OneCare Complete Pharmacy Services Program Procedures

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

Confidentiality Requirements

OneCare Complete is responsible for ensuring confidentiality and protecting the interests of its members. Personal information related to OneCare Complete 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 must be protected by those pharmacies from unauthorized disclosure. Provision of such information is limited only to purposes of pharmacy service delivery.

Determination of Eligibility for OneCare Complete

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 Complete for their Medicare benefits.

Member Eligibility Verification

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

- Upon presentation at the pharmacy, ask to see the member's OneCare Complete membership card.
- If the member is not eligible via online transmission, call CalOptima Health's OneCare Complete Customer Service at **877-412-2734** to obtain member eligibility information.
- Pharmacies may also transmit an E1 query to Medicare/Centers for Medicare & Medicaid Services (CMS). Pharmacists must include, at a minimum, the following patient information in the E1 request for a match to occur:
  1. Cardholder ID
  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
- Refer to the **E1 Medicare Eligibility Matching Logic** for Pharmacy Submission Requirements at medifacd.mckesson.com/siteassets/documents/e1-medicare-eligibility-matching-logic.pdf
- Pharmacies will only be able to submit Medicare Part D as well as Medicare Part A/B eligibility queries in National Council for Prescription Drug Program (NCPDP) version D.0 format. Payer sheets and an

explanation of the services available are on the Medicare Part D Transaction Facilitator website at medifacd.mckesson.com.

- If the member is eligible for OneCare Complete coverage, a customer service representative will add the member to 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 Complete Part D Outpatient Prescription Drug Benefit Summary

The OneCare Complete pharmacy benefit includes a List of Covered Drugs (formulary) for brand-name and generic drugs. The OneCare Complete formulary can be found on our website at www.caloptima.org/en/for-providers/pharmacy#resources. OneCare Complete members will have $0 copays for generic drugs and up to $12.65 for brand-name 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 nonprescription (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 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 Complete. Below is the billing information to submit covered Part D Medication claims via point of service to OneCare Complete, as well as Medi-Cal Rx for excluded Part D medications:

OneCare Complete Plan		**Medi-Cal Rx**
Covered Part D medications BIN: 015574 PCN: ASPROD1 Group Number: CAT04		Excluded Part D medications BIN: 022659 PCN: 6334225 Group Number: MediCalRx

Becoming a Medicare Provider

In order to serve OneCare Complete 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 Complete Health Networks

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

- AltaMed Health Services
- AMVI Care Medical Group
- CalOptima Health Community Network
- Family Choice Medical Group
- HPN-Regal Medical Group
- Noble Mid-Orange County
- Optum
- Prospect Medical Group
- United Care Medical Group

OneCare Complete Identification Card

Each covered member is assigned a unique nine-digit alpha-numeric client index number (CIN). The CIN on the member's OneCare Complete 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 person 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: 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: 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 claims 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 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 Complete formulary drug. If a clinically appropriate alternative exists on the OneCare Complete formulary, pharmacists should discuss this option with the prescribing provider first.

An exception 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 restrictions
- Lost/stolen/damaged medications
- Vacation supply requests
- Noninjectable 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 on 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 Complete 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 their doctor believes the member's health could be seriously harmed by waiting up to 72 hours for a decision. A decision will be made no more 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 found on our website at: https://cop-p-001.sitecorecontenthub.cloud/api/public/content/e942cc279e1d4ff8acbd6edf819c93e5?v=f0b0a133. 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-10-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 previously tried 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 does not guarantee 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 the OneCare Complete formulary or that are subject to certain restrictions, such as PA or step therapy. Members should talk to their providers to decide if they should switch to an appropriate drug that OneCare Complete 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 nonformulary 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).

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 a 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 Restrictions

Claims for formulary drugs that have step therapy protocols will process automatically if the specific criteria are met. Pharmacy manual override is not available. Please note that if the claim is rejected, authorization is required. See the OneCare Complete 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 noninjectable compounded medications should be billed with the NCPDP version D.0 compound segment. TPN and noninjectable compound medications require prior authorization.

The claim will be reimbursed at the OneCare Complete contracted rate for each ingredient and dispensing fee, plus a level of effort (LOE) 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 nonstandard 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 an LOE compounding fee.

*** Nonstandard additives include trace elements not from a standard multitrace 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 nonnutritional purposes (e.g., heparin, insulin, iron dextran, famotidine, cyclosporine, ondansetron).

Durable Medical Equipment

Financial responsibility for Durable Medical Equipment (DME) varies depending on 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 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.
Maintenance Drug Supply	Members can receive a long-term supply of maintenance drugs found on the OneCare Complete formulary from a participating network pharmacy. Up to a 100-day supply can be filled for drugs that a member takes on a regular basis or for a chronic or long-term medical condition. A 100-day supply has the same copay as a one-month supply.
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 Requests and Lost or Stolen Medications	A vacation or replacement supply of medication requires authorization. A supply of medications for no more than 100 days may be approved. For assistance with a vacation or replacement supply, please call the PBM pharmacy help desk at 800-819-5532.
Return to Stock/Claim Reversal Required	Prescriptions filled and submitted for payment but not picked up by the member within 14 calendar days of the 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 Complete for every prescription dispensed to a OneCare Complete 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 Complete 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 Complete for every prescription mailed or delivered to a OneCare Complete 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 Complete by phone or in writing about any aspect of their service provided or arranged by the pharmacy or plan. OneCare Complete 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 on the CalOptima Health website at www.caloptima.org.

OneCare Complete Customer Service department: **877-412-2734**

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

Pharmacy Audit Program

OneCare Complete conducts a comprehensive audit process to ensure pharmacy, member and prescriber compliance with OneCare Complete 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 Complete's request.

Accessing Interpreter Services

Please contact OneCare Complete Customer Service department at **877-412-2734** for assistance in accessing interpreter services.

OneCare Complete Pharmacy Management Department

For questions or additional information, please call the OneCare Complete Pharmacy Management department at **714-246-8471**.