signature
6. If the recipient is not the member, name (printed) and relationship to the member

Payment Cycle

Pharmacies will receive payment weekly from the PBM.

Complaint and Grievance Procedures

Members may contact OneCare by phone or in writing about any aspect of their service provided or arranged by the pharmacy or plan. OneCare's Customer Service staff will explain the complaint/grievance process to the member and mail a complaint form upon request. A copy of the complaint form is also available through the CalOptima Health website, www.caloptima.org.

OneCare's Customer Service department: **877-412-2734**

OneCare's address:
OneCare
Attention: Customer Service
505 City Parkway West
Orange, CA 92868

Pharmacy Audit Program

OneCare conducts a comprehensive audit process to assure pharmacy, member and prescriber compliance with OneCare program policies and procedures.

Pharmacy Credentialing	Any change in credentialing information must be provided in writing within 10 days of notice of change to MedImpact's Credentialing department at 858-357-2530. The credentialing process is repeated every 24 months, or upon OneCare's request.
Accessing Interpreter Services	Please contact OneCare's Customer Service department at **877-412-2734** for assistance in accessing interpreter services.
OneCare Pharmacy Management Department	For questions or additional information, please call the OneCare Pharmacy Management department at **714-246-8471**.