



OneCare Connect Plan (Medicare-Medicaid Plan) Pharmacy Services Program Procedures

CalOptima’s OneCare Connect Cal MediConnect Plan is a Medicare-Medicaid Plan (MMP) for Orange County’s dual-eligible (Medicare plus Medi-Cal) beneficiaries. OneCare Connect contracts with a Pharmacy Benefit Manager (PBM) to assist in the administration of the OneCare Connect Pharmacy Program. OneCare Connect is responsible for pharmacy management, policy development and overall program administration. OneCare Connect oversees the PBM’s role in assisting the pharmacy network with claims processing and daily operations.

Confidentiality Requirements

OneCare Connect is responsible to ensure confidentiality and to protect the interests of its members. Personal information related to OneCare Connect 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 Connect

Eligibility for Medicare benefits is determined by the federal government. CalOptima’s role is to administer the MMP plan benefits for those who choose OneCare Connect for their Medicare benefits.

Member Eligibility Verification

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

- Upon presentation at the pharmacy, ask to see the member’s OneCare Connect membership card.
- If the member is not eligible via online transmission, call CalOptima’s Interactive Voice Response (IVR) System at **1-800-463-0935**. If this is not available, call **1-877-412-2734** 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:
 - Submit 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 last name
3. At least the first digit of patient first name
4. Patient date of birth
5. ZIP/Postal Code (Optional – inclusion of the zip code fields increases the chances for a match)

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 <http://medifacd.relayhealth.com>.

- If the member is eligible for OneCare Connect 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 Connect Part D Outpatient Prescription Drug Benefit Summary

The OneCare Connect pharmacy benefit includes formulary brand-name and generic drugs. The OneCare Connect Formulary can be found on the OneCare Connect website at <https://www.caloptima.org/en/Providers/Pharmacy/OneCareMedicarePartD.aspx>.

OneCare Connect members are required to pay co-pays** up to \$0.00 for formulary generic drugs, and up to \$9.20 for formulary brand drugs.

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

Claims Submission

Claims may be submitted or reversed online up to 180 days from the date of fill. Below is the billing information to submit claims via point of service to OneCare Connect:

OneCare Connect Plan	
<i>Covered Part D and Medi-Cal Medications</i>	
BIN:	015574
PCN:	ASPROD1
Group Number:	CAT02

Drugs Formerly Covered Under Medicare Part B

Outpatient drugs formerly covered under Medicare Part B may be covered under the OneCare Connect pharmacy program. Some of these medications require prior authorization to determine if coverage should be under Part B or Part D.

Becoming a Medicare Provider

In order to serve OneCare Connect 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 1-866-238-9652, and request an application for a Medicare supplier ID number.

OneCare Connect Health Networks

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

- AltaMed Health Services
- AMVI Care
- Arta Western Medical Group
- CalOptima Community Network
- Family Choice Medical Group
- HPN-Regal Medical Group
- Monarch Physician Group
- Noble Mid-Orange County
- Prospect Medical Group
- Talbert Physician Group
- United Care Medical Group

OneCare Connect Identification Card

Each covered member is assigned a unique nine-digit alpha-numeric Client Index Number (CIN). The CIN on the member's OneCare Connect 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 NPI number and prescriber’s individual NPI number (National Provider Identifier) may be submitted online for pharmacy claims. The NPI Online Registry enables you to search for a Provider’s NPI number: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

If the prescriber does not have an individual NPI number or the prescriber’s organizational NPI number is used, the claim will reject. Prescribers with no NPI number should be referred to the website to apply for an NPI number: <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>

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 1-800-819-5480.

Prior Authorization (PA) Information

Online claims submitted for non-formulary medications or 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 contact the prescriber to submit a PA or exception request, the pharmacist should assess whether the prescribed medication may be changed to a OneCare Connect formulary drug. If a clinically appropriate alternative exists on the OneCare Connect 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 restrictions
- 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 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 Connect will not be financially responsible for the medication.

Prior Authorization, Exceptions and Override Procedures

The PBM accepts PA, override and exceptions 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 CalOptima obtains a medical justification supporting statement from the prescriber.

Requests submitted by phone:

Prescribers may phone the PBM at 1-800-819-5480 for urgent or standard requests.

Requests submitted by fax:

Submit requests to the PBM's Prior Authorization department by fax at: 1-858-357-2556

- The PA form is revised periodically and is found on our website at www.caloptima.org. 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 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 specific time duration, refill limitation or both. An authorization does not require 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 Connect'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 CalOptima covers or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug.

While these new members might 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 new membership. For each of the drugs that is not on our formulary or that have 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 Connect 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 of our plan. If a new member needs a drug that is not on our formulary or subject to other restrictions, such as Step Therapy or dosage limits, but the new member is past the first 90 days of new membership in our plan, 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 those drugs that are “Part D drugs” and 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 1-800-819-5480.

ESRD Medications

All ESRD-related injectable drugs, biologicals and oral equivalents of those injectable drugs and biologicals 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 (ST) 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 Connect 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.

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 Connect’s contracted rate for each ingredient and dispensing fee, plus a level of effort compounding fee effective March 1, 2013. 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 Ingredients 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

Total Parenteral Nutrition (TPN) Billing:

Authorization for TPN (TPN billing should include the non-standard additives*** and lipids; these should not be billed separately) is obtained through the PBM. Claims for TPN should be submitted online to the PBM using the NCPDP version D.0 compound segment. The claim will be reimbursed at OneCare Connect’s contracted rate for each ingredient and dispensing fee plus a level of effort compounding fee effective March 1, 2013.

*** 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, and vitamin K) or products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran, famotidine, cyclosporine and 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 Claims department at **1- 714-246-8885**.

**Emergency Supply
Policy**

For an emergency override claim, please call the PBM pharmacy help desk at 1-800-819-5480 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 claims for hospital discharge medications, pharmacies should contact the PBM pharmacy help desk at 1-800-819-5480 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 1-800-819-5480 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 Connect for every prescription dispensed to a OneCare Connect 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 date the medication was picked up. Logs must be available for a minimum of 10 years for audit purposes. OneCare Connect 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 Connect for every prescription mailed or delivered to a OneCare Connect 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 Connect by phone or in writing about any aspect of their service provided or arranged by the pharmacy or plan. OneCare Connect’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 website, www.caloptima.org.

OneCare Connect’s Customer Service department phone number: **1-855-705-8823**

OneCare Connect’s address:

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

Pharmacy Audit Program

OneCare Connect conducts a comprehensive audit process to assure pharmacy, member and prescriber compliance with OneCare Connect 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 via fax at 1-858-357-2530. The credentialing process is repeated every 24 months or upon OneCare Connect’s request.

Accessing Interpreter Services

Please contact OneCare Connect’s Customer Service department at **1-855-705-8823** for assistance in accessing interpreter services.

OneCare Connect Pharmacy Management Department

For questions or additional information, please call the OneCare Connect Pharmacy Management department at **1-714-246-8471**.